# Development and psychometric evaluation of the nurse caring patient scale

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# DEVELOPMENT AND PSYCHOMETRIC EVALUATION OF THE NURSE CARING PATIENT SCALE

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Development and Psychometric Evaluation of the Nurse Caring Patient Scale

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A metasynthesis of 90 published qualitative studies was conducted on the nurses', students', and patients' perception of nurse caring. A mid-range theory of Nurse Caring emerged from the data, including three attributes: Presence, Concern for the Other, Knowledgeable, Competent Care, and Respect for the Person. The Nurse Caring Patient Scale (NCPS) was developed from patient descriptors within the metasynthesis. NCPS was tested to establish the psychometric properties of the instrument with 341 adult acute in-patients of a northeastern United States metropolitan teaching medical center. Initial reliability for total NCPS was .92. Factor analysis using principal components analysis with varimax rotation resulted in a parsimonious three factor solution that accounted for 50.49 % of the total variance. The final NCPS was 23 items with an alpha of .91. Component 1 (Presence, Concern for the Other) was comprised of 11 items with an alpha of .89. Component 2 (Knowledgeable, Competent Care) contained five items with an alpha of .77. Component 3 (Respect for the Person) had seven items and an alpha of .73. Participants were asked to write about an experience with a nurse. Components of caring and uncaring experiences described by participants did not add to the body of data from the metasynthesis or to the items of the NCPS. This study was limited by sample population, and the items of NCPS may be applicable only to those included in the synthesized qualitative studies. The metasynthesis of qualitative studies and mid-range theory of Nurse Caring add to the theoretical concept of caring by including the patients'

perceptions of the nurse-patient encounter. Components of Nurse Caring add competency, and respect to presence with the patient for a comprehensive definition of caring. NCPS offers nurses and administrators a valid reliable measure for patient perceptions of quality of care and satisfaction that were until now unseen and unmeasured. The theory of Nurse Caring provides nurse educators with a framework for nursing curricula, since the theory incorporates all aspects of nursing practice within its definition.

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# CHAPTER 1

## Introduction

### *Statement of the Problem*

A nationwide inquiry (2004) of the public's perception of health care quality reported that 55% of consumers surveyed were dissatisfied with health care in 2004, as compared to 44% in 2000. This study, conducted by the Kaiser Foundation, asked patients to rate their health care services, including experiences with medical errors, and asked patients to offer suggestions for change within the health care system. Despite the increased dissatisfaction noted by this national survey, there was lack of data exploring the clients' perceptions of their dissatisfaction with care. Dr. Drew Altman, President of Kaiser Family Foundation (2004), noted that quality health care from the patients' perspective was not about numbers or outcomes, but about their personal experience.

Nurses comprise the largest group of employees within a hospital. While nursing care often represents the largest share of the patient care experience, few responses on patient satisfaction surveys reflect questions that evaluate the nurse-patient encounter. Professional nurses respond to consumers' call for patient centric care (American Nurses Credentialing Center, 2008; Institute of Medicine, 2003) by ensuring competency in clinical practice (e.g. clinical certifications), focusing on improvements in patient satisfaction with care, and promoting best practices. While the quality of technical nursing care can be measured by competency testing, and patient satisfaction data for specific nursing interventions (e.g. intravenous therapy techniques and pain management), other components of nursing care are not considered. Nurse-patient caring

encounters that do not focus on technical competence remain hidden and unmeasured (J. E. Rogers, 1990a). As a result, caring, the essence of nursing (American Nurses Association, 2004), is missed by traditional screening mechanisms.

Nursing scholars have attempted to describe and measure patient experiences with nursing practice within the framework of caring. This focus has resulted in a variety of theoretical definitions about caring. In addition, a variety of instruments have been developed to measure caring behaviors. Despite this work, there remains an inability to clearly define the ontology of nurse caring, in part resulting from a focus on nursing perspectives of caring with

little or no inclusion of the patients' perceptions of feeling cared for (Morse et al., 1990; Paley, 2001; Rankin, 2003). Although the number of qualitative studies exploring patient health care experiences has increased in recent years, there has been no comprehensive synthesis of the qualitative data to evaluate this body of literature. In addition, there has been no development of a valid, reliable instrument to capture the patients' perceptions of nurse caring from these synthesized studies.

*Background*

For more than 25 years, nurses have attempted to describe caring from a disciplinary perspective. Nursing theories, including Leininger's Theory of Cultural Care (1989), and Watson's Theory of Human Caring (1985, 2006) developed theoretical constructs to operationalize caring as a central component of professional nursing. A middle range theory of caring developed by Swanson (1991), and a caring model, Modes

of Being With Another (Halldorsdottir, 1991), were generated to describe caring and uncaring nursing behaviors.

The development of instruments to measure the concept of caring built upon these theoretical perspectives provided additional knowledge and a better understanding of the caring phenomenon within the context of nursing science. Since 1984, 25 instruments, including revisions (see Appendix A), were developed to measure dimensions of caring (Radwin, Alster, & Rubin, 2005; J. Watson, 2002; Wolf et al., 2006; Wu, Larrabee, & Putman, 2006). For example, Larson (1984) developed an instrument that allowed nurses and patients the ability to prioritize nurse caring behaviors. Larson's CARE-Q survey, administered to other patient populations and cultures (Gooding, Sloan, & Gagnon, 1993; Holroyd et al., 1998; Komorita, Doehring, & Hirchert, 1991; Larson, 1984, 1986; Rosenthal, 1992; von Essen & Sjoden, 1991b, 1993, 2003; Widmark-Petersson, von Essen, & Sjoden, 1996, 1998a, 1998b, 2000), validated Larson's (1984) earlier findings . In resulting data from these studies, patients stressed professional competency as a priority for care overall, while nurses stressed psychosocial skills as the priority for nursing care.

Another frequently cited caring instrument, the Caring Behaviors Inventory (CBI), developed by Wolf (Brunton & Beaman, 2000; Green, 2004; Larrabee et al., 2004; Wolf, 1986, 1998a, 1998b; Wolf, Giardino, Osborne, & Ambrose, 1994) measured nurses' perceptions of nurse caring. A later adaptation of the CBI, Caring Behavior Inventory for Elders (CBI-E)(Wolf et al., 2004; Wolf et al., 2006) was developed to evaluate elder adults' perceptions of nurse caring. The CBI was constructed from a

nursing theoretical concept of caring. CBI-E was derived the original instrument. The CBI-E survey was piloted among one group of elders and reviewed by nursing experts for content validity prior to psychometric evaluation.

Qualitative research studies on caring have been conducted using case studies [e.g. Engebretson (2000)], ethnography [e.g. Cara (2001), Rankin (2003)], grounded theory [e.g. Bowers (1987), Powell-Cope (1994)], qualitative descriptive [e.g. Collins, McCoy, Sale, Weber (1994), Hogan (2000)],and phenomenology [e.g. Appleton (1990), Beck (1991, 1992b), Gramling (2004), Halldorsdottir & Karlsdottir (1996)] to explore the concept from nurses, nursing students, patients and caregivers' perspectives. In each study, nurse researchers distilled the information provided by study subjects into a set of themes and subthemes that described caring interactions between nurses or nursing faculty and their clients (patients or students) (see Appendix B). From 1984-1990, there were 21 qualitative studies published in the nursing literature specifically exploring caring behaviors from nurse or patient perspectives. Of these studies, ten were from the nurse's perspective, three involved students, one involved nurses and patients, and seven involved patients (in two of the patient studies the sample size was one).

In the early 1990's there was a focus on the patient's perception of caring in order to provide a more complete definition of the concept (Meleis, 1992; Morse et al., 1990). Additional qualitative research, exploring patients' perceptions of the nurse-patient encounter, was one response to this proposal. From 1990-2005, 69 qualitative studies on perspectives of caring were reported in the literature. Of these, 34 involved patient/family interviews or observations. Previous theoretical work, instrument

development, and qualitative research conducted to further caring knowledge, have been subjected to the criticism that nursing epistemology of caring is incomplete and lacks the inclusion of the patient's perspective on the concept (Morse et al., 1990; Paley, 2001).

Nurses appear to have a personal viewpoint of what incorporates excellent nursing practice. This nursing perspective of excellence includes knowledge that embodied the art and science of the profession. At its essence, nursing is described as caring (American Nurses Association, 2004). In nurse-patient studies using CARE-Q (Larson, 1987; Rosenthal, 1992; von Essen & Sjoden, 2003), nurses viewed psychosocial behaviors as the most important caring function, but patients noted that technical competency as most important. In other quantitative studies using specific instruments to measure caring, nurses and patients reported different perspectives of nurse caring.

Data emerging from qualitative studies found that patients addressed some of the same concerns as the nurses about the psychosocial aspects of care such as connection, but added safety, competency, and respect in their descriptions of caring (Beauchamp, 1993; L. Brown, 1986; Fareed, 1996; Gramling, 2004; Somerville, 2005). Research data suggested the patient's perspective was needed to better describe to better describe the nurse-patient caring encounter.

Without the ability to better evaluate caring by nurses, some aspects of the nurse-patient experience continue to be invisible, with the full impact of nursing on patient outcomes hidden. Developing and testing an instrument synthesized from qualitative research about the impact of nursing care from the patients' viewpoint of the caring experience could offer a significant contribution to articulating nurse caring.

## *Purpose of the Study*

The purpose of this study had two aims. The first aim was to inductively derive a new comprehensive definition of the concept of caring by conducting a meta-synthesis of qualitative studies that asked nurses, students and patients about their perceptions of the nurse-patient encounter. Development and testing of the psychometric properties of an instrument, the Nurse Caring Patient Survey (NCPS), developed to measure the patient's perceptions of feeling cared for by nurses, was the second aim of this study. A descriptive question was included to validate the findings of the meta-synthesis and to provide further insight for future development of the instrument.

### *Research Questions*

Questions that guided the meta-synthesis were:

1. What were the specific perceptions of caring as reported by the researchers?
2. How were the nurses', students', and patients' perceptions of caring similar? How did they differ?
3. Could a single set of categories describe the reported perceptions of caring?

Research questions for the second aim of this study, instrument development, were:

1. To what extent does the NCPS demonstrate internal consistency reliability prior to establishing factoral validity?
2. To what extent can the components of NCPS, created from a metasynthesis of qualitative studies on caring be demonstrated in Principal Component Analysis?
3. To what extent do the resulting factors demonstrate reliability to stand as independent factors

4. What specific descriptors of caring (uncaring) are described by participants? Do the results of the descriptive question provide insight for further development of the instrument?

*Study hypotheses for analysis of the instrument*

1. The NCPS total scale, and the instrument subscales will attain a Cronbach's alpha co-efficient of .70 or greater.
2. Principal Components Analysis will result in three factors. Items that fall within each factor will have a positive relationship to patient descriptors of caring and uncaring encounters with the nurse as synthesized from the reviewed qualitative studies.

## *Definition of Study Terms*

Terms used throughout this study included the following:

1. Participants – Adult males and females admitted as in-patients to an acute care facility, irrespective of medical diagnosis, for at least 24 hours. An adult was defined as a person 18 years old or older.
2. Nurse – A Registered Nurse who may have had an associate degree, diploma, bachelor's degree, master's degree or doctoral degree as a terminal degree of education
3. Expert patient – An adult who had a recent (within 18 months) hospitalization of at least 24 hours.

4. NCPS –Nurse Caring Patient Survey that included 50 survey statements with Likert-scale responses, a demographic questionnaire, and one descriptive question requiring a short paragraph narrative.
5. NC –Nurse Caring, a new definition for caring derived from meta-synthesis of qualitative studies of caring, having three attributes; namely *Presence, Concern for the Other, Knowledgeable, Competent Care,* and *Respect for the Person.*

### *Study Assumptions for Instrument Development*

Throughout the study it was assumed that:

1. Participants were able to speak, read, and write English.
2. Participants were cognitively able to complete the tool on their own. Cognitive ability of the patient was determined by the nurse(s) caring for the patient when surveyed.
3. Participants completed the survey tool. The researcher or a family member may have assisted the participant with recording the responses to study questions, but the answers documented were the participant's.
4. Participants answered the statements truthfully and accurately.
5. Participants experienced nursing care during their in-patient hospitalization

### *Study Limitations*

The following limitations were addressed in the study:

1. The mid-range theory of Nurse Caring emerged from published qualitative studies in English since 1984. Studies published in other languages may not correspond with the current definition.

2. Outcomes of the study were limited to the demographics of the sample population. Other populations and cultures, if sampled, may provide different results.

### *Framework of the Study*

The framework for this study was guided by a theoretical representation of elements from the writings of theorists on caring (Gaut, 1983; Halldorsdottir, 1991; Leininger, 1981; Roach, 1987; M. C. Smith, 1999; Swanson, 1991; J. Watson, 2006) Caring has been a difficult concept to define because of its ubiquitous presence across professional disciplines and among humankind. Nurse theorists have attempted to describe caring as it pertains to nursing practice for decades. This study was structured on a synthesis of scholars' descriptions of professional nurse caring.

Gaut,(1983) described nurse caring as a practical activity based on knowledge. Roach (1987), influenced by Mayerhoff (1971) stated that caring was a human mode of being, but noted that nursing was professionalized caring where the object of care was valued. Leininger's (1981) Theory of Transcultural Nursing contained the concept of etic caring described as professional nurse caring. Etic caring was defined as cognitively learned behaviors that led the nurse to assist, support, enable and facilitate acts towards others. Watson's Theory of Human Caring (2006) emphasized in the Caritas Processes loving-kindness, a helping-trusting relationship, engaging in true teaching-learning, assisting with basic needs, and attending to the spiritual needs of the patient which contribute to the study's framework.

Swanson's Middle Range Caring Theory (1991) offered a description of caring that included: holding in esteem, being nonjudgmental, seeking cues (from the patient), listening, being present with, comforting, preserving dignity, protecting, supporting, and informing-explaining. Swanson noted noncaring behaviors such as controlling, ignoring and being task-oriented as important constructs to address. Hallsdorsdottir's (1991) model "Modes of Being with Another" focused on the spectrum of caring from the ideal called biogenic (life-giving) to its opposite biocidic (life-destroying) care. Descriptors of the spectrum of caring such as connecting with the true center of the other; restores; reforms; potentiates learning and healing; supports; encourages; reassures; gives security and comfort; is detached; causes discouragement, uneasiness, distress and despair; destroys joy of life; and hurts and deforms the other contribute a range of the caring-uncaring experience; and were considered important elements for the framework of this study.

Marlaine Smith (1999) analyzed caring knowledge and summarized it within the unitary-transformative paradigm. Smith's definitions of caring attributes important to this study framework included: preserving dignity and humanity; placing value on another as worthy of love; knowing the other; knowing when to move, speak, be silent, touch, and withdraw; spiritual union between nurse and patient; and transformation of each participant involved in the caring process.

The framework of this study also embraced a definition of caring that included the theoretical foundation (i.e. the relationship between the nurse and the patient) influenced by patient perceptions of the behaviors and actions by the nurse in the performance of

patient centric care. This theoretical foundation, new definition of caring, emerged from a synthesis of 90 qualitative studies concerning the relationship between the nurse and patient as related to researchers by nurses, students, patients and families.

Thorne, Jensen, Kearney, Noblit, and Sandelowski (2004) stated that meta-synthesis of qualitative research was a methodical process in which particular data within each study was analyzed, and formed into a new integrated interpretation. Synthesis of the reviewed studies resulted in the emergence of a mid-range theory of *Nurse Caring* (NC) containing three attributes. Attributes of NC were labeled *Presence, Concern for the Other; Respect for the Person;* and *Knowledgeable, Competent Care.* Each attribute contained descriptors of the nurse-patient encounter as related by nurses, students, and patients. NC provided a theoretical representation caring that differed from previous caring definitions derived from nursing theory on caring (Halldorsdottir, 1991; Leininger, 1991; Roach, 1992; M. C. Smith, 1999; Swanson, 1991; J. Watson, 2006), and caring themes listed in the meta-analyses of caring literature (Beck, 2001; Morse, Bottorff, Neander, & Solberg, 1991; Sherwood, 1997; M. C. Smith, 2004; Swanson, 1999; Tripp-Reimer & Cohen, 1990; Warren, 1988), because NC incorporated both nursing theoretical ideas of caring and the patient's nurse caring perspective. *Nurse Caring* included the spectrum of technical and interpersonal acts of caring and uncaring encounters between nurses and patients as listed in Appendix A. The three attributes of NC and the specific descriptors of caring and uncaring nurse-patient encounters given by patients provided the framework for developing an instrument to measure the patient's perception of feeling cared for by nurses.

*Significance of the Study Problem*

Meleis (1992) stated that nursing research in the 21st century would be built upon a synthesis of research findings. Although new instruments used to measure the patient's perception of feeling cared for by nurses have been developed, all were derived from nursing theoretical descriptors, a single qualitative study or a tool pilot. This silo approach reflected thinking in isolation. To date quantitative researchers have consistently approached the problem of learning about patient perceptions of feeling cared for by assuming knowledge about patient's needs and wants, and then asking patients, "How did you like the product (caring) we provided?" Scholars have also conducted qualitative studies using various settings, but there has been no metasynthesis of qualitative research that intentionally includes the patient's perception of feeling cared for by the nurse.

Synthesis of reviewed qualitative studies resulted in a blended (nursing/patient) theoretical definition of nurse caring. This emergent mid-range theory provided a focus for instrument development. An instrument developed from this approach, data synthesis to a theoretical definition, can now ask with some confidence, "How did you perceive the care you were given?" The answers may provide an objective appraisal of nurse caring, and may afford the opportunity for nurses to take action. Information from result of using this new instrument may also increase visibility of nurse caring, and better inform evaluations of patient satisfaction.

Patient centric care identified in professional practice models [e.g. Massachusetts General Hospital patient care services (2008), and the Institute of Medicine(2003)],

guided by American Nurses Credentialing Center's (ANCC) Forces of Magnetism (2008), are current standards for excellence in nursing practice. In a patient care delivery model such in the University of Virginia Health System (2008), patient/family-nurse relationships are the core of care. A new conceptual definition of nurse caring that is inclusive of patients' perceptions as described in new mid-range theory of *nurse caring*, may help to articulate the focus of the delivery of patient centric care within the professional practice models. Delivering nursing care with knowledgeable competence, with respect for human dignity, and with sense of being there in the moment in connection with the person receiving care, describes the scope of patient centric care as well as depicting the attributes of the mid-range theory of *nurse caring*.

The Nurse Caring Patient Scale should not only address symptom treatment (knowledgeable, competent care), but also the nurse-patient interaction which consists of being with and having concern for the other while demonstrating personal respect. Nurse caring is the primary product sold to the consumer in an in-patient situation (diagnostics and medical interventions aside). Impact of nursing care on the patients, as determined by an accurate evaluation of hidden and undocumented nurse behaviors using objective quantitative measurement, may provide data that can more accurately describe nursing's contribution to care outcomes, beyond measured technical skills. Further, comparison of data between groups may provide insights into disparities of care between different ages, genders, ethnicities, and those of differing socio-economic status.

Validation of the instrument can contribute in the evaluation of the conceptual framework of NC as constructed from the literature metasynthesis. The concept of nurse

caring may be better understood with a valid instrument derived from patient experiential knowledge, and this expanded understanding of nurse caring can contribute to the body of nursing knowledge. Findings from the study's open-ended question may validate or refine and expand the instrument's utility and relevance. Further research may include confirmatory analysis of the instrument in other settings and populations, and comparison of instrument results with patient satisfaction of nursing care.

### *Summary*

The purpose of this study was first to synthesize caring descriptors using nurses, students, patients and families responses reported in qualitative studies from 1984-2005 in order to secondly develop and test an instrument that measured patient perceptions of feeling cared for by nurses. The meta-synthesis resulted in a new definition and mid-range theory of *nurse caring* with three attributes. The *Nurse Caring Patient Scale* was developed from the patients' descriptors of *nurse caring*. Initial psychometric evaluation of the instrument demonstrated: a) initial reliability of the tool to measure patient perceptions of feeling cared for, b) content validity by using expert patient evaluations of the tool that validated their experiences, c) support for construct validity by comparing descriptive responses of the participants to the statements contained in the scale, and d) further support and extend the mid-range theory of *nurse caring* as the factors found in psychometric evaluation compared to the attributes from the qualitative research meta-synthesis .

Excellence in nursing practice contains in part a goal to provide patient centric care. *Nurse caring*, a mid-range nursing theory, evolved from a meta-synthesis of qualitative

studies of the nurse-patient encounter, may provide nurses with a framework to further this goal. Since no caring instrument was available to measure “patient perceptions of feeling cared for” that was derived from patients’ experiences, the NCPS was designed to measure patients’ perceptions of being cared for by nurses. The NCPS may provide clinical practice nurses with improved insight into patients’ perceptions of their care from a patient theoretical concept of caring. Further, the study’s significance is that development of NCPS will bring the profession closer to describing what patients perceive as “caring”, so nurses can provide more effective nursing care that is responsive to patients’ physical, emotional, and spiritual needs. Morse et al (1990) stated that the definition of caring was incomplete with only nurse theoretical definitions. It is with the addition of patient perceptions of feeling cared for that nurse caring becomes better defined.

# CHAPTER 2

## Review of the Literature

### *Introduction*

For the past three decades, nurses have worked to define and measure the concept of caring. Beliefs grounded in naturalistic, philosophical, psychoanalytic, metaphysical or spiritual, behavioral, and theoretical perspectives have been used to operationalize caring as a central nursing concept. Many nurse theorists have described caring as the essence of nursing (Gaut & Leininger, 1991; Lewis, 2003, 1988). The American Nurses Association (2004) declared that the art of the profession of nursing was grounded in a framework of care. They expanded the language of caring to include "spirituality, healing, empathy, mutual respect, and compassion" (p. 12). This review of the literature will include definitions of caring from nursing and other disciplines, theoretical descriptions of nurse caring, criticisms of caring scholarship, a review of quantitative research using instruments to measure caring, and a metasynthesis of qualitative research on nurses', students', and patients' perceptions of nurse caring behaviors that emerged as a midrange theory of *Nurse Caring* with its three attributes: *Presence, Concern for the Other; Knowledgeable, Competent Care;* and *Respect for the Person.*

### *Literature Review*

Over the past two decades nursing scholars have attempted to comprehensively define caring within nursing. This literature review examines the state of the science of caring in nursing, and includes nursing theory, instruments developed to measure caring priorities of nurses and patients, meta-analyses of caring research.

*Caring Perspectives*

Care, as a concept in nursing ,was first described by Florence Nightingale (1992) as the art of nursing and participation in the patient reparative process that went beyond giving medications and applying poultices. Care or caring was a term linked to professional nursing since Nightingale, but little scholarship on care or caring was produced until the 1970's. Early work on caring was generated by nurse theorist Leininger (1989). This "Theory of Transcultural Care" was developed in response to technological innovations becoming the focus of professional nursing, and the subsequent denigration of caring in nursing as too feminine. In addition to Leininger, several nursing scholars gleaned ideas about caring from other disciplines including philosophy, psychology, and religion. Mayeroff, (1971), a philosopher, described caring in humanistic, and psychoanalytical terms. 'Caring for' another person was viewed by Mayeroff as the outcome of personal growth or self-actualization. Natural caring was describe as knowing another implicitly and explicitly, alternating rhythms or behaviors, patience, honesty, trust, humility, hope and courage (Mayeroff). Roach (1992), used Mayeroff's conceptualizations to denote that in nursing, human caring was an essential ingredient in human development and survival. Roach, a Catholic nun, described caring for one's neighbor as a natural response emerging from faith and love in God. For Roach, caring was a human way of being. Nursing was the professionalization of caring which included a capacity for care development and accounted caring as a response to valuing the object of care.

Knowledge about caring was also developed from value-laden concepts such as compassion, love, and empathy. Jean Watson's (2004) theoretical conceptualizations of caring were linked to a philosophical, moral and intellectual blueprint for the discipline of nursing. The Theory of Human Caring included assumptions related to moral commitment, intention, and a caring consciousness. Love and caring formed an ethic that was a critical prerequisite to engaging in healing practices (J. Watson, 2003).

Another approach to understanding the concept of caring was described as behavioral. Gaut (1983) viewed caring as a practical activity, and identified knowledge as a key component of caring. When nurses cared, they recognized the need for care, knew appropriate actions for positive changes based on that knowledge, and identified outcomes of care based on the patient's welfare.

*Nursing theory and caring: Leininger*

Leininger (1977) defined caring as central to the practice of professional nursing. "Caring was the dominant intellectual, theoretical, heuristic, and practice focus of nursing, and no other profession was so totally concerned with caring behaviors, caring processes and caring relationships than nursing (p. 33). Leininger incorporated beliefs about caring into the "Theory of Transcultural Nursing" after observing that nurses devoted less time to conversing and listening to patients, and allocated more time to technological innovations that were accepted and incorporated into nursing practice. For Leininger, nurses dismissed the concept of caring as too feminine, holding back the progress made by the profession related to feminism. From an anthropological view, Leininger (1981) saw caring as a universal human phenomenon that varied in application

according to cultural norms and “biophysical, cultural, social and environmental dimensions” (p.11) of caring that could be studied and incorporated into nursing practice. According to Leininger, her theory was generated without the influence of a singular person, or specific ideology or theory. Creative thinking and anthropological ideas led to the formation of the culture care theory or “Theory of Transcultural Nursing”.

For Leininger (1981), the culture of care was defined as a” holistic and unified perspective to reflect individuals or groups caring lifeways or influences on their well being or illness (p. 23). The “Theory of Transcultural Nursing’s” central tenet was caring, described as the “essence of nursing and the central, dominant, and unifying focus of nursing” (p.35). Leininger divided caring into two components, emic or generic caring and etic or professional nurse caring. Emic caring included culturally learned and transmitted indigenous folk knowledge or skills that provided support and enabling acts toward others. Professional or etic caring was formal and cognitively learned used to provide “assistive, supportive, enabling or facilitative acts” towards others (p. 38).

Transcultural care decisions and action were divided into three “modes” that occurred in the environment of the culture. They included social, cultural, political, religious, educational, technological and economic factors namely: a) preservation/maintenance, b) accommodation/negotiation, and c) repatterning/restructuring. Preservation/maintenance referred to acts that allowed individuals or groups to maintain or retain meaningful care values and lifeways. Accommodation/negotiation referred to professional actions that helped a designated subculture to adapt or negotiate for meaningful health outcomes.

Repatterning/restructuring spoke to professional actions that helped clients change their lifeways for beneficial health outcomes (Leininger, 1991; Leininger & McFarland, 2002). Leininger's theory was used to guide caring research (Beeby, 2000a; Bush, 1988; Donoghue, 1993) , and yielded results to support some of Leininger's basic assumptions.

*Nursing theory and caring: Watson*

Watson's Theory of Human Caring(1988, 1989, 1997, 2006) has evolved over time. The original carative factors were created as part of curriculum development, and described the core of nursing that potentiated therapeutic healing relationships and processes between the nurse and the client. Over the years, Watson's theory was expanded to include a spiritual dimension and evocation of love as demonstrated by changing carative factors to clinical caritas processes. The newly named caritas processes or 'clinical caritas'(2006) were consistent with the most mature nursing framework of caring-healing theory. Caritas, the relationship of love to caring, was described as inner healing of the self and others that extended into the environment. Watson considered this evolving theory more a "philosophical, ethical, and intellectual blueprint for nursing" (2006, p.3) rather than a concrete theory for clinical practice. Both postmodern and existential, the caritas theory acknowledged love and care as promoting inner healing for self and the other, extending into the environment (universe). In this evolved theoretical perspective, processes were used to replace the term factors, because the original terms were viewed as static, whereas the new terms implied more fluidity (Table 1). Watson defined caring as the core of nursing, the aspects of nursing care that potentiated healing

processes and relationships, and noted that the clinical caritas processes were a more open way to organize the framework of caring.

*Nursing mid-range theory of caring: Swanson*

Swanson's (1991) Middle Range Theory of Caring (see Table 2), was developed from data grounded in three qualitative studies with post partum women, and provided nursing with a description of caring that was more practical. Five caring processes emerged from these qualitative phenomenological investigations: knowing, being with, doing for, enabling, and maintaining belief. "Knowing" was defined as striving to understand an event as it had meaning in the life of the other. "Being with" was described as being emotionally present with the other, able to share feelings without burdening the one cared for. "Doing for" entailed providing care competently, including behaviors such as comforting, anticipatory care, and protection of the other's needs. "Enabling" reflected the ability to facilitate the other through events, by providing expert knowledge and allowing the other to focus on personal concerns such as thinking through options and solutions for situations. "Maintaining belief," linked to Mayerhoff's (1971) work isolated caring as helping someone to grow and actualize himself, and was defined as enabling the other through transition (Swanson, 1991). Characteristic of maintaining belief was the caregiver's hope-filled attitude and realistic optimism towards the one cared for. Although similar to Watson's (1989) carative factors, Swanson provided nurses with more concrete terminology that could be used in practice.

Swanson (1990) described caring as "acting in a way that preserves human dignity, restores humanity, and avoids reducing persons to the moral status of object"

Table 1
*Watson's Evolved Factors to Processes*

| Carative Factors | Caritas Processes |
|---|---|
| Formation of humanistic-altruistic system of values | Practice of loving-kindness and equanimity within context of caring consciousness |
| Instillation of faith-hope | Being authentically present, and enabling and sustaining the deep belief system and subjective life world of self and one-being-cared-for |
| Cultivation of sensitivity to one's self and to others | Cultivation of one's own spiritual practices and transpersonal self, going beyond ego self |
| Development of a helping-trusting, human caring relationship | Developing and sustaining a helping-trusting, authentic caring relationship |
| Promotion and acceptance of the expression of positive and negative feelings | Being present to, and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one being cared-for |
| Systematic use of a creative problem-solving caring process | Creative use of self and all ways of knowing as part of the caring process, to engage in artistry of caring-healing practices. |

| Carative Factors | Caritas Processes |
|---|---|
| Promotion of transpersonal teaching learning | Engaging in genuine teaching-learning experience that attends to unity of being and meaning attempting to stay within other's frame of reference |
| Assistance with gratification of human needs | Assisting with basic needs with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mindbodyspirit, wholeness, and unity of being in all aspects of care, tending to both embodied spirit and evolving spiritual emergence. |
| Assistance with gratification of human needs | Assisting with basic needs with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mindbodyspirit, wholeness, and unity of being in all aspects of care, tending to both embodied spirit and evolving spiritual emergence. |

| Carative Factors | Caritas Processes |
|---|---|
| Allowance for existential-phenomenological-spiritual forces | Opening and attending to spiritual-mysterious and existential dimensions of one's own life-death, soul care for self and the one-being-cared-for |

*Note.* From http://www2.uchsc.edu/son/caring/ by J. Watson, 2008. Adapted with permission from the author.

(p. 64). The components of this perspective included: caring, attaching, managing responsibilities, and avoiding bad outcomes in the context of the "whole story". In a meta-analysis on the state of the science of caring, Swanson (1999) reviewed more than 130 publications from 1980-1996, and concluded that the data supported a "theoretical framework for categorizing therapeutic caring interventions based on Swanson's middle range theory of caring" (p. 56). Hanson (2004) conducted a survey of critical care nurses using Swanson's theory as a framework for open-ended questions. Results from 84 respondents in Hanson's study revealed that descriptions of intensive care nurses' experiences with patients could be categorized under the Swanson's theoretical attributes thus supporting the theory.

*Nursing theory, a caring model: Halldorsdottir*

Halldorsdottir's (1991) model, "Modes of Being with Another," is a mid-range theoretical perspective of caring in nursing. The model evolved out of a literature search and two phenomenological studies (Halldorsdottir, 1989, 1991) that yielded both caring and uncaring dimensions to support the spectrum of nurse-patient caring encounters.

Phenomenological data was analyzed and resulted in the emergence of a middle range theory that included five modes of being with another (Table 3). This conceptualization of caring offered nurses a practical meter and a means to evaluate observed patients' responses against 'Modes of Being with Another'.

Table 2
*Swanson's Middle-Range Theory of Caring*

| Attribute | Descriptive Subcategories and Terms |
|---|---|
| Maintaining belief | Believing in or holding in esteem: Holistically viewing the other, unconditionally regarding the other, respecting the other<br>Helping find meaning: affirming the experience, finding peace,<br>Offering realistic optimism: having a positive attitude, offering encouragement<br>Offering a hope-filled attitude: instilling and sustaining realistic hope, aiming for success<br>Going the distance: caring beyond expectations, hanging in there no matter what |
| Knowing | Avoiding assumptions: being open to the other's reality, being nonjudgmental, checking back and checking out, (noncaring) distorting and minimizing<br>Assessing thoroughly: assessing needs, assessing skills and capabilities |

| Attribute | Descriptive Subcategories and Terms |
|---|---|
| Knowing | Seeking cues: monitoring vigilantly, sensing concerns, picking up cues |
| | Centering on the one cared for: attending to the other, take the other's perspective, |
| | Listening |
| | Noncaring: focusing away from the other, feeling negative about the other performing routinely/task-oriented, ignoring |
| Being with | Being there: being present/there/with, connecting with the other |
| | Not burdening: being responsible, building trust, preserving self |
| | Conveying availability: reaching out, following up/following through, being accessible or available |
| | Enduring with: ongoing relationship, investing time |
| | Sharing feelings: loving, feeling together |
| Doing for | Comforting: relieving pain and suffering, comforting/easing |
| | Performing competently and skillfully: technically skilled, knowledgeable performance, meeting needs |
| | Preserving dignity: doing with, preserving the other's self |

| Attribute | Descriptive Subcategories and Terms |
|---|---|
| Enabling | Anticipating: being ready, rapidly responding, attending to many things at once<br>Protecting: guarding safety/privacy, modifying the environment, negotiating the system, advocating for<br>Informing/explaining: telling it like it is, informing, communicating, many teaching – communicating styles<br>Validating/giving feedback: confirming/affirming, normalizing |
| Enabling | Supporting/allowing: providing support, (noncaring) controlling<br>Focusing: focusing on specific concerns<br>Generating alternatives/thinking it through: assisting with self-care decisions, empowering/increasing self-efficacy, counseling/problem solving |

*Note:* From "Empirical Development of a Middle Range Theory of Caring," by K. M. Swanson, 1991. *Nursing Research, 40(3),* p.161-166. Copyright 1991 by Lippincott, Williams & Wilkins. Adapted with permission of the author.

Winman & Wikblad (2004) extended the Halldorsdottir model in a study that focused on observing encounters between emergency room nurses and patients on video. The authors observed both caring and uncaring behaviors in Emergency Room nurse-patient encounters, and created a more detailed illustration to describe the interaction. In the "Continuum of Caring" uncaring observations of the nurse-patient encounter were

labeled as: instrumental behavior, disinterest, insensitivity, coldness, and inhumanity. Observations of caring behaviors between nurses and their patients were placed on the created continuum, and included: being open and perceptive of others, being genuinely concerned for the other, being truly present, and being dedicated, and having the courage to be appropriately involved.

*Nursing theory and caring: Other contributions*

Nurse theorists extended the significance of caring by aligning this concept with nursing's meta-paradigm and the concept of health. Newman, Sime, & Corcoran-Perry,(1991) identified the concepts of caring and health as linked based on theoretical tenets of Benner (1988), Leininger (1989) and Watson (1988; Weiss, 1988)). These authors submitted, "Nursing was the study of caring in the human health experience" (p. 3). They suggested that the paradigmatic perspective of the nurse affected the definition of caring, and the unitary- transformative perspective, which focused on viewing the focus as an indivisible whole, was the best theoretical perspective to explicate the caring concept.

*Caring: The focus of the discipline*

Smith (1999) clarified the concept of caring in relation to the unitary-transformative paradigm by analyzing support for the ideas and objections to concept of caring within the nursing profession. In the analysis, Smith reviewed the historical background of caring, noting Mary Jane Smith (1990) also linked caring to the unitary-transformative view of nursing, describing caring as the essence of nursing. Mary Jane Smith believed that caring was knowledge based on sentiment and tasks, because it

Table 3
*Definitions of Modes of Being with Another*

| Modes | Definition |
|---|---|
| Life-giving/biogenic | Affirmation of the personhood of the other by connecting with the true center of the other in a life-giving way. Relieving the other's vulnerability, making the other stronger, enhancing growth, restoring, reforming, and potentiates learning and healing. |
| Life-sustaining/biostatic | Acknowledging the personhood of the other, supports, encourages, and reassures the other. This mode gives security and comfort, and positively affects life in the other. |
| Life-neutral/biopassive | In this mode there is no affect life in the other. |
| Life-restraining/biostatic | Being insensitive or indifferent and detached from the true center of the other. The result is discouragement and developing uneasiness in the other. It has a negative affect on the existing life in the other. |
| Life-destroying/biocidic | In this mode there is depersonalization of the other, destruction of the joy of life, and an increase in vulnerability. The other becomes distressed, is in despair, and feels hurt and deformed. Negative energy or darkness is transferred from the caregiver to the other. |

*Note.* From "Five Basic Modes of being with Another," by S. Halldorsdottir, 1991 in D. A. Gaut & M. M. Leininger (Eds.), *Caring: The compassionate healer* (pp. 37- 49). Copyright 1991 by the National League for Nursing. Adapted with permission from the author.

sidestepped the theoretical base of nursing. However, Smith (1999) noted that a nurse, knowledgeable in the science and invested in the patient's well being, was involved in a caring presence. Smith also believed that a clear conceptualization of caring was needed, and it could be provided within a conceptual model or grand theory in nursing.

Smith (1999) analyzed the dialogue on caring, countering arguments that caring was an ambiguous term, limiting and perspectival to nursing, a ubiquitous term, non-substantive as a body of knowledge, non-generalizable, and feminine. In this analysis, Smith agreed that the term lacked clarity and needed to be conceptualized within the assumptions of nursing theory. She emphasized nursing was not caring, but that nursing could not exist without caring, and as a concept, caring transcended nursing theory to become central to the practice of nursing (p. 18). Further, caring was ubiquitous and not unique to nursing, but no other discipline had developed knowledge about caring, related to health, healing and quality of life. Smith noted that none of the concepts used in nursing such as health, healing, and quality of life transcended cultural differences Smith dismissed an argument that caring could not be central to nursing even though caring could not be generalized to all cultures.

Lastly, because nursing incorporated feminine values such as caring that was reflected in its disciplinary perspective, it did not mean that knowledge development about caring in nursing should be devalued. Smith synthesized five constitutive meanings of caring within the unitary-transformative framework for nursing from this analysis: manifesting intention, appreciating pattern, attuning to dynamic flow, appreciating the infinite (Table 4). Watson (2004) agreed with Smith's (1999) analysis,

but extended the theoretical concept of caring in nursing by advocating its inclusion in the nursing metaparadigm of health, patient, environment and nursing. For Watson, caring buttressed nursing's epistemology and was the ontological base of the profession.

### *Qualitative and Quantitative Research on the Concept of Caring*

Published research (in English) conducted on the concept of caring by nurses from 1984-2005 was reviewed. Watson (2002) listed and summarized the instruments developed to measure caring. Seven meta-analyses (Beck, 2001; Morse et al., 1991; Morse et al., 1990; Sherwood, 1997; M. C. Smith, 2004; Swanson, 1999; Tripp-Reimer & Cohen, 1990; Warren, 1988) were conducted to examine and analyze the findings of qualitative and quantitative studies concerning the nurses' and patients' perceptions of caring. Published quantitative and qualitative studies about caring in the nurse-patient encounter that were not included in the meta-analyses or Watson's publication were also reviewed current investigation. A review of the meta-analyses, caring instruments and quantitative research, and other qualitative and quantitative research follows:

#### *Quantitative Research*

Since 1981, 20 instruments were developed, and nine instruments were revised to measure the concept of caring. Watson (2002) assessed caring epistemology in nursing and the health sciences from 1984-2001 and listed 18 of the instruments that measured caring, noting that many researchers either cited Watson's (1988, 1989, 1997) Theory of Human Caring in their background information or used the theory as a conceptual framework for their study.

Table 4
*A Unitary-Transformative Meaning of Caring*

| Caring Term | Definition |
|---|---|
| Manifesting intention | Co-operation with the emerging order including: centering on the other, preserving dignity and humanity with reverence for human life, being committed to alleviating another's' vulnerabilities, providing attention and concern, humility, and authentic presence (p.21). |
| Appreciating pattern | Seeking the wholeness of the other as reflected in the uniqueness of pattern such as placing value on another as worthy of love, acknowledging an emerging pattern without trying to change it, seeing the other as perfect in the moment and unfolding possibilities of becoming, and knowing the other (p. 23). |
| Attuning to dynamic flow | Sensitivity to the rhythmic pattern of relating or knowing "when to move, be still, speak, be silent, laugh, cry, touch or withdraw" (p.24). |

| Caring Term | Definition |
|---|---|
| Experiencing the infinite | Spiritual union that happens when the nurse connects with the patient also described as divine love, and the highest form of knowing (p.24). |
| Inviting creative emergence | Transformation that occurs in the caring process that is mutual for nurse and patient. Those experiencing caring as giver or receiver express growth as an outcome. Growth may be an expansion of human capacities, or an increase in the capacity to care. |

*Note.* From "Caring and the Science of Unitary Human Beings," by M. C. Smith, 1999, *Advances in Nursing Science, 21(4),* p. 14-28. Copyright 1999 by Aspen Publishers, Inc. Adapted with permission from the author.

Since 2002, there were two revisions of the instruments listed (Wolf et al., 2004; Wolf et al., 2006; Wu et al., 2006), and two scales were developed (Hegedus, 1999; Radwin, Alster, & Rubin, 2002).

Watson (2002) credited caring research efforts as having added to knowledge about the concept. She illustrated how researchers attempted or showed the lack of theoretical direction in the compilation of the existing measures of caring. Some instruments were developed using a theoretical framework such as Watson's Theory of Human Caring (1985, 1989, 1997). Other instruments were developed without any

citation of a theoretical framework. There was a lack of qualitative studies guiding the development of the instruments reviewed. Most of the instruments reviewed were used only once or twice, compromising an opportunity to confirm psychometrics and test-retest reliability of the instruments. Several instruments were developed in dissertations or reflected organizational attempts to measure institutional caring. Study results from these instruments were never published. There are three scales developed in the 1980's however, that remain the most frequently used instruments today. They are the CARE-Q and the revised CARE-SAT, the Caring Behaviors Inventory (CBI) including a revised version, and the Caring Behaviors Assessment (CBA) with a revised version. Appendix B lists all of the instruments grounded in a nursing theoretical concept of caring, and two exceptions. One exception was the Caring Behaviors Inventory for Elders (CBI-E), Wolf's et al (2004) revised instrument was derived from the original CBI along with item content evaluation from a group of patients. Radwin's (2002) instrument was developed from a single qualitative study of oncology patients.

CARE-Q, developed by Larson (1981), has been used more by nurse researchers than any other caring tool available to nursing. Psychometric analysis was not reported for the original instrument in the literature. Twenty studies were reviewed from the literature using this instrument. The CARE-Q instrument was translated from English into Swedish, Finnish and Chinese and administered to patients with cancer, psychiatric, coronary, and other medical, surgical diagnoses; and in rehabilitation and long-term care. Research using CARE-Q has occurred in the United Kingdom, Canada, Finland, Sweden, Hong Kong and the United States (Gooding et al., 1993; Holroyd et al., 1998; Keane &

Chastain, 1987; Komorita et al., 1991; Larson, 1981, 1984, 1986, 1987; Larson & Dodd, 1991; Larson & Ferketich, 1993; Larsson et al., 1998; Rosenthal, 1992; Scharf & Caley, 1993; von Essen & Sjoden, 1991b, 1993, 2003; Widmark-Petersson et al., 1996, 1998a, 1998b, 2000). Results from these studies consistently demonstrated that nurses and patients valued different caring behaviors. Nurses tended to value psychosocial skills as most important. Patients rated clinical competency as foremost.

Cronin & Harrison (1988) developed the Caring Behavior Assessment (CBA) using Watson's Theory of Human Caring (1988) designed to measure patient perceptions of nurse caring behaviors. Psychometric analysis resulted in an instrument with a seven factor solution and reliabilities of .63-.90. Seven studies (Baldursdottir & Jonsdottir, 2002; Dorsey, Phillips, & Williams, 2001; Huggins, Gandy, & Kohut, 1993; Marini, 1999; Mullins, 1996; Parsons, Kee, & Gray, 1993; Schultz, Bridgham, Smith, & Higgins, 1998) using the Caring Behavior Assessment (CBA) instrument (Cronin & Harrison, 1988) reporteded that competent nursing care was rated as most important by patients.

Wolf's (1994) revised Caring Behavior Inventory (CBI) identified five caring factors from psychometric analysis as: attentiveness, positive connectedness, maintaining belief, respectful deference, and human presence. Psychometrics for the CBI revised, not reported on the original instrument, revealed a scale reliability of .96 and four factors with Cronbach's alphas of .80 or greater. The CBI was reported as the second most often used tool in the literature. All of the retrieved studies using the CBI were conducted in the United States (Brunton & Beaman, 2000; Green, 2004; Larrabee et al., 2004; Wolf,

1998a; Wolf et al., 1994; Wolf, Miller, & Devine, 2003b; Wu et al., 2006; Yeakel, Maljanian, Bohannon, & Coulombe, 2003)

The CBI for Elders (CBI-E), revised instrument (Wolf et al., 2004), also revealed five caring dimensions: attending to individual needs, showing respect, practicing knowledgeably and skillfully, respecting autonomy, and supporting religious/spiritual beliefs (Wolf et al., 2006, p.53-54). Total CBI-E instrument reliability was .94. Five factors had Cronbach's alpha of .65-.93, with one factor containing only one item. Differences between factors for the CBI and the CBI-E reveal a shift from nurse focused psychosocial emphasis (positive connectedness, and maintaining belief) to patient competency-focused preferences (practicing knowledgably and skillfully). This difference in nurse-valued psycho-social skills as opposed to patient-valued competent care is similar to the findings of researchers using CARE-Q and CBA instruments.

*Additional quantitative research not documented by Watson*

Other studies using caring instruments were found in the literature, but were not reported in Watson's (2002) review. There were 18 quantitative studies were reviewed by the investigator. Of the quantitative studies seven investigations, researchers used CARE-Q (Gooding et al., 1993; Scharf & Caley, 1993; von Essen & Sjoden, 2003; Widmark-Petersson et al., 1996, 1998a, 1998b, 2000) and reported findings similar to all other studies using CARE-Q. Six investigators used the CBI (Brunton & Beaman, 2000; Green, 2004; Larrabee et al., 2004; Wolf et al., 2003b; Wu et al., 2006; Yeakel et al., 2003) with results similar to others using the CBI instrument. One researcher used the

CBA (Dorsey et al., 2001) with reported findings similar to other studies using this instrument.

*A nurse caring behaviors instrument*

Hegedus (1999) developed the Nurse Caring Behaviours (NCB) instrument from the caring literature, informal interviews with nurses, and clinical observations. Content validity for the instrument was obtained from a panel of academic and clinical nurses. The scale of 20-items was tested in two groups, nurses and patients. Participants were asked to rank the items on the NCB by placing cards in stacks labeled very caring, average caring and least caring. A Wilcoxian rank-sum test was conducted on the resulting data to test the differences between the nurses and patients responses. Findings indicated that some behaviors were rated similarly by nurses and patients. One difference was that patients valued behaviors that recognized the patient as an individual person; whereas nurses placed a greater emphasis on psycho-social aspects of care such as comfort, and allowing patients to express their feelings. Findings from this study were similar to findings using CARE-Q where participants and nurses differed in what they ranked an important caring behavior. No psychometric analysis of the items was reported in the literature.

*A caring instrument based on qualitative study*

Radwin (2005) developed the *Oncology Patients Perceptions of the Quality of Nursing Care Scale (OPPQNCS)* from a single qualitative study of oncology patients. A middle range theory of excellent cancer nursing care emerged from the qualitative data and included eight attributes: professional knowledge, continuity, attentiveness,

coordination, partnership, individualization, rapport, and caring. The OPPQNCS was developed from conceptual definitions and theoretical descriptions of caring found in the literature, and from qualitative study verbatim data reflecting patient perceptions of cancer nursing quality. Two versions of the instrument were reported in the literature. Psychometric analysis of the longer version of the instrument ($\alpha$= .99) had four subscales labeled responsiveness, individualization, desired level of involvement, and proficiency. The Cronbach's alphas for these factors ranged between of .87-.99. On the short form psychometric analysis resulted in a total score reliability of .95 with a four-factor structure and alpha co-efficients between of .69-.81. This was a newly developed instrument, and no further documentation of its use was found in the literature.

*Meta-analyses of Quantitative and Qualitative Caring Studies*

One hundred seventy-five qualitative studies and twenty-seven quantitative studies were included in the seven meta-analyses conducted to describe caring knowledge from research. Twenty-four studies were repeated in two or more of the analyses, resulting in 178 studies reviewed. Warren (1988) reviewed nine studies from 1975-1986. Seven of these studies had qualitative methodologies, and five studies were from unpublished dissertations or theses. Warren summarized the research by suggesting that the patients involved in studies wanted humane physical care and involved emotional care. Physical care included gentle, considerate, competent, timely and accessible care. Emotional care was included concern, involvement, sharing, touching, voluntary presence, and humor. Counseling, collaboration and more resources for clients were concepts added by nurses who participated in the reviewed studies.

Morse, Solberg, Neander, Bottorff, and Johnson (1990), and Morse, Bottorff, Neander and Solberg (1991) examined 14 qualitative studies as part of their analysis on the concept of caring. Summary of their analysis included theoretical descriptions of the concept of caring provided by nurse scholars as well as data from qualitative studies. The authors summarized caring as: a human trait, a moral imperative, an affect on the nurse and patient, an interpersonal interaction, and a therapeutic intervention (Morse et al., 1991; Morse et al., 1990). Outcomes of caring were included in a description of the patient's subjective experience, and the patient's physical response (Morse et al., 1990).

Tripp-Reimer and Cohen (1990) analyzed 25 qualitative studies, and six quantitative studies describing lay and professional concepts of care. In this analysis Tripp-Reimer and Cohen reported that lay care in reviewed anthropological, ethnographic studies provided baseline data for the nurse to understand how the patient perceived care. Professional care studies revealed a discrepancy between what patients and nurses valued in caring which created increased stress for the patient and caregivers. Their analysis noted concepts of care from studies of professional care, and indicated the concepts needed to be incorporated into practice. The authors concluded that there was little evidence of sustained programs of research in caring (in 1990) and noted that qualitative studies reported lacked scientific rigor.

Sherwood (1997) evaluated fourteen qualitative studies of which nine were unpublished dissertations describing caring from the patient's perspective. Examining the summary findings of each researcher, Sherwood uncovered essential patterns of nurse caring such as: healing interaction, knowledge, intentional response, and therapeutic

outcomes. A caring model emerged from the data illustrating components of caring (interacting, responding, knowing and healing) which occurred in the nurse-patient encounter.

Swanson (1999), in the "State of Caring in the Science of Nursing" analyzed 73 qualitative studies related to caring. Data from the studies were conceptualized into four levels of caring: the capacity for caring; concerns/commitments; patient, nurse or organizationally-related conditions that affect caring; caring actions; and caring consequences. Data around caring actions emerged from nine quantitative studies using Larson's (1981) CARE-Q instrument as well as the reviewed qualitative studies. Swanson found that caring actions documented in the reviewed studies, provided additional support to attributes and definitions for Swanson's Middle Range Theory of Caring (1991).

In reviewing 14 qualitative studies on caring Beck (2001) found that among and between among nurse faculty nurse faculty, students and patients metaphors of caring emerged from this metasynthesis including: presencing, sharing, supporting, competence, and uplifting effects. Presencing was defined as "striving to enter the world of another" "attentive listening" "sensing" and being "conscious of." Supporting included encouragement, unquestioning acceptance, remaining with the person, and patience. Competence was defined as possessing knowledge and clinical skills to appropriately respond to patient needs. Uplifting effects were the results of caring such as being respected, belonging, growth, learning to care and a desire to care. Findings from this

metasynthesis supported Sherwood's (1997) metasynthesis of nurse caring from the patient's perspective.

Smith (2004) analyzed 14 qualitative and 20 quantitative studies related to Watson's (1997) Theory of Human Caring. Strengths of the reviewed research included consistency of findings that could inform practice, such as the incongruence of prioritizing caring between nurses and patients. Competence in caring, viewed as a priority by patients, was assumed by nurses who prioritized caring as a way of being and attending that supported health, healing and quality of life (M. C. Smith, 2004). Weaknesses in the reviewed research reviewed included study theoretical frameworks that did not consider Watson's most recent theoretical work, and the presence of weak theoretical linkages where findings were not clearly related to theory.

*Commonalities of studies from the reviewed meta-analyses*

The seven meta-analyses reviewed revealed that the researchers came to comparable conclusions about the concept of caring. Similarities contained in each meta-analysis included:

1. Caring as a term used in nursing, was not fully conceptualized.
2. Caring frameworks found in nursing research were primarily focused on nurse-driven theoretical definitions. Qualitative studies about caring were conducted primarily with nurses, and student nurses.
3. Quantitative studies revealed that nurses and patients prioritized caring concepts differently.

4. Qualitative studies were lauded for the research attempt to derive a caring definition from samples of nurses, students, patients, and families.
5. Qualitative studies reporting on the dimensions of caring were criticized for lack of scientific rigor. Scholars called for improvement in the validity and reliability of such tools by using standardized qualitative methods to gather and analyze data.
6. More patient-focused qualitative research was seen as essential to arrive at a more complete understanding of caring in nursing

*Criticisms of Caring Scholarship*

Some scholars have criticized research used to define the concept of caring within nursing. Paley (2001) scoffed caring research scholarship. He argued that building caring knowledge on things said about caring, identifying caring attributes based on an arbitrary resemblance, and aggregating knowledge about caring was preparadigmatic, related to pre-scientific methods of knowledge accumulation. Paley, citing Foucault (1970), argued that nursing's knowledge of caring could be found in a thesaurus, that it was knowledge of things said, not true knowledge. Caring was the domain of elusive knowledge, and it would remain elusive.

But Foucault (1972) recognized that knowledge might be gained when a person took a position and spoke of personal experiences. He noted that knowledge was also a field where "concepts appear, are defined, applied and transformed…" (J. Watson & Smith, 2002). Watson & Smith countered that knowledge from the caring literature was not new, but rather an affirmation of what was already known at an experiential level.

According to Deary (2002), Paley's criticism of caring scholarship, reflected a disapproval of survey research as a method. To social sciences, use of multiple perspectives to enrich understanding of a phenomenon was important. Researchers often generated lists of descriptors, and exposed the concept and statistical analysis in order to yield useful data. DeGroothis (2004) stated "correspondence with reality is what truth is or consists of… just because truth is sometimes difficult to know or discover does not imply that linguistic communities construct…truth" (p. 45). Accordingly, the truth about caring could be found in the reality of the experience.

Criticism levied on the scholarship on caring also occurred because of the continued link to nursing theoretical base without patients' perceptions (Morse et al., 1990; Paley, 2001). For Morse, there was a need to redirect nursing's understanding about caring. These authors determined that the majority of studies about the concept of caring used measures that were limited in value and scope, especially if the goal of caring was to influence patient outcomes. Morse reported that nurse-theoretical ideas of caring were well developed, but that patient perceptions were needed in order to gain a fuller understanding of caring. Concept-initiated patient-focused research was seen as a strategy needed to move caring knowledge forward

Meleis (1992) noted that understanding health and illness required awareness of what people value in life, and how they thought and felt about care. Qualitative research of patients perceptions of feeling cared for by nurses was needed in order to describe professional nurse caring more fully. Patient-centered theory testing, using middle range theories or models foundational to research foci was viewed as instrumental in evolving a

caring concept in professional nursing. To extend nursing's knowledge of the concept of caring, addition of patient's perspective of the nurse-patient caring encounter was necessary. Qualitative research exploring the nurse-patient encounter from nurses', students', patients', and families' viewpoints had been conducted over the past two decades. A metasynthesis of qualitative studies findings was thought important, and could lead to a more complete definition of caring within the nurse-patient encounter.

### *Summary*

Caring is described as the essence of nursing (Gaut, 1983; J. Watson, 2004). Decades of scholarship focused on defining the concept. Theories and models were constructed with caring as the central concept (Halldorsdottir, 1991; Leininger, 1991; Swanson, 1991; J. Watson, 1985, 1989, 2006). Instruments were developed from nursing-theoretical ideas of caring (Cronin & Harrison, 1988; Larson, 1981; Wolf, 1986), and revised. More recently instruments were revised to reflect patients' perceptions of caring from single qualitative studies, and linked to satisfaction (Radwin et al., 2005; Wolf et al., 2004; Wolf et al., 2006).

Criticisms of caring research voiced by Morse et al (1990) and later by Paley (2001) continue to be relevant. Morse et al expressed concern that caring tools developed in the 1980's had limited usefulness in nursing since patients and nurses regarded different caring behaviors as most important. In addition, Morse et al noted that if the goal of caring research was to improve patient outcomes, then the focus of studies both qualitative and quantitative studies needed to be centered on the patient. Paley also called for patients' perceptions of caring in order to more completely define the concept. Since

1990, consideration of patients' perspectives on nurse caring behaviors has been the focus of an increased percentage of all qualitative studies on the caring experience. Yet no instrument has been developed from a synthesis of the conducted research.

Smith (2004) criticized caring studies as atheoretical or with weak, indiscernible links between the research and theory. Nursing epistemology, it has been suggested, is increased when theory is tested to confirm or disprove constructs such as caring. Without a discernible link to theory, nursing research operates in a silo that provides some new data without credibly associating it to the current body of knowledge. Meleis (1992) stated that future research would be built on the synthesis of past research findings. Building on past research by synthesizing the findings of qualitative studies was needed to discern the patient's perspective and incorporate it into the body of caring knowledge built on nursing theoretical ideas. With a new more comprehensive caring perspective, an instrument could be developed to measure patient perceived outcomes of the nurse-patient encounter.

The aims of this study were to synthesize qualitative studies that asked nurses, students and patients about their perceptions of the nurse-patient encounter, and then to develop and psychometrically test a new instrument that measured the patient's perception of feeling cared for by nurses. To that end the following study was conducted.

# CHAPTER 3

## Meta-synthesis of Qualitative Studies

### *Introduction*

This study had two aims. A meta-synthesis of qualitative studies published in English from 1984-2005 was the first aim of the study. The focus of the meta-synthesis was to formulate an extended definition of the concept of caring by incorporating nurses', students' and patients' perceptions of the nurse-patient encounter. This chapter discusses the methodology of the meta-synthesis process, and the resulting findings.

### *The Meta-synthesis Process*

There was little consensus about summarizing qualitative research studies (Sandelowski, Doherty, & Emden, 1997; Thorne et al., 2004). These authors believed that summarizing qualitative studies resulted in destruction of an individual project's integrity. In addition, diverse approaches to data collection existed, which seemed to negate any effort to synthesize studies. There were also diverse opinions about what elements comprised "good" qualitative research. On the other hand, arguments for synthesis supported the aim of reaching higher analytic goals, and enhancing generalizability of the particulars of qualitative research (Sandelowski et al.). Thorne et al (2004) stated that metasynthesis was not a critical literature review, but a methodical process designed to grasp " the particulars within the wholes" (p.1346), and to "facilitate knowledge development" (p. 1346) resulting in an novel, interpretive integration of studies' findings.

Synthesis of qualitative studies was not according to a pre-existing set of steps such as in quantitative analysis. Sandelowski et al (1997) stated that there were various ways to synthesize data, and that the process of meta-synthesis was in flux. Two ways could be applicable to this meta-synthesis: synthesizing findings of different investigators, or conducting a comparative analysis of an aggregation of qualitative findings from cases across different studies. In order to select the most appropriate method, this question was posed: Was there a coherent theme derived by the qualitative study researchers?

To elicit the answer to the question, the investigator examined published qualitative studies of nurse, student and patient' perceptions of caring. The reviewed studies included various methodologies to study caring such as: ethnography (Rankin, 2003), phenomenology (Beck, 1993; Beeby, 2000b; Bunkers, 2004; Cara, 2001; Clayton, 1989; Gramling, 2004; Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996; M. D. Hanson, 2004; Jensen, Back-Pettersson, & Segesten, 1996; Schaefer, 2003; Steeves, Cohen, & Wise, 1994; Wiman & Wikblad, 2004), case study (Beauchamp, 1993; Engebretson, 2000), qualitative descriptive (J. Brown & Ritchie, 1989; Halldorsdottir, 1991; Hogan, 2000; Pound, Bury, Gompertz, & Ebrahim, 1995), grounded theory (Ray, 1989), and the Delphi technique (Wolf et al., 2003a). Although some themes were similar in these studies, [e.g. attentive presence (Beck, 1991), presence (Engebretson, 2000), being totally present (Jensen, Back-Pettersson, & Segesten, 1993), and e.g. valuing (Davies & O'Berle, 1990), and humanism (Coulton, Krause, & Anderson, 1996), patients [being] valued (Pound et al., 1995). It was impossible to create a synthesis of meaning

from the analysis, because researchers used the same or similar descriptive terms expressed by study subjects to illustrate several themes within a single study, and the terms were given different meanings in different studies. Smith (2004) supported this noting that it was difficult to analyze commonalities from qualitative studies in her analysis of research studies related to Watson's (1985, 1997) theory of caring, because there was no consistency between studies. Due to the difficulties in comparing an aggregation of qualitative items, qualitative comparative analysis was selected as the overall method for the meta-synthesis.

Qualitative comparative analysis has two distinct modes of synthesizing data: a holistic view retaining causes and outcomes, and a variable oriented analysis (Sandelowski et al., 1997). Variable oriented analysis was chosen for this meta-synthesis because of the difficulties in creating a cohesive meaning from so many studies (90). Outcomes or themes of each researcher were so different that it would be impossible to synthesize the outcomes of studies into a singular definition of caring.

In order to conduct a variables oriented qualitative comparative analysis (Sandelowski et al., 1997) and to synthesize findings of 90 published qualitative studies in English that asked nurses, students, and patients their views on the nurse-patient encounter which would result in a new conceptualization of caring; the following steps were taken (Thorne et al., 2004):

1. Define the problem.
2. Explicate the inclusion criteria.
3. Measure the characteristics of the study on a common scale.

4. Identify, classify, and code the findings.
5. Aggregate the findings.
6. Calculate the effects.
7. Formulate the new conceptualization.

The purpose of the meta-synthesis was to investigate the meaning of caring as reported by the subjects in the reviewed studies, and to integrate the resulting findings. Synthesis questions were:

1. What were the specific perceptions of caring as reported by the researchers?
2. How were the nurses, students, and patients' perceptions of caring similar? How did they differ?
3. Could a single set of categories describe the reported perceptions of caring? Did study findings lead to a new comprehensive definition for the concept of caring?

*Defining the Problem*

Despite the enormous amount of scholarly work that centered around the conceptualization of caring including nursing philosophical ideas, observations and qualitative and quantitative research, Morse et al (1990) and Paley (2001) criticized it for the lack of the patient's perception of caring. In 1990 Morse et al called for an increase in the number of qualitative studies asking the patients their perceptions of the nurse-patient encounter. Since that time there has been an increased focus on patient centered studies. The studies however, were conducted with the silo approach. No researcher built upon the work of others by synthesizing the body of qualitative studies found in the literature.

A meta-synthesis incorporating the nurses', students' and patients' perceptions of caring would begin to fill this gap in caring knowledge.

*Inclusion Criteria*

Many quantitative and qualitative research studies were found in the literature that considered the concept of caring. Of the qualitative research done, various approaches to the topic were used. Since the criticism of the conceptualization of caring was the missing patient's view (Morse et al., 1990; Paley, 2001), it was decided to include studies that specifically asked nurses, students, and patients about the caring encounter. Studies were chosen if they were published in English and qualitative in design involving nurses, students or patients responses to the concept of caring. Studies were not judged for their "goodness", but were accepted based on their presence in peer-reviewed journals. The investigator considered the contributions of participants in the reviewed studies to be important in further defining the concept of caring within the nurse-patient encounter. In addition the included potential studies reviewed had a potential impact for populations other than those participating in these studies. Ninety studies (in English) were found in the published literature from 1984-2005 that met the inclusion criteria.

*Measuring Characteristics of the Study (Synthesis Questions)*

Large volumes of studies for meta-synthesis impeded deep analysis. Sandelowski et al (1997) stated that a meta-synthesis of more than 10 studies required a tight sampling strategy in order to distill the findings into a comprehensive whole. Thorne et al (2004) concurred stating that the characteristics of the study should be measured on a common

scale. Synthesis questions provided a means of reviewing the data in order to achieve the best sampling strategy.

*Synthesis question 1: What were the specific perceptions of caring as reported by researchers?*

Since the themes were difficult to compare and synthesize, this study investigator began to examine and log each of the recorded terms used by study subjects (nurses, students, patients, and families) to describe caring or uncaring encounters. The descriptive expressions used by theses participants seemed to illustrate four dimensions of caring: presence, respect (of human dignity), competent care, and a metaphysical/spiritual interaction (Appendix A). A definition of caring was constructed from this analysis called *nurse caring*. *Nurse caring* (NC) is defined as a learned, intentional act by a nurse. It includes a presence with the patient/client, a respectful honoring of a unique individual (or family/group/community), resulting in a spiritual connection or transcendence as the nurse partners with the patient/client in actions that foster enhanced well being and reciprocity.

*Synthesis question 2: How are the nurses', students', and patients' perceptions of caring similar? How do they differ?*

Because the gap in caring epistemology lacked patient perceptions about the nurse-patient encounter (Morse et al., 1991; Paley, 2001), the investigator returned again to the patient-focused qualitative studies to locate the recorded descriptive terms of caring. Patients used words similar to those expressed by nurses and students which could be easily placed under the same attributes constructed from subject responses in the

reviewed studies. Two exceptions existed. First, there were no spiritual/metaphysical terms were used by the patients. The closest term that described what nurses called communion or a metaphysical connection was "connection". For example "This connection was very natural, and that was very important for me to be able to be completely myself and not having to put up some kind of a front" (Halldorsdottir & Karlsdottir, 1996, p. 369).

Second, uncaring was found in the expressions of patients as they described nurse/patient encounters. Each of the uncaring terms used by patients were opposites of the positive comments about nurse caring, and could be placed within the attributes of caring as their antithesis. Students also related uncaring terms that were similar to patients when describing the faculty-student encounter. Nurses and students rarely conveyed terms to describe uncaring when describing the nurse-patient encounter. Uncaring was manifested by disinterest and disrespect for the other, with little or no communication and incompetent delivery of nursing care. Halldorsdottir's (1991) theory, "Modes of Being with Another," derived from qualitative study, theoretically illustrates this finding of "uncaring" on a continuum from caring to uncaring. Of the 90 qualitative studies reviewed by the investigator, uncaring behaviors were reported in six studies in the United States (Burfitt et al., 1993; Drew, 1986; Finn, 1993; Reimen, 1986; Williams, 1992), four studies in Iceland (Halldorsdottir, 1989, 1991; Halldorsdottir & Hamrin, 1997; Wiman & Wikblad, 2004), and one study in Sweden (Lovegren, Engstrom, & Norberg, 1996). Swanson (1999) also noted uncaring behaviors in her meta-analysis of caring in the nursing literature.

*Identifying, coding, and aggregating findings*

Nurses and patients had some differences in describing their perceptions of the nurse-patient encounter, particularly spiritual descriptions of the experience. In order to code the data to fit nurses, students, and patients' perceptions of *Nurse Caring* an aggregation of findings needed to occur.

*Synthesis question 3(a): Can a single set of categories describe the reported perceptions of caring?*

Patient perceptions of nurse caring were placed beneath three of the renamed attributes for caring: *Presence, Concern for the Other; Respect for the Person;* and *Knowledgeable, Competent Care*. The spiritual/meta-physical terms relayed by nurses and students were reflective of a deep connection with the patient/faculty. Since the term "connection" was the term most used by patients, the investigator folded the spiritual/metaphysical attribute into the attribute of *Presence, Concern for the Other* (see Appendix E). The definition of n*urse caring* remained unchanged and fit patients', nurses' and students' descriptions of the ideal. The three attributes *Presence, Concern for the Other; Respect for the Person;* and *Knowledgeable, Competent Care* emerged from the meta-synthesis of the data as subsets of *nurse caring*. "Uncaring", defined as the absence of professional regard exhibited by indifference, mutual avoidance, disconnection, and at its nadir, coldness and inhumanity, emerged from the data reviewed as the antithesis of n*urse caring*. The following is the definition of each attribute as elucidated by nurses, students, and patients, and the specific descriptors as found in the reviewed studies.

*Presence, Concern for the Other*

*Presence, Concern for the Other* is one attribute that emerged from the data. It is defined as the act of being there with the patient/family/group/community that can be described as interconnectedness, a relational connecting, a communion with the other, having insight and concern so needs are anticipated and comprehended, and it can result in a spiritual connection/transcendence.

*Presence, Concern for the Other as described by nurses and students*

Nurses described the experience of *Presence, Connecting with the Other* in 11 terms (see Appendix D). "Being present", "being with" or "being there" was the most common descriptor of presence depicted by students in the United States (Beck, 1991, 1992a, 1992b, 1993, 1994; Boyd & Munhall, 1989; Bush, 1988; Engebretson, 2000; L. Hanson & Smith, 1996; Hughes, 1993a), and by nurses in many areas of clinical practice. Nurses describing presence were found in the United States in medical-surgical practice (Green-Hernandez, 1991; Miller, Haber, & Byrne, 1992; Nelms, 1996), oncology (Steeves et al., 1994), obstetrics (Swanson-Kauffman, 1986), and neonatal intensive care (Swanson, 1990). Nurses from other countries also described "presence" such as medical-surgical nurses in England (Clarke & Wheeler, 1992), New Zealand (Euwas, 1993) and Sweden (Jensen et al., 1993), intensive care nurses in England (Beeby, 2000b), and pediatric nurses in Canada (J. Brown & Ritchie, 1989).

"Connection" also noted as interconnection, relationally connecting, involvement, and fitting with patients was the second term describing *Presence, Connecting with the Other*. Student nurses used "connection" to describe *Presence, Connecting with the Other*

(L. Hanson & Smith, 1996; Kahn & Steeves, 1988; Kosowski, 1995; Schaefer, 2003). In the United States nurses describing "connection" practiced in pediatrics (Burns, 1994), acute medical-surgical care (Clayton, 1989; Green-Hernandez, 1991), education (Grigsby & Megel, 1995), and as acute care nurses and staff (Ray, 1984). Nurses in other countries also identified "connecting" with patients including acute care nurses in Sweden (Back-Pettersson & Jensen, 1993; Jensen et al., 1993), and oncology nurses in Canada (Bottorff, 1993; Davies & O'Berle, 1990). A similar descriptor "sharing" was also noted by Davies & O'Berle, Kosowski, and Ray.

A sense of "comfort" was the third common descriptor noted by this investigator. Students identified "comfort" (Beck, 1991; Boyd & Munhall, 1989; Schaefer, 2003). Nurses who described "comfort" practiced in acute care (Peterson, 1985; Ray, 1984, 1987) in the United States. Spangler (1993) described differences in care values between Anglo-American and Filipino-American nurses. "Comfort" was a descriptor for caring noted by Filipino-American nurses. In Canada, oncology nurses named "comfort" as caring (Bottorff, 1993).

"Perception," "insight," "comprehension," and "knowing" were described seen as an aspect of nurses caring by students (Engebretson, 2000), in the United States (Beck, 1992a, 1992b; Hughes, 1993a) and in Iceland (Halldorsdottir, 1989)as "sharing" of time and one's life in respect of humanness was an important component of caring. United States nurses identifying "knowing" practiced as the attitude within pediatrics (Burns, 1994), acute care (Donoghue, 1993; Leners, 1993), and neonatal intensive care (Swanson, 1990). In Canada, acute care nurses described "knowing" as caring (Forrest, 1989).

Other terms included under the attribute of presence was “belonging” as reported by oncology nurses (Steeves et al., 1994), “love” noted by students (Engebretson, 2000) and acute care nurses (Ray, 1984), and “having a sense of humor” (Ray, 1987) as described by critical care nurses. Some terms evoked a spiritual aspect of caring such as “spiritual union” noted by students and perioperative nurses (Bush, 1988; McNamara, 1995), and “transcendence” described by acute care nurses (Montgomery, 1992). “Concern” was identified by students in Iceland (Halldorsdottir, 1989) and the United States (Schaefer, 2003). Nurses in public hospitals (Donoghue, 1993) and perioperative care (McNamara, 1995) also noted “concern” as an aspect of caring. “Giving back of self” was described by some students (Beck, 1991; Chipman, 1991; Hughes, 1993a), as well as by acute care nurses in England (Clarke & Wheeler, 1992) and Canada (Davies & O'Berle, 1990). “Being open” to the moment was noted by acute care nurses in the USA (Dietrich, 1992). Building an atmosphere of “trust” was noted by nurses in New Zealand (Euwas, 1993), England (Clarke & Wheeler, 1992), and the United States (Ray, 1987).

*Presence, Concern for the Other as described by patients/families*

Patients and families used fewer terms to describe presence. A commonly expressed descriptor used was the term “presence,” or “being there”. Those who used the term “presence” were patients with Human Immunodeficiency Virus and Autoimmune Deficiency Syndrome (HIV/AIDS)(Beauchamp, 1993), female out-patients (Bunkers, 2004), and obstetric patients (Propst, Schenk, & Clairain, 1994) in the United States (USA), and emergency room patients in Iceland (Winman & Wikblad, 2004). “Being there” was noted by obstetric patients (Drew, 1986; Finn, 1993; Swanson-Kauffman,

1986), pediatric (Williams, 1992) and adult (Winters et al., 1994) oncology in the USA , postpartum women (Collins et al., 1994) and acute care patients (Fareed, 1996) in England, and elderly home care patients (Poole & Rowat, 1994) in Canada.

Patients referred to "connection" as "connects" or "being with". Patients/families in the USA used this term in diverse situations such as acute care (Miller et al., 1992), intensive care (Gramling, 2004), obstetrics (Swanson-Kauffman, 1988), and pediatric oncology (Williams, 1992). People from other cultures described "connection" or "sharing humanness" as nurse caring in acute situations (Fareed, 1996) in England, oncology patients in Iceland (Halldorsdottir & Hamrin, 1997), and neurological patients (Milne & McWilliam, 1996) in Canada.

The nurse's attitude was reported to be important to patients. Terms such as "friendly," "kind," "pleasant," "having a smile," and "having a positive manner" were used by patients to describe this attitude. In the United States obstetric patients (Propst et al., 1994), hospice families (Raudonis & Kirschling, 1996), and surgical patients (Sherwood, 1991) mentioned "friendliness/kindness" as an aspect of nurse caring. Acute care (Fareed, 1996) and stroke patients (Pound et al., 1995) in England, surgical patients in Australia (Hogan, 2000), intensive care patients in Canada (Jenny & Logan, 1996), and primary and acute care patients in Sweden (Lovegren et al., 1996) also reported that "friendliness/kindness" as an aspect of nurse caring.

Being able to "trust" the nurse, to feel like they were "in good hands" was another descriptor for presence. Patients in the intensive care (Gramling, 2004), psychiatric depressed patients (Mullaney, 2000), family/caregivers of HIV/AIDS patients

(Powell-Cope, 1994), and oncology patients (Winters et al., 1994) from the United States noted "trust" as part of caring. Those patients who included "trust" as a descriptor of caring were found in acute care (Fareed, 1996) in England, and oncology in Iceland (Halldorsdottir & Hamrin, 1997).

"Genuine concern" and "caring" were described in studies as aspects of nurse caring for patients. Acute care (Paternoster, 1988), surgical and obstetric patients (Drew, 1986), hospice families (Raudonis & Kirschling, 1996), and parents of pediatric patients (Williams, 1992) in the USA reported care and concern as aspects of nurse caring. Oncology in Iceland (Halldorsdottir & Hamrin, 1997), oncology (Jensen et al., 1996) and acute care (Jensen et al., 1993) in Sweden, stroke patients in England (Pound et al., 1995), and elderly home care patients in Canada (Poole & Rowat, 1994) noted "concern" and "caring" as a component of the concept nurse caring.

"Comfort" was another descriptor of nurse caring noted by patients in reviewed studies. In the United States patients from acute care (Clayton, Murray, Hornes, & Greene, 1991; Paternoster, 1988; Sherwood, 1991), and obstetrics (Swanson-Kauffman, 1986) identified "comfort" as an aspect of caring. Postpartum (Collins et al., 1994) and stroke (Pound et al., 1995) patients in England noted that "comfort" was a facet of nurse caring.

Patients had additional descriptors for the term "presence". Descriptors included a "calm demeanor" for American acute care patients (Clayton, 1989), "emotional support/reassurance/empowerment" for neonatal intensive care parents (Lemmer, 1991)

and oncology patients (Winters et al., 1994), and “love” for HIV/AIDS patients (Beauchamp, 1993) and for Danish women with cancer (Jensen et al., 1996).

*Uncaring descriptions of presence by nurses, students and patients*

Nurses, students and patients described instances where uncaring behaviors occurred. The descriptors given by the participants in studies reviewed were the antithesis of nurse caring and its attribute presence. *Uncaring* emerged from the data of the reviewed studies and was defined as the absence of professional regard exhibited by indifference, mutual avoidance, disconnection, and at its nadir, coldness and inhumanity.

Burfitt et al (1993) identified “indifference,” and low effort (“just a job”) as uncaring behaviors expressed by intensive care nurses in the USA. Kahn & Steeves (1988) found that “just a job” and “animosity” were reported as an absence of caring by nurses in graduate studies. Chipman (1991) interviewed students who stated that uncaring was “not giving of self” and “no comfort”. “Disconnected,” “dishonest,” and “distant” were uncaring behaviors described by acute care nurses in the United States when interviewed (Parker, 1994). Solberg & Morse (1991) found that neonatal nurses in Canada thought uncaring as “distant” with “no engagement” and “no comfort” for the patient. Halldorsdottir (1989) interviewed students in Iceland and uncovered that to them, uncaring behaviors expressed a “lack of concern”.

Patients used similar words to describe uncaring presence. In the United States, obstetric patients noted “indifference” (Drew, 1986), being “minimally present,” and “remote” (Finn, 1993). Adolescent psychiatric patients stated that nurses were “only

doing a job"(Hinds, 1988). Reiman (1986), using a case study methodology, found that the patient described nurses as uncaring when they appeared to be "only doing a job".

In Sweden, hospitalized and primary care patients asserted that nurses acted as if " work was only a job," their routines were "inflexible', and they were "indifferent"(Lovegren et al., 1996). Oncology patients in Iceland stated that there was a "disconnection" with the uncaring nurses, that these nurses were "indifferent" to the patients, and the patients "distrusted" them (Halldorsdottir & Hamrin, 1997). Icelandic obstetric patients said that nurses were "unkind" (Halldorsdottir & Karlsdottir, 1996).

*Respect for the Person*

A second attribute that emerged from the meta-synthesis data was a sense of "respect" for the dignity of others. *Respect for the Person* was defined as an emotional honoring of human dignity exhibited by empathy, listening, anticipating, trusting, and being dependable and supportive, compassionate, authentic in sharing, accessible and vulnerable to the exchange.

*Respect for the Person as described by nurses and students*

"Human dignity," "consideration," and "respect" were values incorporated within caring for many nurses. Doctoral students in the United States (Bush, 1988) and students in Iceland (Halldorsdottir, 1989) noted "respect" as an aspect of caring. Acute care nurses (Clayton et al., 1991; Parker, 1994), palliative care nurses (Davies & O'Berle, 1990), and nurses practicing in various specialties (Wolf et al., 2003a) agreed that "consideration" and "respect" were expressed through caring. Filipino-American nurses listed "respect" as a facet of caring (Spangler, 1993). Acute care nurses in Canada (Forrest, 1989) and

Sweden (Jensen et al., 1993) , and intensive care nurses in England (Beeby, 2000b) included "respect" in descriptions of nurse caring behaviors. "Other regarding" was noted as similar to respect. Nurses noted "the other" should be regarded as unique, and accepted. American students mentioned "other regarding" as an aspect of respect (Kahn & Steeves, 1988; Schaefer, 2003). Nurses noting "other regarding" practiced in acute care in the United States (Clayton et al., 1991; Parker, 1994).

"Empathy" was often mentioned as a characteristic of respect. Students included "empathy" in descriptions of caring behavior (L. Hanson & Smith, 1996; Kahn & Steeves, 1988). Nurses in acute care (Clayton et al., 1991; Donoghue, 1993; Green-Hernandez, 1991; Parker, 1994; Ray, 1984; Wolf et al., 2003a), perioperative care (McNamara, 1995), and pediatric oncology (Williams, 1992) noted empathy as caring. Outside the United States, nurses who included "empathy" as a descriptor for caring, were acute care nurses from Canada (Forrest, 1989)and Sweden (Jensen et al., 1993).

Respect included being "supportive" or aware of others' needs. In the United States students (L. Hanson & Smith, 1996), obstetric nurses (Peterson, 1985), oncology and pediatric oncology nurses (Steeves et al., 1994; Williams, 1992), and nurses in various practice areas (Green-Hernandez, 1991) reported "support" as an aspect of caring. "Supporting" the patient was described by students (Beck, 1992a, 1993, 1994; Hughes, 1993a), and perinatal (McNamara, 1995). Acute care (Dietrich, 1992; Ray, 1984; Wolf et al., 2003a) nurses in the United States. Clarke & Wheeler (1992), and acute care nurses in England noted "support" in their definition of caring. Other expressions of respect related to support included "affirmation" and "motivation"

(L. Hanson & Smith) and "maintaining belief" in the patient's ability to succeed by neonatal intensive care nurses (Swanson, 1990).

Nurses and students mentioned "listening" as a facet of caring. Kahn's & Steeve's (1988) study of nursing students perception of caring included "listening". "Listening" was noted in a list of caring components by United States nurses in public hospitals (Donoghue, 1993), and nurses in various practice areas (Green-Hernandez, 1991; Ray, 1987; Wolf et al., 2003a). English (Clarke & Wheeler, 1992) acute care nurses and Swedish (Jensen et al., 1993) acute care nurses include "listening" with caring descriptors.

"Respect" for human dignity was also included in such terms as "dependability by truth telling" (Steeves et al., 1994) and "consistency" (Williams, 1992). "Commitment" or "fidelity" of the nurses to patients and family were noted by some advanced practice students (Schaefer, 2003), and nurses (Burns, 1994; Grigsby & Megel, 1995) in the USA, and nurses in Sweden (Jensen et al., 1993). Two American studies noted "anticipates" as an aspect of caring (Clayton, 1989; Miller et al., 1992). Student nurses reported they "anticipate" the needs of the patient (Coulon, Mok, Krause, & Anderson, 1996) in Australia.

*Respect for the Person as described by patients and families*

Patients frequently identified "respect" for human dignity in qualitative studies. Terms used by patients to describe being treated with dignity were "respect," "personally valued," and being "known". In the United States "respect" was mentioned by HIV/AIDS (Beauchamp, 1993), intensive care patients (Bunkers, 2004; Gramling, 2004), as

"acceptance" by depressed women (Mullaney, 2000), and as "considerate" by hospice patients (Raudonis & Kirschling, 1996). Postpartum patients in England (Collins et al., 1994) and Iceland (Halldorsdottir & Karlsdottir, 1996), oncology patients in Iceland (Halldorsdottir & Hamrin, 1997) and Denmark (Jensen et al., 1996), acute and primary care patients in Sweden (Lovegren et al., 1996), and elderly patients in Canada (Poole & Rowat, 1994) stated that "respect" was an aspect of caring encounters with nurses. Those who used "personally valued" or "known" as descriptors for respect in the USA were surgical (Sherwood, 1991), obstetric (Swanson-Kauffman, 1988), and acute care patients (Tanner, Benner, Chesla, & Gordon, 1993). Patients fromother countries also valued "being known" such as surgical patients in Australia (Hogan, 2000), intensive care patients in Canada (Jenny & Logan, 1996), and acute and primary care patients in Sweden (Lovegren et al., 1996). "Respect for patients' families" was listed as a component of caring by patients' families (Powell-Cope, 1994), and oncology patients (Winters et al., 1994).

"Having situational control" was valued by intensive care patients in the United States, that had choice and actively participated in their healthcare (Gramling, 2004). Obstetric couples whose "rights were respected" (Lemmer, 1991), and pediatric oncology patients who felt "empowered" (Williams, 1992) supported this inclusion. Danish women with cancer valued "autonomy" in nurse encounters (Jensen et al., 1996), and acute and primary care patients in Sweden (Lovegren et al., 1996) thought "situational control" was important for patients to feel cared for.

Other descriptors used to describe a respectful honoring of the patients were "dignity" by HIV/AIDS patients in the USA (Beauchamp, 1993), and acute/primary care patients in Sweden (Lovegren et al., 1996); "empathy" by cancer patients (Winters et al., 1994), obstetric patients(Finn, 1993), and supported by patients' families (Powell-Cope, 1994) in the United States. Respect for "individuality" was mentioned by intensive care patients (Gramling, 2004), obstetric couples (Lemmer, 1991), and acute care patients (Tanner et al., 1993) in the USA, post partum women in England (Collins et al., 1994; Jensen et al., 1996), and cancer patients in Denmark. Clayton(1989) and Poole & Rowat (1994) found that Canadian patients interviewed valued the nurse's "patience". Patients and family members wanted nurses to be "accessible" and available (Fareed, 1996) (England). Some patients named "honesty" with regard to their treatment or medical condition as an aspect of caring (Sherwood, 1993; Swanson-Kauffman, 1988). Some English obstetric (Fareed, 1996) and Canadian (Poole & Rowat, 1994) home care patients regarded "encouragement" as the nurse honored the patient's uniqueness a caring aspect. "Compassion" was valued by cancer patients in Iceland (Halldorsdottir & Hamrin, 1997). "Sensitivity" to the patient as a person was also named by HIV/AIDS patients (Beauchamp, 1993), obstetric patients and their spouses (Finn, 1993), and depressed patients (Mullaney, 2000). Acute care patients stated that nurses who "anticipated" their needs were caring (Clayton et al., 1991).

"Listens" was mentioned as a caring component by acute care patients in the United States (Clayton et al., 1991; Williams, 1992). Post partum (Collins et al., 1994) and acute care (Fareed, 1996) patients in England, acute/primary care patients in Sweden

(Lovegren et al., 1996) and home care patients in Canada (Poole & Rowat, 1994) stated that nurses that "listen" were caring.

*Uncaring descriptions of Respect for the Person by nurses, students and patients*

Antithetical to for human dignity were uncaring acts by nurses. Uncaring behaviors noted by nurses were described as "disrespect" (Parker, 1994) and patients "treated as an objects" (Burfitt et al., 1993). Nurse researchers in Iceland observed nursing actions they labeled as "inhumanity" from their study of nurses in an Emergency Room (Winman & Wikblad, 2004).

Descriptions of uncaring under the nurse caring attribute of *Respect for the Person* by patients were "impatient," "hurried," or "irritated" (Drew, 1986; Reimen, 1986); "dismissive" (Drew; Lovegren et al., 1996); "harsh" and "insensitive" (Drew; Halldorsdottir & Karlsdottir, 1996; Hinds, 1988; Winman & Wikblad, 2004). Reiman found that patients felt "belittled" by nurses. Some patients felt that nurses were "cold" (Drew; Finn, 1993; Halldorsdottir & Karlsdottir; Winman & Wikblad), "unconcerned" and "disinterested" (Drew; Halldorsdottir & Karlsdottir; Winman & Wikblad). Other patients felt as if they were "treated as objects" instead of persons (Finn; Lovegren et al.; Reimen; Swanson-Kauffman, 1988; Winman & Wikblad).

*Knowledgeable, Competent Care*

Nurse caring (NC) is not complete without inclusion of the technical interventions nurses perform with knowledge and expertise. The NC attribute of *Knowledgeable, Competent Care* is defined as knowledgeable; competent in all interventions which include helping, monitoring, and attending; being able to communicate as a teacher and

advocate; and being able to provide nurturing support, healing, protection, and attention through touch.

*Knowledgeable, competent care as defined by nurses and students*

The most common descriptor for nursing action by nurses and students was "communication". "Sharing information" or "communicates" was noted by doctoral nursing students (Bush, 1988), registered nurse master's students (Kahn & Steeves, 1988; Schaefer, 2003), and bachelor degree students (Hughes, 1992, 1993a) in the United States; and nursing students in Australia (Coulon et al., 1996). Acute care nurses (Green-Hernandez, 1991; Ray, 1987), perioperative nurses (McNamara, 1995), and neonatal intensive care nurses (Swanson, 1990) in the United States stated that "communication" was a component of caring. Likewise, medical-surgical nurses in England (Clarke & Wheeler, 1992), Canada (Davies & O'Berle, 1990), and New Zealand (Euwas, 1993) included "communication" in their description of caring.

A descriptor related to communication was called "teaching". Nurses from various areas of practice in the USA listed "teaching" as a component of caring (Ray, 1984; Steeves et al., 1994; Williams, 1992; Wolf et al., 2003a). Forrest (Forrest, 1989) documented that nurses studied in Canada also included "teaching" as a component of caring.

"Attending," "touch," and "taking care" was frequently noted by researchers conducting qualitative studies in their documentation of caring descriptors. Students in the United States (Chipman, 1991; L. Hanson & Smith, 1996; Kosowski, 1995; Schaefer, 2003) and Australia (Coulon et al., 1996)included "attending" to patients or touch as a

descriptor for nurse caring. American nurses practicing in acute care (Green-Hernandez, 1991; Ray, 1984), obstetrics (Finn, 1993), perioperative care (McNamara, 1995), and intensive care (Ray, 1987); and acute care nurses in England (Clarke & Wheeler, 1992) stated that "attending" to the patient was a component of caring.

"Knowledgeable" and "competent" were two related descriptors of caring declared by nurses and students. Schaefer (2003) noted that students in the United States thought "knowledge" was a component of caring. Kosowski (1995) and Engebretson (2000) reported that students valued "competence" as caring. Coulon (1996) discovered that students interviewed in England listed "competency" and "knowledge" as caring components. Students in Iceland valued "knowledge" and "competence" in caring (Halldorsdottir, 1989). Nurses in the USA, declaring "knowledge" as an aspect of nurse caring, practiced in acute care (Clayton et al., 1991; Donoghue, 1993). "Competence" or "right decisions" were included as part of the definition of caring by nurses in acute (Green-Hernandez, 1991; Parker, 1994; Ray, 1984) and critical care (Ray, 1987). Nurses interviewed by Leners (1993) stated that "intuition" was a process of caring. Benner (1984) noted that nurses needed to master intervention skills before they can begin to think of the patient as a person. Intuition occurred when the nurse became an expert, competent in practice.

"Helps," "acting promptly," "meeting needs," and "enables" others to become were aspects of caring articulated by nurses and students. Students (Hughes, 1993a) and acute care (Clayton, 1989; Green-Hernandez, 1991; Ray, 1984), critical care (M. D. Hanson, 2004), and neonatal intensive care (Swanson, 1990) nurses in the United States

listed “helps” as a nurse caring component. Wolf et al (2003a) discovered that nurses interviewed included “acting promptly” as an aspect of caring. Euwas (1993) found that New Zealand nurses voiced “meeting needs” as part of nurse caring. Hanson’s (L. Hanson & Smith, 1996) study of students and Swanson’s interviews in the neonatal intensive care unit revealed that participants thought “enabling” so that others may become was a descriptor for caring.

“Advocates” and “protecting” were elements of nurse caring in some qualitative studies. In the USA students (Kahn & Steeves, 1988; Kosowski, 1995) and acute care nurses (Clayton, 1989) stated that “advocating” for patients was an aspect of nurse caring. Nurses in Sweden (Back-Pettersson & Jensen, 1993; Jensen et al., 1993) and Canada (Davies & O'Berle, 1990) also mentioned “advocates” as a nurse caring component. Oncology (Steeves et al., 1994), critical care (Ray, 1987), perioperative (McNamara, 1995), and obstetric (Peterson, 1985) nurses in the United States noted that “protecting” patients was an act of caring.

Technical aspects of “acting” and “monitoring” were reported as aspects of nurse caring. Researchers reported “observation” and “monitoring” as part of nurse caring by acute care nurses (Ray, 1984; Steeves et al., 1994). Steeves documented “acting” as an aspect of caring.

Other aspects of caring noted by nurses and students included “problem solving” through assessment of the patient by nurses (Ray, 1984), being “responsive” and sensitive to patients needs by students (L. Hanson & Smith, 1996; Hughes, 1993a), “responsiveness” by connecting patients with support systems by nurses (McNamara,

1995; Ray), an “attentiveness” to patients through acts of “patience” by Filipino-American nurses (Spangler, 1993).

*Knowledgeable, competent care as described by patients and families*

Patients reported that nursing competence, or “knowing how to” was the most important aspect of nurse caring. Nurses who were “knowledgeable” and “able to enact the skills” required for the patient also exhibited confidence, ease, expertise, and understanding. These were important caring components for acute care (Miller et al., 1992; Paternoster, 1988), intensive care (Cooper, 1993; Gramling, 2004), surgical (Sherwood, 1991), obstetric (Finn, 1993; Lemmer, 1991; Propst et al., 1994) patients, and hospice families (Raudonis & Kirschling, 1996) in the United States. Acute care patients in Australia (Hogan, 2000), England (Fareed, 1996)and Sweden (Lovegren et al., 1996), oncology patients in Denmark (Jensen et al., 1996) and Iceland (Halldorsdottir & Hamrin, 1997), post partum patients in England (Collins et al., 1994) and Iceland (Halldorsdottir & Karlsdottir, 1996), and home health patients in Canada (Poole & Rowat, 1994) all thought nurse caring included “competence”.

“Enacting skills” was the second most common response from patients and placed under the nurse caring attribute of nursing action. Acute care (Clayton et al., 1991), pediatric (L. Brown, 1986), neonatal intensive care (Swanson, 1990), obstetrics (Swanson-Kauffman, 1986), outpatients (Bunkers, 2004), and surgical (Sherwood, 1991) patients in the United States stated that “enacting skills” or “doing physical tasks” was a component of nurse caring. Stroke patients in England (Pound et al., 1995), neurological (Milne & McWilliam, 1996), home health (Poole & Rowat, 1994) patients in Canada,

and oncology patients in Denmark (Jensen et al., 1996) also noted “enacting skills” as caring action.

Related to “enacting skills” was “helping,” “assisting,” and “doing for” as caring nursing actions. HIV/AIDS patients (Beauchamp, 1993), adolescent psychiatric patients (Hinds, 1988), depressed women (Mullaney, 2000), and obstetric (Swanson-Kauffman, 1986, 1988) patients acknowledged the nurse’s “touch” as skills enacted as caring. “Helping” was also noted by acute care patients in Sweden (Lovegren et al., 1996), intensive care patients in Canada (Jenny & Logan, 1996), and obstetric patients in England (Collins et al., 1994).

“Communicating” or “providing information” was considered by some patients to be an act of nurse caring. In the United States neonatal intensive care parents (Swanson, 1990), patient families (Powell-Cope, 1994), and obstetric (Lemmer, 1991; Swanson-Kauffman, 1988) patients stated that “communicating” was caring. Acute care patients in England (Fareed, 1996), and Sweden (Lovegren et al., 1996), intensive care (Jenny & Logan, 1996) and home health (Poole & Rowat, 1994) patients in Canada, oncology patients in Denmark (Jensen et al., 1996), and surgical patients in Australia (Hogan, 2000) thought “providing information” was important as an act of nurse caring.

Additional descriptors of nursing action included “doing extra things” for intensive care (Gramling, 2004), obstetric (Propst et al., 1994) American patients, and acute care patients in Sweden (Lovegren et al., 1996). “Surveillance” or “monitoring” were identified by acute care (Miller et al., 1992), adolescent psychiatric (Hinds, 1988), intensive care (Burfitt et al., 1993; Gramling, 2004), oncology (Winters et al., 1994),

pediatric (L. Brown, 1986), and surgical (Sherwood, 1991) patients in the United States. Adolescent psychiatric patients valued "persistence" by nurses (Hinds). Obstetric (Swanson-Kauffman, 1986) and pediatric (Bowers, 1987) patients and families valued nurses who were "protective". Neurological (Milne & McWilliam, 1996) and home health (Poole & Rowat, 1994) patients in Canada,, and surgical patients in Australia (Hogan, 2000) stated that nurses who "facilitated the integration of services" were exhibiting caring practices. "Providing pain relief" in a timely manner was considered a caring action by intensive care patients in the USA (Gramling, 2004), and by obstetric patients in England (Collins et al., 1994), and acute care patients in Sweden (Lovegren et al., 1996).

*Uncaring behaviors in knowledgeable, competent care as defined by nurses, students and patients*

Nurses did not describe any behaviors associated with nursing action that were uncaring in the reviewed studies. Chipman (1991) however, found students noted that patient needs were "not met in a timely manner". Patients described several uncaring actions such as a nurse treating a patient "roughly" (Reimen, 1986), "withholding contact" (Finn, 1993; Reimen; Swanson-Kauffman, 1988), or "being incompetent" (Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996).

*Nursing Theorists Descriptors of Nurse Caring Attributes*

Nursing theorists who focused on the concept of caring also listed descriptors of caring that could be categorized under the Nurse Caring attributes of presence, respect, and nursing action similar to the clinical nurses interviewed by researchers. Leininger

(1989, 1981) used terms such as “comfort”, “succorance”, and “presence” describing the attribute presence. “Listening” and “support” were descriptors used that fit with respect. Nursing action terms used by Leininger were “touch”, “assistive”, and “enabling”.

Watson (2006), in the most current account of the Theory of Human Caring listed caring descriptors for presence such as “authentically present,” “trusting,” “enabling/sustaining faith/hope,” “being present to,” “allowance for existential forces,” and “transcendence/spiritual union”. “Loving-kindness,” “equanimity,” “supportive,” “protective,” and “creating a healing environment” described respect. Nursing actions were “helping,” “teaching-learning” and use of “ways of knowing”.

Swanson’s (1991) Middle Range Theory of Caring used terms such as “being with,” “emotionally present,” and “attaching” that described presence. “Preservation of human dignity” is caring according to Swanson, and is an apt descriptor for the NC attribute *Respect for the Person*. “Doing for”, “providing care” and “comfort,” “enabling using expert knowledge,” and “actualizing” by maintaining belief in patients fit with nursing action.

Marlaine Smith (1999) wrote a review of caring within the Science of Unitary Human Beings the theory developed by Rogers (1990b, 1994). Smith listed aspects of caring within the theory that were consistent with the attributes of Nurse Caring. Descriptors for presence included “authentic presence,” “knowing the other,” “spiritual union,” and “divine love”. Smith’s descriptions of “reverence for human life”, “attention”, and “concern” fit within the definition of *Respect for the Person*. Nursing intervention was listed as “knowing when to move, to be still and to speak.”

*Identification of the Effect of Nurse Caring*

Part of the distillation of data in this meta-synthesis included the identification of indices and effects of the nurse-patient encounter (Thorne et al., 2004). Below antecedents (indices) and consequences (effects) of *nurse caring* are reported.

*Antecedents to nurse caring in the literature*

In the process of identifying and defining a concept, antecedents and consequences were identified (Walker & Avant, 1995). Antecedents define those elements that preceded the behavior "nurse caring" and provided a means of identifying underlying assumptions about the concept (Walker & Avant). Some researchers reported specific antecedents to caring encounters. Gaut (1983) stated that caring required intent, context and action. Euwas (1993) discussed that preconditions for caring included: "ready to be in contact," "bringing benevolence to the interaction," "commitment," and "competency" among nurses and patients in New Zealand. In the United States, Engbretson (2000) stated that students listed "intentionality" as a prerequisite to caring. Parker (1994) noted that "inner harmony" and "accountability" was required for nurse caring to occur. "Being available" was an antecedent to caring in to a study of parents and health care professionals (Williams, 1992). Swanson (1999) in conducting a meta-analysis of caring theory quantitative and qualitative studies found that caring capacities included "compassion," "empathy," "knowledge," "positive(ness)," and the "ability to be reflective".

*Consequences to Nurse Caring in the literature*

Consequences to caring or uncaring behaviors were also noted in the qualitative studies, and were useful in determining positive or neglected aspects or relationships with the concept, caring (Walker & Avant, 1995). When nurse caring occurred patients felt relaxed, confident, stronger, and in control (Drew, 1986). Sherwood (1993) reported that consequences to caring included a "positive mental attitude," "decreased anxiety," "emotional needs were met," a "feeling of safety," "protected," "reassurance," "dignity," "acceptance," "trust," and "satisfaction". Paternoster (1988) stated that patients felt "good," "secure," "connected," and "validated". Brown & Ritchie (1989) reported for Canadian patients a "reciprocal relationship" resulted from nurse caring. Raudonis (1993) stated that American hospice patients also experienced a desire for "reciprocal sharing". Students told researchers that they felt "respected as individuals," "energized," "able to reach out" (Beck, 1991), and a reciprocal relationship (Beck, 1992b) when experiencing a caring relationship with faculty. In a meta-analysis of caring Swanson (1999) noted that consequences for caring behaviors for the nurse were "feeling important," "accomplished," "purposeful," "aware," "integrated," "whole" and "confirmed," (p.53) and a "sense of collegiality".

Uncaring consequences were also described by students and patients within the qualitative studies reviewed. Drew (1986) discovered that patients in the USA reported "increased stress," "decreased energy," and "anger" in uncaring situations. Halldorsdottir's (1989) interviews with students in Iceland revealed "decreased energy," "anger," "disbelief," "helplessness," "fear," and "uneasiness" after an uncaring experience with faculty.

*Synthesis question 3(b): Did study findings lead to a new comprehensive definition for the concept of caring?*

A single set of categories (Appendix A) were created from the synthesis that incorporated the nurses', students,' and patients' perceptions of the nurse-patient encounter. The result of this meta-synthesis was to identify a new conceptualization of caring. *Nurse caring* was the synthesized redefinition of caring from nurses, students, and patients' perceptions of the nurse-patient encounter that is recounted as follows:

*Nurse Caring: a mid-range theory*

A mid-range theory for nurse caring emerged from the qualitative data reviewed (Figure 1). Over twenty years ago, Gaut (1983) stated that caring, as a whole experience, was summed up by intent, context, and action. Nurses, students, and patients/families experienced and reported similar descriptors within caring encounters. These accounts of *nurse caring* were analogous across various cultures and the years since Gaut's statement. *Nurse caring* was defined as a learned, intentional act by a nurse. It included a presence with the patient/client, a respectful honoring of a unique individual (family/group/community), resulting in a spiritual connection or transcendence as the nurse partnered with the patient/client in actions that fostered enhanced well being and reciprocity.

This mid-range theory of *nurse caring* (Figure 1) had three attributes that emerged from the descriptors reported by nurses, students and patients. They are listed and defined as follows:

- P*resence, Concern for the Other* was the act of being present with the patient/family/group/community which could be described as an interconnectedness, a relational connecting, a communion with the other, having insight and concern so needs were anticipated and comprehended, that resulted in a spiritual connection/transcendence.
- *Respect for the Person* was an emotional honoring of human dignity exhibited by empathy, listening, anticipating, trusting, being dependable and solicitous, compassionate, authentic in sharing, accessible and vulnerable to the exchange.
- *Knowledgeable Competent Care* was knowledgeable; competent in all interventions which included helping, monitoring, and attending; being able to communicate as a teacher and advocate; and able to provide nurturing support, healing, protection, and attention through touch.

Students and patients also described uncaring student/faculty or nurse/patient experiences in the reviewed studies. *Uncaring* was defined as the absence of professional regard exhibited by indifference, mutual avoidance, disconnection, and at its nadir, coldness and inhumanity.

A caring encounter was preceded by indices (attitude, intent, context, need, and nursing expertise) which were required for nurse caring to occur. Without the antecedent factors, one or more of the attributes required for a caring encounter might not occur, resulting in an uncaring nurse/patient or faculty/student experience.

Effects of the nurse-patient encounter were positive when nurse caring occurred. Positive outcomes for nurses included accomplishment, enhanced intuition/judgment,

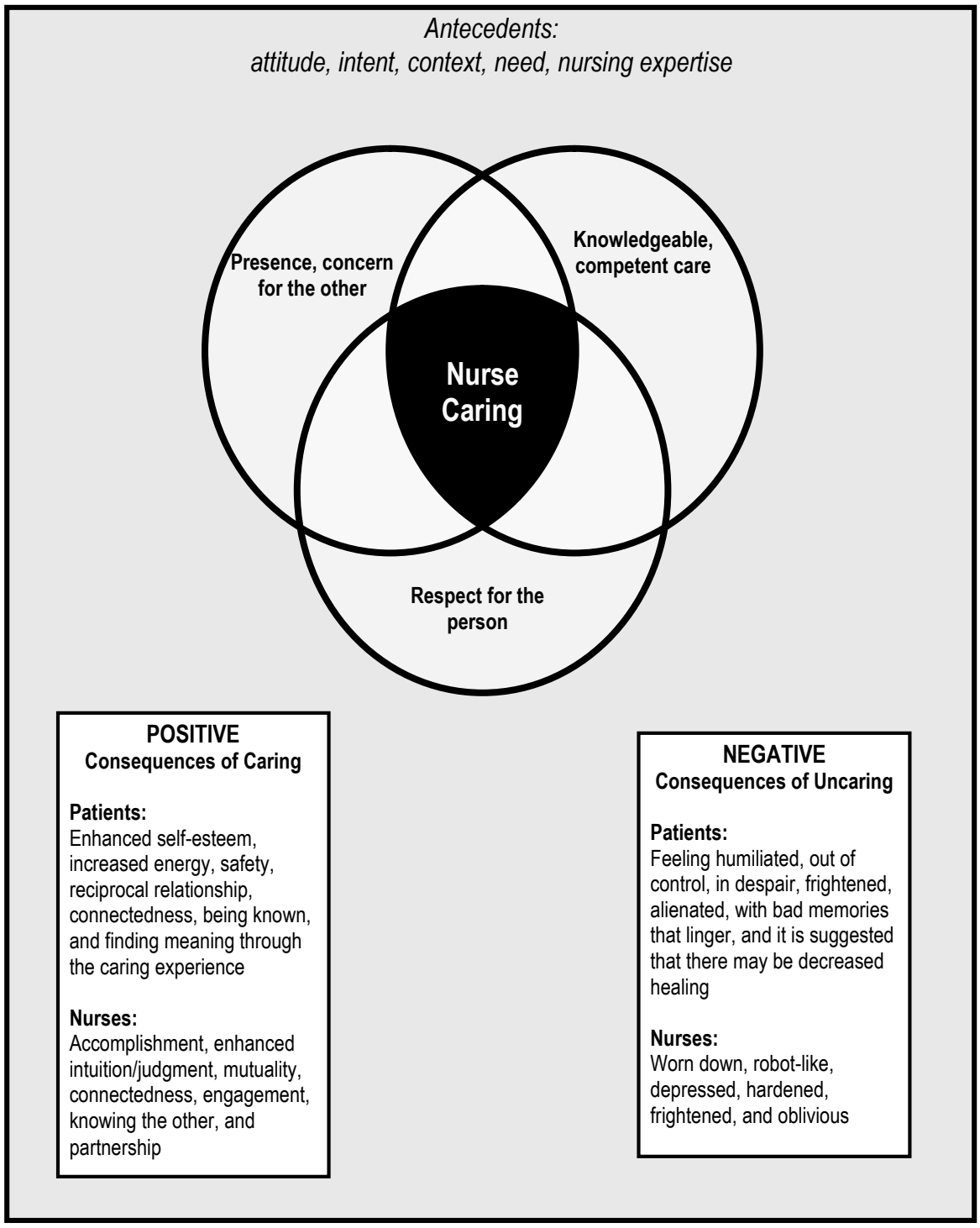
mutuality, connectedness, engagement, knowing the other, and partnership. Patients felt enhanced self-esteem, increased energy, safety, reciprocal relationship, connectedness, being known, and finding meaning through the caring experience. Consequences of uncaring encounters resulted in the nurses feeling worn down, robot-like, depressed, hardened, frightened, and oblivious. For patients, uncaring experiences left them feeling humiliated, out of control, in despair, frightened, alienated, with bad memories that linger, and it was suggested that there might be decreased healing.

### *Summary*

A meta-synthesis of 90 qualitative studies that explored the nurses, students or patients' perceptions of the nurse-patient encounter was the first aim of this study. A mid-range theory of *nurse caring* emerged from the data. *Nurse caring* is defined as a learned, intentional act by a nurse. It included a presence with the patient/client, a respectful honoring of a unique individual (or family/group/community), resulting in a spiritual connection or transcendence as the nurse partners with the patient/client in actions that fostered enhanced well being and reciprocity. Indices that led to the event of nurse caring included the attitude of the nurse toward the patient, the intent and context of the encounter, an expressed or unexpressed need, and nursing expertise. Consequences of the caring encounter affected both nurses and patients.

Three attributes emerged from the meta-synthesis data that described components of *nurse caring*. One attribute was *Presence, Concern for the Other.* It was defined as the act of being there with the patient/family/group/community that could be described as

*Figure 1*. A Mid-range Theory of Nurse Caring



interconnectedness, a relational connecting, a communion with the other, having insight and concern so needs are anticipated and comprehended, and it can result in a spiritual connection/transcendence. Another attribute of *nurse caring* was *Respect for the Person* which was defined as an emotional honoring of human dignity exhibited by empathy, listening, anticipating, trusting, and being dependable and supportive, compassionate, authentic in sharing, accessible and vulnerable to the exchange. *Knowledgeable, Competent Care* was the third attribute. It was defined as knowledgeable; competent in all interventions which include helping, monitoring, and attending; being able to communicate as a teacher and advocate; and being able to provide nurturing support, healing, protection, and attention through touch. These three attributes comprised the ideal of nurse caring.

The emergent mid-range theory of nurse caring and conceptual model (Figure 1) provided a more comprehensive definition of caring within the profession of nursing, and a framework for instrument development. A new instrument, the *Nurse Caring Patient Scale* (NCPS) that measured the patient's perceptions of feeling cared for by nurses, was developed from the patient descriptors of *nurse caring*. Chapter four outlines the methodology for the development and analysis of the NCPS.

# CHAPTER 4

# Methodology

## *Introduction*

Development and testing of the psychometric properties of the Nurse Caring Patient Scale (NCPS), was the second aim of this study. In order to create an instrument that contributes to the body of caring knowledge, an evaluation of caring descriptors as reported by nurses, students and patients needed to be evaluated to establish an more comprehensive definition of caring concept. A mid-range theory of nurse caring emerged from a meta-synthesis of 90 qualitative studies that reported nurses, students and patients' perceptions of nursing care. The new instrument (NCPS) reflected the patient perceptions of the nurse-patient encounter, and it was supported by the theoretical framework of caring as identified in the literature. This chapter discusses the research methodology including: the design, setting, sample, instrument development, and data collection of NCPS; protection of human subjects; treatment of NCPS data; and NCPS data analysis.

## *Design*

An inductive methodological design was used to develop an instrument to measure patient' perceptions of feeling cared for by nurses. NCPS was evaluated by conducting psychometric evaluation of the validity and reliability of the survey distributed to a sample of patients for testing and validation.

Specific questions to be answered were:

1. To what extent did the NCPS demonstrate internal consistency reliability prior to establishing factoral validity?

2. To what extent did the components of NCPS, created from a metasynthesis of qualitative studies on caring be demonstrated in Principal Component Analysis?
3. To what extent did the resulting factors demonstrate reliability to stand as independent factors
4. What specific descriptors of caring (uncaring) were described by subjects? Did the results of the descriptive question provide insight for further development of the instrument?

## *Setting*

The Professional Nurse Caring Patient Scale was developed for an in-patient population, and was tested on patients who have been hospitalized for more than 24 hours. Because of the number of statements on the initial survey, a large number of in-patients were needed for the best possible statistical analysis. A large urban teaching medical center in the northeastern United States was chosen to conduct the study. The medical center served patients from a large area in the local community and beyond its northeastern location.

### *Sample*

In factor analysis, especially when determining initial factor structure, sample size and representativeness were key concerns. DeVellis (2003) stated that a large sample produced a more stable factor pattern. Sample size, however, was not always determined by a standard ratio to the number of variables. A ratio of 5-10 subjects per survey item up to 200 participants was suggested by Tinsley and Tinsley (1987). Another set of guidelines stated that samples of 300 or more may have relaxed standards (Comrey,

1988). NCPS contained 50 specific statements. Using Tinsley and Tinsley's ratio, 250-500 participants were needed for a valid sample size. Comrey (1973, 1988) stated that a sample of 200 would be adequate for surveys of 40 questions, but also constructed a guideline of 300 subjects as good, 500 subjects as very good, and 1000 subjects as excellent that applied to surveys with greater than 40 questions.

*Sample for the descriptive question*

Qualitative research required a different practice for determining the required number of inquiries for validity. There are no specific guidelines used to determine the best number of study participants. Having something to say at the end of the study was an important issue (Patton, 2002). The focus of qualitative inquiry was depth of information gleaned from subjects. When patterns emerged, and no new information was gleaned from subsequent subjects, the sample was considered large enough. In this case, one descriptive question asked that participants recall a nurse-patient encounter during their hospitalization. The purpose of this question was to discover if patients use descriptors for caring and uncaring encounters that were similar or different from the ones used to create the NCPS. The sample was heterogeneous, in that participants were medical-surgical in-patients from a large urban medical center. There was a reasonable expectation of validity since the quantitative sample size was so large.

*Sample inclusion criteria*

Inclusion criteria for the study sample were that participants:

1. Adults age 18 or older.
2. Had an ability to communicate, read, and write in English.

3. Cognitively able to complete the survey as determined by the hospital unit nurse.
4. Were a medical-surgical in-patients for more than 24 hours.

### *Instrumentation*

Three data sources were used in this study: the *Nurse Caring Patient Scale* (NCPS) (Appendix F), a descriptive question (Appendix G) asking the participant to relate an encounter with a nurse during his/her hospitalization, and a demographic sheet (Appendix H).

#### *Instrument Development: Nurse Caring Patient Scale (NCPS)*

The *Nurse Caring Patient Scale* was developed using DeVellis' (2003) guidelines for scale development. A mid-range theory of *nurse caring* (NC) emerged from a meta-synthesis of the literature including quantitative and qualitative research on caring. NC, an ideal, occurs when a nurse enters a nurse-patient encounter with intent, the right attitude, expertise, context and need. Presence, concern of the patient; respect for the individual person, and knowledgeable competent care are essential components of nurse caring. When one of the antecedents or attributes of NC are absent, uncaring may occur. Caring and uncaring may vary in intensity. This is associated with attitude and skills brought by the nurse to the encounter, and informed by the context or environment in which the encounter happens. NCPS was created from this framework, and specifically from descriptors of *Presence, Concern for the Other; Respect for the Person;* and *Knowledgeable, Competent Care* provided by patients and families in response to qualitative studies conducted over the last two decades (Appendix E).

#### *Generation of an Item Pool*

The *Nurse Caring Patient Scale* (Appendix F) was a 50-item instrument designed to measure the patient's perceptions of feeling cared for by the nurse. NCPS was developed from an analysis of 39 qualitative patient studies (Appendix B), for specific descriptors of caring or uncaring (Appendix E). Descriptors of caring and uncaring placed within the three attributes of NC became the foundation of each statement in NCPS. The initial instrument was 34 statements, and three overall statements.

DeVellis (2003) stated that Likert scales were most commonly used to measure opinions and attitudes of participants. In order to create a scale that measured the frequency of a caring or uncaring experience, a six-point Likert scale was created : 0 = none of the time, 1 = rarely, 2 = a few times, 3 = some of the time, 4 = most of the time, and 5 = all of the time. Each term used asked for the patient's perception of how often caring or uncaring occurred. Six terms from "all of the time" to "none of the time" were used to capture most possible time descriptions. A second six-point Likert scale was created to measure how many nurses from the patient's perspective provided caring or uncaring encounters: 0 = none, 1= a few nurses, 2 = some nurses, 3 = many nurses, 4 = most nurses, and 5 = all nurses. Thus, the participant had two Likert scales to respond to for each item, one measuring how often an event happened, and the second measuring how many nurses provided the care.

The NCPS was then given to a group of 15 Clinical Nurse Specialist (CNS) leaders in a large metropolitan teaching hospital. Each CNS filled out the scale as though she were a patient participant. Then the CNS's was asked to determine how well the items in the NCPS reflected the definition of n*urse caring* and the listed descriptions of

the attributes *Presence, Concern for the Other, Knowledgeable, Competent Care, and Respect for the Person*. Assessment of the relevancy of instrument items in relation to the phenomenon being measured, along with item clarity and conciseness was evaluated. Additional descriptors of caring or uncaring that might be missing from the instrument as provided were asked for from the group. All the CNS's then met with the investigator to review their evaluative responses for each item in the instrument. A 10-point visual analogue scale from easy to confusing was used to grade each item. All statements were reviewed, and changes made to arrive at 100% consensus of the group. Changes included rewording sentences to improve clarity, altering negative statements to positively worded sentences, and eliminating the second Likert scale measuring "how many nurses" that was described by the panel as confusing and redundant. With the changes, the group agreed that each statement expressed a descriptor of NC, was clear, easy to read, and understandable. One nurse, who was unable to attend the group meeting, sent in her written comments to the investigator. All objections voiced by this absent nurse were duplicates of those voiced, and changed to create 100% agreement in the larger group.

NCPS was sent with the changes to an external content expert researcher at a large university nursing school familiar with the content of caring. Recommendations from the expert content reviewer included: changing affective language in the tool to simple declarative sentences and addition of several missing components of caring. All statements that contained the verbs "felt" or "seemed" were changed to simple declarative statements. Thirteen additional statements were added to the instrument based on the review and included descriptors verbalized by patients in the qualitative studies,

and items suggested by the reviewer as descriptions of the caring concept. Review of the scale with a methods expert resulted in the three "overall" statements being dropped from the survey. Each of the overall statements was deemed redundant to the specific statements and without a defined purpose. After adding items to the NCPS, the total number of statements was 50.

*Determination of Initial Instrument Content Validity*

DeVellis (2003) stated that to maximize content validity it was necessary to have a group of persons knowledgeable in the content area to assess the tool. Evidence based on test content is concerned whether the instrument items are representative and comprehensive (Frank-Stromberg & Olsen, 2004). To meet this criterion instrument items were evaluated by a panel of experts who were selected according to specific standards. Each item was judged for its content relevance. An index of content validity (CVI) showing the proportion of agreement by the panel was calculated for each item and the total instrument.

The original 50-item NCPS instrument was examined by five adults who had been hospitalized for more than 24 hours within the last 18 months, were currently outside of the hospital, and who agreed to participate. Each was considered an expert panelist because each had personal experiences with nurses as acute in-patients. "Expert" patients were personal acquaintances of the investigator. Each "expert" patient filled out the survey as though he/she was a study participant, noting the amount of time it took to complete. The investigator then reviewed each question with the expert patient, using a 10-point visual analogue scale from easy to confusing, to analyze clarity, readability, and

understandability (Table 5). General questions were asked about the overall feel of the format, ease of following the formatted statements and ease of rating the answers. Additionally each "expert" patient was asked if the instrument easy to read and understand overall. Finally, each "expert" patient was able to identify anything he/she thought was missing from the study instrument. Each "expert" was also asked if he/she could identify the nurse from the total pool of caregivers who entered his/her hospital room. Finally, all of the "expert" patients filled out the three descriptive questions with their own experiences.

"Expert" patients included one male and four females with an age range of 42-79 years. Each "expert" patient had experienced more than 48 hours as an in-patient in hospitals in the northeastern United States. There was 100% agreement that 38 of 50 items were clear, readable, and easy to understand, with the expert patients scoring all items as 8-10 on the visual analogue scale (Table 5). Twelve items had lower scores. One expert patient had objections to eight items (# 1, 2, 11, 25, 27, 31, 39, & 43) but objections were due to her concern that others might not understand the terms. This expert denied any personal difficulty reading and understanding the objectionable statements. One "expert" had difficulties with six items (#13, 17, 20, 26, 34, & 50). The third "expert" had difficulty with two items (# 17, & 47). A fourth "expert" patient scored four items (#1, 26, 34, & 47) lower than the others. The fifth "expert" had no objections to any of the items.

When two or more "experts" objected to an item, the investigator considered the item for change or elimination. Item one "The nurses knew what I needed" had

Table 5

*Expert Patient Item Review Directions*

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**Directions to the Reviewer:**
On the following pages, please read each item on the Nurse Caring Patient Scale, and evaluate it using the visual analogue scale provided. A sample of the evaluation statements are below. Please circle the response that best represents your answer.

SAMPLE:

1. The statement is clear.

1 2 3 4 5 6 7 (8) 9 10
Very Confusing Very clear

2. The statement is understandable

1 2 3 (4) 5 6 7 8 9 10
Very Confusing Easy to understand

3. The statement is readable.

1 2 3 4 5 6 (7) 8 9 10
Very Confusing Easy to read

---

objections from two patient "experts." Both stated that the statement, concerning what the patient needed, could be interpreted from multiple points of view. Since the object of the survey was the perception of patients, and caring includes physical, psychological, and spiritual components, the investigator determined that the item should remain in the survey unchanged.

Item 17 "The nurses were worried about what I was going through as a patient" was objectionable to two "expert" patients, because each thought the nurse should not be

"worried". Both agreed that the alternate word "concerned" was a better choice for this statement. The change was made to item 17.

Two "expert" patients scored item 26 "The nurses respected my choices in health care" lower than "easily understood". One "expert" patient stated he had no choices, but to follow the expectations of his physician and nurses. The other "expert" stated that she was unsure what was meant by "healthcare". Because each was a separate issue, not noted by the others, the investigator elected to keep the item unchanged.

Item 34 "The nurses were unable to care for me" was problematic for two "expert" patients. Each stated that "unable" was unclear, and might have multiple meanings. In order to promote clarity in this case the investigator changed the wording to "The nurses were incompetent with my care" with the agreement of both "experts."

Two "expert" patients found difficulties with item 47 "The nurses always put my needs first." One "expert" patient objected to the word "always" as an extreme qualifier. The second "expert" patient thought that "my needs" could have multiple meanings. Since the Likert answer scale asks the patient to respond from always to never, the word always in the item was confusing, and unnecessary. It was removed from the statement. The investigator conceded that "my needs" could have multiple meanings. However, the object of the survey was patient perception of caring by the nurse that could include any patient physical, psychological or spiritual need. No further changes were made to item 47.

Content Validity Index was calculated for this panel's review of the NCPS. Table 6 illustrates the CVI of this panel of "experts." All of the "expert" patients thought that

the format used for the scale was easy to read and understand. One "expert" patient thought that the Likert scale was "busy" because each scale included the words and numbers however; she stated that it did make it easier to follow when she scored the survey. The investigator elected to keep the Likert scale as is, because it was anticipated that the majority of participants would be elderly or have some level of pain control or sedation that might impair full clarity of thought. The scale allowed the participant to follow the item and scale across the page, and give the possible responses for each statement.

Content validity was also revealed through the narratives written by the "expert" patients answering: "Can you give me an example of what if felt like to be cared for by the nurses?" and "Can you tell me of a time when you did not feel cared for by the nurses?" Each of the "expert" patients responded to at least one of the questions. The narratives were analyzed for descriptors of caring or uncaring terms (Table 7). No new descriptors were named by the experts in comparison with patient descriptors from the qualitative studies (Table 7).

A third descriptive question, "Describe to me who you thought were the nurses" was asked of each "expert" patient. Three patient "experts" answered the question. Two stated that the nurse would introduce herself. One "expert" wrote that the nurses were hurried, and most of the physical care was given by an aide. Another said that the nurses came to do the "big" procedures, like pulling tubes, and changing dressings. The third patient "expert" was clear about whom the nurses were, stating that she had several nurses during her stay including charge nurses and students.

Table 6

*CVI of the Expert Panel for NCPS*

| NCPS Item | Changes Made | CVI to relevance before changes | CVI to relevance after changes |
|---|---|---|---|
| 1 | None – Objection was to the ability for various interpretations of "needed" which was the intent of the statement. No objection to relevance of the statement. | 100% | 100% |
| 17 | Objections to wording. Changed "worried" to "concerned" | 60% | 100% |
| 26 | One objection to healthcare choices for relevance. No change made. | 80% | 80% |
| 34 | Objection to "unable to care for" to "incompetent care" | 60% | 100% |
| 47 | Objection to "always" as a terminal qualifier. Term dropped. | 60% | 100% |
| | Total instrument (100% agreement on items) | 76% | 99.98%* |

*One question out of 50 had less than 100% agreement.

Table 7

*Expert Patients' Descriptors of Caring and Uncaring Behaviors*

| *Presence, Concern for the Other* | *Respect for the Person* | *Knowledgeable, Competent Care* |
|---|---|---|
| comforts | personally valued | competent |
| smiled (friendly) | family respected | helps |
| reassurance | listens | did extra things |
| anticipates needs | sensitive (to my needs) | vigilance (immediately noticed) |
| | available | gave information (explained) |
| Uncaring | | |
| | too busy | ignored (no communication) |
| | impersonal (insensitive) | |
| | unkind | |

The final version of NCPS contained 50 specific caring/uncaring statements (Appendix F). There are 14 items that reflected Presence, Concern for the Other (nine caring and five uncaring), 20 items that reflected Respect for the Person (15 caring and

five uncaring), and 16 items that reflected Knowledgeable, Competent Care (14 caring and two uncaring). Scoring of each item was on a 6-point Likert scale of always to never, answering the question "how much of the time did it happen?" Reading ease was 70.7%, and grade level was 5.7 (Flesch Readability Formula, 1974).

Descriptive questions were reduced to one item (Appendix G) that asked: "Tell me about an experience with a nurse during this hospitalization." Since this was the first time this instrument was tested, this question provided a way to collect any additional descriptors subjects might provide from writing a narrative of his/her experiences. Terms describing caring and uncaring encounters that were similar to descriptors for NC attributes and therefore NCPS statements, provided content validity for the scale. Being unable to tell the story was a criticism of other scales, so this additional question allowed patients to write of their experiences.

A question to determine whether the potential participant thought he/she had been cared for by registered nurses primarily during hospitalization was placed in the patient script for the researcher to ask prior to consent signing (Appendix I). Content expert analysis revealed that professional nurses might be difficult to identify since the health care team, comprised of many different professionals and allied health care workers, dress alike. In Sweden, there were two terms that are related to caring (Widmark-Petersson et al., 1998a). Caring was a term related to nursing and often used interchangeably with the word "care". Clinical care described the work of all health care professionals and was considered a broader term. When two groups of patients were tested using the CARE-Q tool (Larson, 1984), there was no difference found in patients'

choices when asked to evaluate caring verses clinical care (Widmark-Petersson et al.). Patients in the United States could experience difficulty differentiating professional nurses from other health care professionals because of similar uniforms, and because no other descriptive term exists in English to cognitively separate the work of each group.

### *Demographic Sheet*

A demographic data sheet (Appendix H) was created to obtain specific information about participants. The demographic data for this study included age, gender, ethnicity, marital status, household income, number of household members, and educational level. Primary and secondary diagnoses, and any surgical interventions or major procedures while hospitalized were collected by the researcher after the participant finishes filling in the forms.

### *Institutional Review Board Approval and Protection of Human Subjects*

Boston College's policy on human subject research required a review by the Institutional Review Board. Institutional Review Board (IRB) approval was obtained from Boston College, and the medical center sponsoring the study according to the policies and procedures of each review board.

Application was made to Boston College IRB using the required format. A copy of the proposed Informed Consent document (Appendix J) was included with the application. Contents of the informed consent contained: the purpose of the study, the subject's willingness to participate, the anonymity of the subject, confidentiality of all written information, the name and telephone number of the investigator for subjects' questions, the ability of subjects to refuse to answer any question in the survey and

withdraw from the study at any time, a statement of the usefulness of the results of the study to nurses and patients, and a statement that the research was approved by Boston College and the medical center for human subject research.

Once approval was granted by each institution, administrative nurses at the medical center were apprised of the study purpose, and how the study could potentially affect patients on the medical-surgical units in a regularly scheduled management meeting. Each administrative nurse received a letter that many chose to post for their unit staff to read. The letter contained a brief background of the NCPS development, the purpose of the study, expectations of the managers and staff at the hospital, and the promise of a report of the study results (Appendix K). Nurses on the unit were asked if the potential participant was cognitively able to fill out the NCPS instrument. Otherwise unit nurses were not involved in the study.

A master list was created to record the name of each participant matched to a unique code number. Codes unique to each patient and each hospital unit were created. Participant codes allowed the investigator to identify the subject for medical record information entry. Computer data entry was handled by subject codes. Participant names and corresponding codes are kept in a separate locked file with patient consents, available only to the researcher.

### *Data Collection*

Prior to obtaining Institutional Review Board (IRB) approval for data collection, the investigator met with the acting Vice President of Patient Care Services of the medical center to elicit interest in having nursing research conducted in the facility, as

well as approval to apply to the medical center's IRB. The Vice President of Patient Care Services agreed to the proposed research, was willing to have nurses and nurse managers involved in the process of nursing research, and supported application to the IRB. A formal letter of preliminary acceptance was written by the Vice President of Patient Care Services from the institution to the investigator (Appendix L).

### *Treatment of the Data*

Each survey was examined for completeness. Data was entered into a personal computer using the Statistical Package for the Social Sciences version 14 (SPSS). When the NCPS had more than 10% items incomplete, the survey was excluded, and the investigator assumed the patient elected to withdraw from the study. Missing qualitative and demographic data was not considered as a reason to eliminate the participant from the study.

### *Data Analysis*

Descriptive statistics of study variables was used to compute systematic missing data, outliers, and distinct skewness. In order to answer the research questions of the second aim of this study, the following analyses were performed:

*Research Question 1*

*To what extent does the NCPS demonstrate internal consistency reliability prior to establishing factoral validity?*

In preparation for psychometric testing of the data, negative items (#2, 7, 10, 13, 15, 20, 24, 28, 31, 34, 43, and 46) were reverse scored. Descriptive statistics were compiled for each of the items in the study. NCPS items were reviewed for missing values and

skewness. Items with greater than 10% missing responses were considered for deletion. A score that best represented the mid-range response was considered for items that had less than 10% missing data. Reliability testing of the original scale was hypothesized to result in an alpha of greater than .90.

*Research Question 2*

*To what extent can the components of NCPS, created from a metasynthesis of qualitative studies on caring be demonstrated in the Principal Components Analysis?*

Principal components analysis with varimax rotation and Kaiser normalization for multiple factors was conducted on the 50 NCPS statements. Four criteria were used to analyze and interpret the analysis. Eigen values >1 were reviewed to establish the percentage of explained variance in the matrix. A Scree Plot and the theoretical congruence and parsimony of each factor were considered in determining the final factor structure. A factor structure that had acceptable factor loadings with eigenvalues > 1 and was most parsimonious was selected. Acceptable factor loading was $\geq .300$. Factor structure was also reviewed for congruence with the findings of the meta-synthesis from which the items were constructed.

Hypothesis one for the NCPS total scale was tested.

*The NCPS total scale and the instrument's subscales will attain a Cronbach alpha co-efficient of .70 or greater.*

Co-efficient alpha was derived from factor analysis first of the tool as a whole, and then of each of the factors. Nunnally (1978) stated that a value of .70 was the lowest level of alpha acceptable for a new tool. DeVellis (2003) however, stated that co-efficient

alpha values of .70-.80 were viewed as respectable, and .80-.90 very good. At .90 or above the scale should be shortened.

Acceptable Cronbach's alpha was ≥ .70 for each factor.

Hypothesis two was tested.

*Principal Components Analysis will result in three factors. Items that fall within each factor have a positive relationship to patient descriptors of caring and uncaring encounters with the nurse as synthesized from the reviewed qualitative studies.*

A repeat Principal Components Analysis with varimax rotation and Kaiser normalization was conducted for three factors. Eigen values ≥ 1 was reviewed for the percentage of explained variable. Factor loading was ≥ .300, be parsimonious, and conform to the findings of the metasynthesis from which patient descriptors were used to construct instrument items.

*Research Question 3*

*To what extent do the resulting factors demonstrate reliability to stand as independent factors?*

Reliability testing was conducted on each of the resulting factors, and the final instrument. The remainder of hypothesis one was also tested, in that each factor with a Cronbach's alpha of >.70 was adequate to stand as an independent scale (DeVellis, 2003).

*Research Question 4*

*What specific descriptors of caring (uncaring) are described by participants? Do the results of the qualitative question provide insight for further development of the instrument?*

Analysis of the descriptive question was conducted to clarify validation of the instrument by duplicating patient perceptions of NC in reviewed studies. Qualitative data was coded, and specific terms used by participants to describe caring and uncaring were compared to the patient descriptors contained in NC (Table 2) that were used to construct the NCPS. New descriptors were analyzed for compatibility with the attributes of NC. Amending the list of descriptors, the attributes of NC, and items in the instrument with the focus on the nurse caring were considered in light of the resulting data.

Ease or difficulty in identification of the professional nurse provided insight into whether this tool measured nurse caring or caring within a health care facility by all caregivers. Changes to the target assessment group might be required if the "nurse" was not easily identifiable.

### *Summary*

Meta-synthesis of 90 published qualitative studies on nurses', students' and patients' perceptions of caring was the first aim of this study. Questions for this synthesis led to the emergence of a new comprehensive definition of caring that included nurses', students', and patients' perceptions of the nurse-patient encounter. Instrument development, psychometric analysis, and use of qualitative data to provide new insights or instrument validity of the Nurse Caring Patient Scale (NCPS) comprised the second aim of this methodological study. NCPS was developed to measure patients' perceptions

of feeling cared for by nurses from descriptors of qualitative studies conducted from 1984-2005. Content validity was ascertained by interview of a panel of expert patients who reviewed the instrument for clarity, readability, understandability, and whether the items conformed to their perceptions of nurse caring. The NCPS, demographic sheet and qualitative questionnaire was administered to more than 250 participants who were in-patients for more than 24 hours. Internal consistency and reliability of NCPS and each subscale was determined by its co-efficient alpha. Qualitative analysis of narrative caring and uncaring questions further determined NCPS' construct validity of the scale and the validity of the new definition of nurse caring by comparing study results to meta-synthesis descriptors. Analysis of the demographic responses described the sample population. DeVellis (2003), and Polit and Beck (2004) portrayed the process used for instrument development and psychometric analysis. Analysis of the descriptive question followed Sandelowski et al (2000) described method. Results of these analyses were described in Chapter 5.

# CHAPTER 5

## Study Results

### *Introduction*

The second aim of this study was instrument development and psychometric analysis. A methodological process was used for instrument development in that patient descriptors derived from the meta-synthesis findings formed the basis of statements to measure the patient's perception of feeling cared for by nurses. Psychometric analysis of this new instrument, the *Nurse Caring Patient Scale* followed data collection. Results of this research are presented in this chapter as follows: characteristics of the sample, the preliminary data analysis, results related to the research questions, the data from principal components analysis, an analysis of the descriptive question responses, and a summary of the results.

### *Characteristics of the Sample*

Data were gathered in a northeastern United States urban teaching medical center that had 387 licensed beds and an average inpatient census of 215. Bedside clinical staff included Registered Nurses and nurses' aides. Staffing ratios were typically 4-5:1 (patients: nurses) with one or two nurses' aides on each unit depending on the shift. When queried, 88.2% of the patient respondents believed most of their direct care at the bedside was delivered by Registered Nurses. Participants also believed they could identify Registered Nurses that entered the room to provide their care.

Approximately 700 acute hospital inpatients were approached as potential respondents for participation in the study. From this population, 341 consented to

participate, and 301 returned study materials. Four case materials were discarded because more than 20% of the questions in the NCPS were unanswered. The final sample size was 297.

Tables 8 and 9 describe in greater detail descriptive statistics of this sample population. The majority of patient respondents were female (68.6%), with a median age of 46 years and were college educated. A majority of participants were married (61.3%), and living with 1-3 people (67%), with a median income of $70,000. Patients were admitted to the hospital with multiple diagnoses, but when categorized by primary diagnosis approximately 69% were admitted with medical diagnoses, 31% were admitted for surgery. When asked to report their ethnicity, subjects responded with European American descriptors (Irish, French, Polish, Portuguese, and Italian). Some participants refused to identify ethnicity, and called themselves "Americans". Others identified themselves by their religion such as Jewish, Catholic, and Orthodox Christian. In order to categorize these choices in a succinct manner, groups combined were all who self-identified as: European descent, White or Caucasian (76.1%); American (2.9%); African-American, African descent and Black (8.3%); Spanish/Latino and Puerto Rican (5.1%); Asian and Chinese (4%); Biracial (1.1%); and by religious affiliation (2.5%).

*Preliminary analysis*

Prior to answering the research questions, the following procedures were performed. Descriptive statistics were computed on study variables, and the variables were examined for marked skewness, outliers, and presence of systematic missing data. In the preliminary analysis of the NCPS, negative items (# 2, 7, 10, 13, 15, 20, 24, 28, 31,

34, 43, and 46) were reversed scored. Descriptive statistics for NCPS variables were examined for random and systematic missing data. Some items had a number of "not applicable" responses rather than no response. For example some respondents stated that they had not had any pain while in the hospital, so they could not comment on the question about pain. "Not applicable" was not equal to "zero", because "zero" meant the nursing care in question had not occurred. All "not applicable"

Table 8

*Frequency and Percent of the Participants' Characteristics by Group (N=297))*

| | Personal Characteristics | Description | N | % |
|---|---|---|---|---|
| Gender | Male | | 93 | 31.4% |
| | Female | | 203 | 68.6% |
| Previous Hospitalization | Yes | | 57 | 19.6 % |
| | No | | 234 | 80.4% |
| Marital Status | Single | | 52 | 17.5% |
| | Unmarried partner | | 16 | 5.4% |
| | Married | | 182 | 61.3% |
| | Divorced | | 17 | 5.7% |
| | Widowed | | 28 | 9.4% |
| Number of family members | | 0-3 | 195 | 67% |
| | | 4-6 | 83 | 29% |
| | | 7-91 | 12 | 4% |
| Diagnosis | Medical | cardiac | 42 | 14.9% |
| | | respiratory | 18 | 6.4% |

| | Personal Characteristics | Description | N | % |
|---|---|---|---|---|
| Diagnosis | Medical | other medical | 78 | 27.8% |
| | | normal delivery | 41 | 14.6% |
| | | antepartum | 14 | 5.0% |
| | Surgical | cardiac | 7 | 2.5% |
| | | orthopedic | 8 | 2.8% |
| | | cesarean section | 43 | 15.3% |
| | | other surgery | 19 | 6.8% |
| | | gyn surgery | 11 | 3.9% |
| Ethnicity | African American/Black | | 20 | 7.2% |
| | African descent other nation | | 3 | 1.1% |
| | American | | 8 | 2.9% |
| | Caucasian/White/European | | 210 | 76.1% |
| | Spanish/Latino/S. American | | 14 | 5.1% |
| | Biracial | | 3 | 1.1% |
| | Asian | | 10 | 3.6% |
| | East Indian | | 1 | 0.4% |
| | Religious affiliation | | 7 | 2.5% |

Table 9
*Means, Medians, Standard Deviations, Minimum and Maximum Score of Subject Continuous Variables*

| | N | Mean | SD | Median | Min | Max |
|---|---|---|---|---|---|---|
| Age | 295 | 49 | 18.86 | 46 | 19 | 89 |
| Income | 226 | 81,346 | 62,885 | 70,000 | 3,600 | 400,000 |
| Family | 290 | 3.58 | 6.73 | 3 | 1 | 91 |
| Education | 289 | 15 | 3.17 | 16 | 3 | 20 |

responses were therefore judged as missing data. Prior to psychometric analysis, all variables with 10% or more missing data (# 18, 19, 21, 26, 30, 35, 41, and 42) were dropped from further examination. Variable medians were then used to replace missing data on the remaining 42 items.

*Research Question 1*

*To what extent does NCPS demonstrate internal consistency reliability prior to establishing factoral validity?*

The following hypothesis was tested: *The NCPS total scale will attain a Cronbach's alpha co-efficient of .70 or greater.*

A reliability of greater than .70 has been reported adequate for instruments used in research (J. C. Nunnally & Bernstein, 1994). Internal consistency reliability testing using Cronbach's alpha was next calculated on the NCPS items. The 50-item NCPS had a standardized alpha of .92 (N = 297), indicating an extremely high internal consistency. Item-total correlations revealed that five items were below .30 (#7, 10, 22, 28, and 33).

These items were dropped from the scale. Cronbach's alpha was not adversely affected since alpha remained at .91 with any of the named items deleted. With eight items dropped because each had more than 10% missing data, and five items dropped because item-total correlations were less than .30, the remaining 37 item scale was considered to have sufficient internal consistency reliability for subsequent Principal Components Analysis.

*Research Question 2*

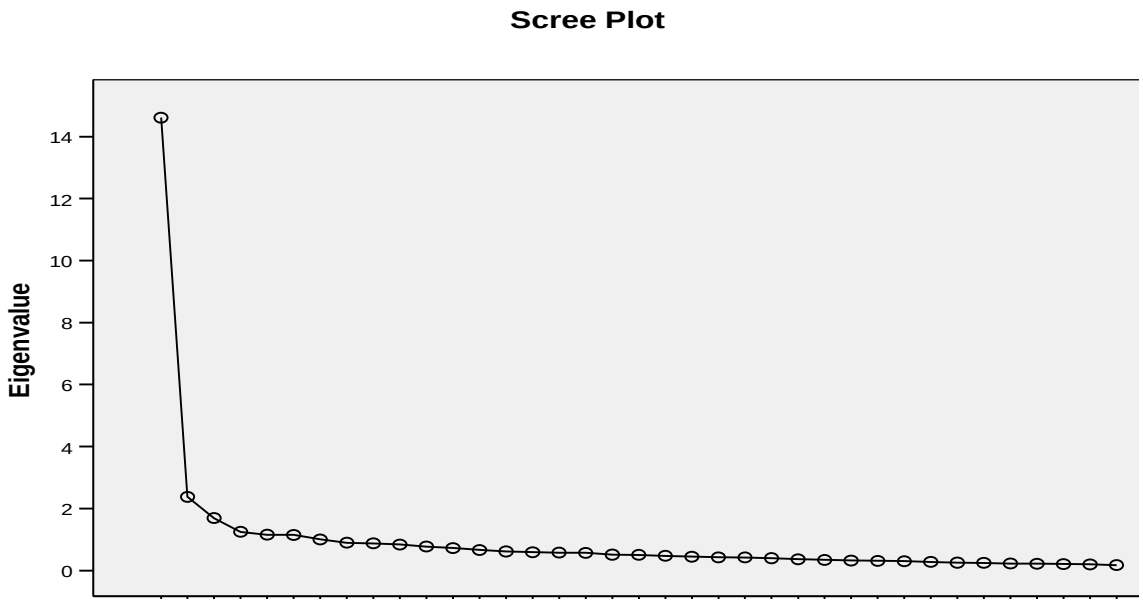
*To what extent can the attributes of NCPS, created from a meta-synthesis of qualitative studies, be demonstrated in Principal Components Analysis?*

The following hypothesis was tested: *The Principal Components Analysis will result in three factors. Statements that fall within the three factors will match the patient descriptors of the three attributes of Nurse Caring.*

The 37 remaining items of the NCPS were subjected to Principal Components Analysis (PCA), varimax rotation, and Kaiser Normalization. Bartlett's Test of Sphericity was significant (.000), signifying that the correlation matrix was suitable for undertaking PCA (Munro, 2001). The Kaiser-Meyer-Olkin Criteria, a measure of sampling adequacy, was .94 indicating that sample size was more than adequate for factor analysis (Munro). Application of the Kaiser criterion of using all unrotated factors of eigenvalues greater than 1.0 resulted in seven factors accounting for 63% of the variance. The Scree plot graphing of eigenvalues was more parsimonious in a three component solution (Figure 2). Since three components were hypothesized, a second PCA specifying three components was performed. This action appeared conceptually congruent since

instrument items were originally developed from descriptors within the three attributes of *Nurse Caring* synthesized from qualitative studies on caring.

*Figure 2.* Scree plot of PCA with 37 items of NCPS




The PCA with varimax rotation and Kaiser normalization extracted three factors in eight iterations demonstrating a parsimonious, interpretable solution that accounted for 50.5% of the variance. All 37 items had component loadings greater than the .30 cutoff level; some with substantial side loadings. Component 1 had an eigenvalue of 10.9 accounting for 29.6% of the variance. Component 2 had an eigenvalue of 4.2 and accounted for 11.4% of the variance. Component 3 had an eigenvalue of 3.5 explained 9.5% of the variance.

*Component 1: Presence, Concern for the Other*

Component 1, consisted of eleven items (1, 5, 16, 17, 25, 29, 38, 40, 44, 48, and 49) with factor loadings of .51-.73, and was labeled *Presence, Concern for the Other*. Table 9 displays these items that focus on being with the patient in the moment of the nurse caring experience, which is compatible with the hypothesized subscale of the *Nurse Caring Patient Scale* (NCPS).

All of Component 1 items (Table 10) were derived from descriptors given by patients in the metasynthesis of qualitative studies that reflected the concept of the nurse being wholly there with the patient. None of the items for Component 1 had side loadings.

Other items that loaded onto this component, but did not reflect the concept of being present with the patient were deleted. For instance Item 4: "The nurses watched me closely in the hospital" was intended to convey nurse monitoring, but the word "closely" may have confused the meaning of the statement by giving the patient a sense of the nurse's presence thus it loaded onto Component 1. Items 4, 8, 11, 12, 14, 36, & 37 (Table 11) reflected descriptors of competent, knowledgeable nursing care so they were not included in the component. Items 31, 32, 39, 47, & 50 (Table 12) were derived from patient descriptors of respect for human dignity and the individuality of the person, and were also not included in Component 1. For example Item 31: "The nurses talked over me, or about me, but ignored me" reflects disregard of the patient as a person; yet participants seemed to view this item as the nurse being present physically, but absent in respect to the person receiving care. Items that were not clearly representative of the concept of being there with the patient were elected to be discarded. All accepted items for Component 1 were congruent with the conceptual definition of the component

Table 10
*Component Loadings, and Communalities for Presence, Concern for the Other*

| Item (N = 11) | (N=297, Scale Cronbach's Alpha = .91) | Factor Loading | Communalities |
|---|---|---|---|
| 1 | The nurses knew what I needed. | .51 | .32 |
| 5 | I could trust the nurses who cared for me. | .66 | .54 |
| 16 | My nurses were really there when I needed a nurse. | .67 | .47 |
| 17 | The nurses were concerned about what I was going through as a patient. | .73 | .56 |
| 25 | My nurses connected with me. | .71 | .56 |
| 29 | My nurses were available whenever I called for a nurse. | .52 | .35 |
| 38 | The nurses comforted me when I needed it. | .72 | .54 |
| 40 | The nurses were calm when they gave me care. | .58 | .37 |
| 44 | The nurses were reassuring. | .61 | .44 |

| Item (N = 11) | (N=297, Scale Cronbach's Alpha = .91) | Factor Loading | Communalities |
|---|---|---|---|
| 48 | The nurses were patient with me. | .70 | .64 |
| 49 | The nurses were friendly. | .58 | .50 |

Table 11
*Component 2: Knowledgeable, Competent Care Items Loading onto Component 1*

| *NCPS Item* | *Item Statement* |
|---|---|
| 4 | The nurses watched me closely in the hospital |
| 8 | The nurse helped me to understand what was happening to me in the hospital. |
| 11 | The nurses gave me help when I needed it. |
| 12 | The nurses were gentle when caring for me. |
| 14 | The nurses spent the time to tell me about procedures I would have in the hospital. |
| 36 | The nurses were available to do acts of kindness for me. |
| 37 | The nurses went beyond what I expected in my care. |

which was the nurse being present, concerned, and wholly focused on the patient.

Component 1, *Presence, Concern for the Other* was defined as: the act of being present with the patient/family/group/community that can be described as

interconnectedness, a relational connecting, a communion with the other, having insight and concern so needs are anticipated and comprehended, and can result in a spiritual connection/transcendence. This definition was intended to focus on the nurse's intentional act of being with the patient by concentrating on the moment of that interaction including the context of the situation to the exclusion of other pressing activities. Some of the items, loading onto Component 1 derived from the other two attributes of NC (see Tables 10 & 11), may have been too similar to descriptors of Component 1, or they may have contained two concepts that were difficult to categorize. For example Item 50 "The nurses were honest with me" was intended to connote respect, but may have been linked with a sense of trust and connectedness with the nurse. Item 11 "The nurses gave me help when I needed it" was intended to convey competent care through the word "help", but "when I needed it" may have been interpreted as the nurse anticipating a need due to the nurse-patient interconnectedness.

Table 12
*Component 3: Respect for the Person Items Loading onto Component 1*

| *NCPS Item* | *Item Statement* |
|---|---|
| 31 | The nurses talked over me or about me, but ignored me. |
| 32 | The nurses treated me with dignity. |
| 39 | The nurses treated me as a unique person. |
| 47 | The nurses put my needs first. |
| 50 | The nurses were honest with me. |

*Component 2: Knowledgeable, Competent Care*

Component 2, defined by five items (23, 27, 34, 45, and 46) with factor loadings of .36-.69, was labeled, *Knowledgeable Competent Care* that was taken from the theoretical attribute within the *Nurse Caring* mid-range theory. Table 13 displays these items that focus on technically proficient nursing care delivered with comprehension of nursing science, which is compatible with the hypothesized subscale of the NCPS. Two items (34 and 46) were drawn from the theoretical attribute, and had no side-loadings. Items 23 (The nurses worked to see that

Table 13

*Component Loadings and Communalities for Knowledgeable, Competent Care*

| Item (N = 5) | (N=297, Scale Cronbach's Alpha = .91) | Factor Loading | Communalities |
|---|---|---|---|
| 23 | The nurses worked to see my pain was relieved | .43 | .50 |
| 27 | The nurses were knowledgeable about my care. | .36 | .39 |
| 34 | The nurses were incompetent with my care. | .49 | .44 |
| 45 | The nurses helped me get what I needed. | .65 | .66 |
| 46 | The nurses ignored me. | .69 | .58 |

my pain was relieved,) 27 (The nurses were knowledgeable about my care,) and 45 (The nurses helped me get what I needed) had significant side-loadings on Component 1 (.507-

.643). Since the descriptor for each of these items was drawn from Component 2 and did not reflect the descriptors of *Presence, Concern for the Other*, it was elected to keep each item under Component 2. Deleted items (see Table 14) included 32 (The nurses treated me with dignity), and 50 (The nurses were honest with me) that met the definition of *Respect for the Person*, but significantly loaded on both Components 1 and 2. Items 31 (The nurses talked over me or about me but ignored me) and 43 (The nurses talked over me rather than to me) loaded significantly only on the *Knowledgeable Competent Care* component, but theoretically fit *Respect for the Person* so they were discarded (Table 14).

Component 2 *Knowledgeable, Competent Care* was defined as follows: knowledgeable; competent in all interventions which include helping, monitoring, and attending; being able

Table 14

*Items Theoretically Excluded from Component 2*

| *Excluded NCPS Item* | *Item with Side-Loadings on Component 1* |
|---|---|
| 32 | The nurses treated me with dignity |
| 50 | The nurses were honest with me. |
| | *Items Not Theoretically Congruent with Component 2* |
| 31 | The nurses talked over me or about me, but ignored me. |
| 43 | The nurses talked over me rather than to me. |

to communicate as a teacher and advocate; and being able to provide nurturing support, healing, protection, and attention through touch. Each of the three items that significantly side-loaded onto Component 1 *Presence, Concern for the Other* and elected to be kept in Component 2, were done so because of the theoretical fit of the items. Item 23, "the nurses worked to see my pain was relieved," included a defining term from Component 2 (helping), and reflected the intent of attending to the needs of the patient as depicted in the definition of *Knowledgeable, Competent Care*. Item 27, "the nurses were knowledgeable about my care", included the term "knowledgeable" with the sense of competence that is incorporated into the definition of Component 2. Item 45, "the nurses helped me to get what I needed", included "helping" and the idea of providing support. Like item 23, item 45 was another way to express the thought of attending to patient needs. While being physically present with concern for the other was required for the nurse to be attentive, help with patient needs, and convey knowledge; none of these items (23,27, and 45) specifically met the definition of Component 1. In the meta-synthesis of qualitative studies involving the nurse-patient encounter, patients described nursing knowledge, helping and pain reduction as related to their sense of nursing competency (see Table 6). Since items 23, 27, and 45 had significant loadings under Component 2, clarity required that they being kept within that component.

Item 31 "the nurses talked over me or about me, but ignored me"; item 43 "the nurses talked over me rather than to me"; and item 50 "the nurses were honest with me loaded" significantly on Component 2. Each of these items conveyed the aspect of respect or disrespect of the person that is defined within Component 3 *Respect for the*

*Person*. Item 32 “the nurses treated me with dignity”, significantly loaded on both Component 1 and 2. Dignity is a component of respecting the person, and does not fit within the definition of competence or presence. Patients, in the meta-synthesis of qualitative studies on nurse-patient encounters described honesty and ignoring as linked to personal respect (Appendix E). Since items 31, 32, and 50 did not load on Component 3, there may have been some aspect within the wording of the statement that blurred the distinction between respect for the patient, and competency or concern. None of these items fit the definition of the Component 2 so they were discarded.

*Component 3: Respect for the Person*

Component 3, defined by seven items (2, 3, 6, 9, 15, 20, and 24) with factor loadings from .40 - .63, was labeled *Respect for the Person*. Table 15 displays items that focus on nurse-patient interactions and reflected respect for the individual and for human dignity, which was compatible with the hypothesized subscale of NCPS.

Two items (2 and 15) that were designed to load on *Respect for the Person*, loaded solely on Component 3. Item 3 “the nurses treated me with respect”, Item 6 “The nurses treated me as a person rather than an illness”, and Item 9 “The nurses listened to me” had significant side-

loadings with Component 1 *Presence, Concern for the Other*. Because each item contained aspects of respectful care by the nurse, congruent with the conceptual foundation of Component 3, they were retained.

Table 15

*Component Loadings and Communalities for Respect for the Person*

| Item (N = 7) | (N=297, Scale Cronbach's Alpha = .91) | Factor Loading | Communalities |
|---|---|---|---|
| 2 | The nurses made me feel like an object instead of a person. | .63 | .44 |
| 3 | The nurses treated me with respect. | .40 | .47 |
| 6 | The nurses treated me as a person rather than an illness. | .49 | .47 |
| 9 | The nurses listened to me. | .42 | .55 |
| 15 | My nurses treated the machines in my room instead of me. | .62 | .41 |
| 20 | The nurses were unkind to me | .42 | .49 |
| 24 | The nurses were unfeeling when they came into my room. | .49 | .49 |

Items 20 "the nurses were unkind to me" and 24 "the nurses were unfeeling when they came into my room" had significant side-loadings on Component 2 *Knowledgeable, Competent Care.* Neither item was characteristic of descriptors for competent nursing care, but both contained features of *Respect for the Person* so they were retained in Component 2.

*Respect for the Person* was defined as an emotional honoring of human dignity exhibited by empathy, listening, anticipating, trusting, being dependable and supportive,

compassionate, authentic in sharing, accessible and vulnerable to the exchange. It was intended to define a relationship between nurse and patient that was a respectful honoring of the human being. Some of the items (20 and 24) reflected negative aspects of respect for the individual person by being unfeeling and unkind. These negative aspects of respect were reported by patients in the qualitative studies of the meta-synthesis (Appendix E) under the attribute that emerged from the metasynthesis entitled *Respect for the Authentic Self.*

Items 12 "the nurses were gentle when caring for me" and 14 "the nurses spent the time to tell me about procedures I would have in the hospital" significantly loaded onto both Component 3 *Respect for the Person* and Component 1 *Presence, Concern for the Other.* The aspects of gentleness and care were components of *Knowledgeable, Competent Care* which included touching within its definition (Appendix E). Education of the patient or teaching was also an element of Component 2. Clear meaning for the items may have been confused by adding "spending time" to item 14. Spending time was similar to "being there, caring and genuine concern" which are characteristics of *Presence, Concern for the Other*. The term gentle was similar to "patience and sensitive" both aspects of *Respect for the Person* (Appendix E). Since the items were created from descriptors of NC attribute *Knowledgeable, Competent Care*, they were dropped from Subscale 3 *Respect for the Person* (Table 16).

Item 13 "the nurses were unconcerned about me as a person" loaded significantly only on Component 3. Concern was a descriptor of the NC attribute *Presence, Concern for the Other* (see Appendix E) as a result of the meta-synthesis. "Unconcerned" was

related to uncaring behaviors in patients' depictions of nurse-patient encounters. Since the patients' descriptions of concern related to aspects of *Presence, Concern for the Other*, the item was deleted from Component 3 (Table 16).

Table 16
*Items Theoretically Excluded from Component 3*

| *Excluded NCPS Item* | *Item with Side-Loadings on Component 1* |
|---|---|
| 12 | The nurses were gentle when caring for me. |
| 14 | The nurses spent the time to tell me about procedures I would have in the hospital. |
| | *Items not Theoretically Congruent with Component 3* |
| 13 | The nurses were unconcerned about me as a person. |

*Research Question 3*

*To what extent do the resulting factors demonstrate reliability to stand as independent factors?*

Internal consistency reliabilities were next computed for the 23-item NCPS total and subscale scores. The 23-item scale had a Cronbach's alpha of .91, which could be judged as highly reliable (Munro, 2001). Factor I: *Presence, Concern for the Other* had a Cronbach's alpha of .89, confirming it reliable as an independent factor. Factor II: *Knowledgeable, Competent Care* had a Cronbach's alpha of .77, confirming that it was reliable as an independent factor. Factor III: R*espect for the Person* had a Cronbach's alpha of .73 indicating that it was reliable as an independent factor. These reliabilities

answered question three, since the NCPS and the three subscales were judged to possess sufficiently high internal consistency reliability for future analysis as independent scales.

*Research Question 4*

*What specific descriptors of caring (uncaring) are described by subjects? Do the results of the descriptive question provide insight for further development of the instrument?*

After completing the NCPS, each subject was asked to respond to the statement, "Tell me about an experience you had with a nurse during your hospitalization. Respondents were allowed a single sheet of paper to write a narrative of their encounter(s) if they desired. A majority of subjects (63%) chose to reply communicating personal experiences that ranged from a brief statement to detailed descriptions of their nursing care experience. One objective for asking a descriptive question was to elicit any new descriptors of the caring experience that did not occur in the meta-synthesis of qualitative studies. Another objective was to see how the participants viewed the nurse-patient experience. It was hoped that participants would use terms to describe care that were similar to those used in the statements of NCPS. There was a 62.6% response rate for this component of the study that included a range of written responses from one sentence to two pages.

Descriptors were gleaned from this question by examining the writings for key thoughts, and events (see Appendix M). Most of the responses were descriptions of the nurse-patient encounter. Some responses were about non-nursing issues or nurse-doctor-hospital issues not relevant to this study. Initial examination of the data was restricted by

an a priori framework (Kearny, 2001). Both researcher and an assistant came to 100% agreement on the descriptions found within the materials, and whether or not they matched descriptors from the meta-synthesis. No new information was gleaned from this data. Descriptors used by the patients were the same or similar to those found in the meta-synthesis of qualitative studies. Indices and effects of experiencing nursing care that were listed as parts of the midrange theory of *Nurse Caring* were also noted by participants (see Appendix M). Some responses (Appendix M) were concerned with hospital processes, and unrelated to patient descriptors of the nurse-patient encounter.

Participants who chose to write a detailed response to the descriptive question used words describe the nurse–patient encounter that repeated thoughts expressed in the NCPS such as care, respect, comfort, competency, sympathy, encouragement, connection (with the nurse), knowledge, and safety. For example one participant wrote the nurses "…treated me with great care and respect; the(y) never left me in pain…." One post-partum patient said, "She made me feel very comfortable in an otherwise very comprising (sic) situation." Another participant noted, "…the nurses not only provided me with the best possible medical care, but also took the time to comfort, sympathize and encourage me when I most needed it." One woman wrote "…we had a connection & I felt relieved & not so nervous." Another participant wrote about her nurse knowing "exactly what she is doing", and that "I feel very comfortable and safe around them (nurses)." Uncaring events were also recorded by participants such as "…they haven't offered me the opportunity to catheterize…they haven't offered to help me with washing and I haven't had my bandages changed, but I feel too sad and angry to ask for assistance…they've

been kind, but haven't been able to reach past into my concerns, anxiety and anger." These examples of the nurse-patient encounter confirmed the findings within the meta-synthesis, but did not add to the descriptors used for the development of NCPS.

*Summary*

This chapter reports the psychometric evaluation of the NCPS. Four research questions, and two hypotheses were reviewed in the process of analyzing the results of PCA for the new instrument *NCPS*. There were 297 acute in-patient subjects participating in this study.

It was hypothesized that the NCPS would exceed a Cronbach's alpha of .70. Initial reliability testing of the *Nurse Caring Patient Scale*, resulted in standardized alpha of .92.

A second hypothesis stated that three factors would be demonstrated through Principal Component Analysis. PCA with varimax rotation resulting in a three-factor solution that explained 50.5% of the variance, and a factor loading cutoff point at .30 was parsimonious and interpretable. This PCA solution resulted in the following: Component 1: *Presence, Concern for the Other* consisted of eleven items, and had an eigenvalue of 10.94 explaining 29.6% of the variance. Component 2: *Knowledgeable, Competent Care* consisted of seven items, and had an eigenvalue of 4.21 explaining 11.4% of the variance. Component 3: *Respect for the Person* contained five items, and had an eigenvalue of 3.53 explaining 9.5% of the variance.

Reliability testing was conducted on the resulting 23-item NCPS, and each of the three subscales. NCPS had a Cronbach's alpha of .91, or little change in alpha from the

original 50-item NCPS (.92). Component 1: *Presence, Concern for the Other* had a Cronbach's alpha of .89. Component 2: *Knowledgeable, Competent Care* had a Cronbach's alpha of .77. Component 3: *Respect for the Person* had a Cronbach's alpha of .73. Subscales were judged reliable as independent scales because each subscale had a sufficiently high alpha.

Research question 4 aimed to distill terms descriptive of the nurse-patient encounter, and compare them to descriptors gleaned from the meta-synthesis. No new terms were found in this sample's narratives that might contribute to the items in the instrument. Participant responses did reflect those descriptors found in the meta-synthesis of qualitative studies.

The purpose of developing a patient derived, reliable, valid instrument to measure nurse caring behaviors was partially attained in this study. The NCPS total scale and the three subscales demonstrated adequate internal consistency reliability for the instrument and the subscales to be used as independent measures in subsequent studies. Figure 3 depicts the steps taken to develop and analyze the data of this study. Further research is indicated to determine more evidence of instrument reliability and validity.

Figure 3

*Steps in the Development and Psychometric Analysis of the Nurse Caring Patient Scale*

Meta-synthesis of Qualitative Studies on Caring

↓

Development of the Mid-range Theory of Nurse Caring with three attributes

↓

Generation of Item Pool from Patient Descriptors of Nurse Caring/Uncaring

↓

Review by Clinical Nurse Specialists and Nursing Theorist

↓

Item language Modification, One Likert Response Scale removed,
Items Added from Patient Descriptor List

↓

Evaluation of Items by Expert Patient Panel

↓

Modification of Two Items, No Additional Items Requested,
No New Descriptors Gleaned from Panel

↓

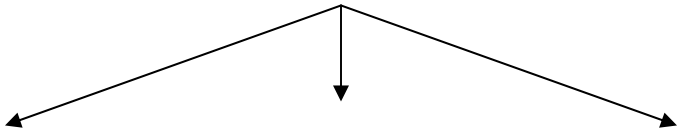
Administration of 50-item NCPS to 341 Adult Acute In-Patients

↓

Data Analysis of NCPS Based on 297 participants

↓

Establishment of psychometric properties of the Nurse Caring Patient Scale



| | | |
|---|---|---|
| Presence, Concern for the Other | Knowledgeable Competent Care | Respect for the Person |

# CHAPTER 6

## Discussion, Conclusions, and Implications

While there were many theoretical definitions for caring found in the nursing literature, and many instruments created to measure caring, the patient's perspective was largely missing from caring definitions and caring measures. Morse's et al (1990) call to focus qualitative research about caring on patient perceptions was heeded by a larger number of investigators during the 1990s. In the new millennium it was time to move beyond silo research and heed another call, building on past research (Meleis, 1992). To that end a meta-synthesis of the qualitative studies asking nurses, students and patients to relate their perceptions of nursing care was conducted.

Similarly researchers used nursing theoretical knowledge, or in one case a single study for item construction in instrument development to measure caring behaviors. No instrument had been developed from a heterogeneous sample of patient viewpoints regarding the nurse-patient encounter. It was also purposed in this study to develop and test a new instrument. The resulting valid and reliable *Nurse Caring Patient Scale* measured the patient's experience of nurse caring providing objective evidence about nursing care that was previously hidden and unrecorded. This chapter is a discussion of the study findings and limitations. Implications for further research and recommendations for nursing theory, research, education, and clinical practice are also included.

### *Discussion of the Meta-synthesis, NCPS and the Descriptive Question Findings*

#### *The Meta-synthesis*

A meta-synthesis of qualitative studies from 1984 – 2005 published in English was the first aim of this study. Using variable oriented qualitative comparative analysis, the investigator reviewed each of the studies for specific descriptors given by the participants, accounting for similarities and differences in responses, with the purpose of finding a new understanding of the concept of caring. A mid-range theory of nurse caring emerged from the data with a new definition of nurse caring that included the patient's perspective. *Nurse caring* had three attributes *Presence, Concern for the Other; Respect for the Person;* and *Knowledgeable, Competent Care* that encompassed the art and science of nursing (see Figure 1).

Definitions of caring stemming from nurses, students, and patients' perceptions of the nurse-patient experience formed the conceptualization for this mid-range theory. The inductively derived model of *nurse caring* demonstrated a dynamic nature to the nurse-patient encounter by accounting for specific indices prior to the encounter; three attributes, which at their intersection resulted in the ideal, nurse caring; and the consequences that ensued.

Gaut (1983) stated that caring in nursing required knowledgeable intent, context, and action. Critical indices that were required for the ideal caring encounter with the patient included *intent*, in that the nurse intentionally entered into the encounter with the patient. There was a situational *context* for the nurse and the patient in each encounter, as each brought all personal life experiences to that moment. Patients reported positive relationships with nurses that were "kind" or "nice" (Propst et al., 1994; Raudonis & Kirschling, 1996; Sherwood, 1991). From this data the investigator concluded that the

nurse's attitude determined the atmosphere for the encounter. *Nursing expertise* was an expectation for the nurse-patient encounter as noted by nurses, students and patients (Clayton et al., 1991; Engebretson, 2000; Miller et al., 1992) in synthesized qualitative studies. Finally there was an expressed or unexpressed *need* for the nurse to encounter the patient.

As shown in the model (Figure 1) each of the attributes of *nurse caring* was required for the ideal nurse patient encounter. For instance, the nurse who was knowledgeable and competent, but disregarded the patient as an individual, might provide excellent care of the body to the neglect of the mind and spirit of the patient. Patients who experienced this type of care used descriptors of the experience such as "being treated as an object" (Finn, 1993; Reimen, 1986), and the nurse was "dismissive" (Drew, 1986), "only doing a job" (Hinds, 1988) or "remote" (Finn, 1993). These situations also resulted in patients feeling angry and helpless (Drew, 1986; Halldorsdottir, 1989), and were defined as uncaring. Oppositely, those patients experiencing the ideal nurse caring encounter reported positive effects such as feeling safe, satisfied (Sherwood, 1993), and connected (Paternoster, 1988). Patients wanted competent nurses, but they also wanted to be treated with respect, and have an interpersonal connection with nurses.

What was interesting about this meta-synthesis was that the patient perceptions of nurse caring were similar across cultures and countries where reviewed studies were conducted. Despite cultural differences, patients desired the nurse to engage them with interest, treat them with dignity and respect while performing interventions skillfully. African, Asian, South American, and Pacific Islander cultures were not represented in the

reviewed studies. The resulting mid-range theory of *nurse caring* might be validated and strengthened or changed with viewpoints of nurses, students and patients from these areas of the world.

*Nurse Caring Patient Scale*

The second aim of the study was to ascertain the psychometric properties of the NCPS designed to measure the patient's perception of feeling cared for by the nurse from a convenience sample of acute in-patients in an urban teaching medical center. Psychometric analysis of NCPS resulted in a parsimonious three-factor solution. All three subscales matched the inductively derived attributes of the mid-range theory of *nurse caring* from which instrument items were developed. Factor analysis of NCPS resulted in instrument construct validity, and each subscale (factor) had sufficient internal consistency reliabilities to use as independent measures in future studies.

In order to achieve the final results of the analysis the investigator made decisions as to the best course of action. For instance the scree plot resulted in one very large factor that accounted for 29.5% of the variance. Factors two and three accounted for 21% of the variance. Component 1 had 10 of its 11 items without side-loadings. Component 2 had three of its five items side-loading on component 1. Component 3 had four of its items with side-loadings on Component 1 and two items with side-loadings on Component 2. Some items were discarded because they loaded significantly onto components that were incongruent with hypothesized factor structure. Since each of the items in NCPS were drawn from descriptors reported by patients in the reviewed literature, each item was originally thought valuable to the instrument.

Two issues were present. First caring as a concept was difficult to define. Theorists such as Watson (2006) and Swanson (1991) used similar terms to describe caritas processes or model attributes because aspects of caring acts were intertwined, one dependant on another. For example Swanson (1991) categorized “knowing” and “being with” as different attributes yet some descriptors of the attributes were very similar. Knowing was described as striving to understand an event as it has meaning in the life of the other” (Swanson, 1999) and included descriptors such as focusing and attending to the other. ”Being with” was to be emotionally present with the other, but included some similar descriptors such as warm attentiveness, involved and engaged (Swanson). Confirmatory testing of NCPS may result in a three factor solution, or because of highly correlated descriptors, a one factor solution may be most parsimonious and representative of nurse caring.

A second issue was that some of the items in NCPS had multiple ideas conveyed such as item 31 “the nurses talked over me or about me, but ignored me.” Item 31 might have been better stated simply as “the nurses ignored me.” Other items had aspects about the statement that might have been confusing such as item 14 “the nurses spent the time to tell me about procedures I would have in the hospital.” In this instance “spent the time” may have been linked to “being there” or “presence”, instead of the intended meaning of informing the patient about procedures. A better way to state item 14 might be “the nurses told me about procedures I would have.” Items that were dropped due to double meanings or multiple items with rewording could be placed as a new item into NCPS for study and factor analysis.

Being able to demonstrate psychometric adequacy of the NCPS is an obligatory antecedent for future use in caring research. While confirmatory analysis is necessary, this valid and reliable instrument will provide useful insights about patients' perceptions of the nurse-patient encounter for clinical nurses and hospital administrators that are presently unmeasured. Further, comparing findings between groups such as by age, gender, socio-economic status, ethnicity, and education may also lead to new insights of perceived differences in nursing care. This instrument has promise for advancing the understanding of nurse caring, as it is perceived by the patient, and may provide nurses and administrators with objective data for meeting goals in delivering patient-centric care.

*Descriptive Question*

A descriptive question asking participants to relate an experience they had with a nurse was added to this study in order to evaluate whether *nurse caring* descriptors, provided by patients in synthesized qualitative studies, could be extended. Since NCPS items were developed from these patient descriptors, analysis of the descriptive question might also provide insight into validating the items used, or extending the descriptors to be considered in future studies.

Initial a priori analysis of the participant narrative responses resulted in a list of descriptors that described personal experiences of the nurse-patient encounter (Appendix M). Although 90 qualitative studies were reviewed for the meta-synthesis, each study's sample size was small. This study had a response from 68% of participants or 202 people. Despite the large number of respondents, no one participant offered new descriptors that

would enhance the mid-range theory of *nurse caring*, or NCPS. It is significant that no new descriptors arose from this study. Results of initial analysis of the descriptive question provide validity for the meta-synthesis findings, validity for the items developed for NCPS, and support for the generalizability of patients' perceptions of nurse caring to the populations where these studies originated. Further in-depth analysis of the descriptive question data may provide new insights into indices and effects of nurse caring, not considered in initial analysis, providing support for and extending the newly emerged theory.

### *Limitations of the Study*

This study had several limitations. One limitation in the meta-synthesis was that studies reviewed were those published in English from eight countries. Missing from this review were those studies published in other languages and from ethnic groups in Africa, Asia, South America, and the Pacific islands. Each of these cultural groups may have responded differently, thus altering or expanding the mid-range theory of nurse caring.

A limitation of the analysis of NCPS was the use of a convenience sample. All subjects who agreed to participate were located in a single hospital. Of the approximately 700 patients approached about participating in the study, only 341 consented to be subjects, and 297 completed the study materials. Responses from the 297 participants might be different than potential responses from patients who refused to participate, did not finish completing study materials, or who were not contacted. Additionally if more than one site had been used, there might have been a different outcome.

Another limitation of NCPS analysis was the demographics of the sample population. Because this sample was not representative of the general population in gender, ethnicity, education or socio-economic status, further research of a more heterogeneous sample may produce different results.

A limitation of the descriptive question analysis was the potential bias of the investigator and assistant. Since each were knowledgeable of the meta-synthesis results, and invested in furthering knowledge in the concept of caring, these biases may have interfered with objective analysis. However, because the initial analysis was a priori, the effect of this limitation might be small, since the objective was to find all patient descriptors of the nurse-patient encounter.

### *Implications for Nursing*

This methodological study had two aims. A meta-synthesis of qualitative studies investigating nurses, students and patients' perceptions of the nurse patient encounter with the purpose of eliciting a new conceptualization of caring was the first aim. An inductively derived theory emerged from the data in the qualitative studies that augments caring knowledge by including the patient's perceptions of nurse caring and can provide a practical framework for nursing theory, clinical practice, research, education, and public policy. Further the congruency of synthesis findings from 90 studies conducted in eight countries is also significant in being able to predict future patient responses to caring and uncaring encounters with nurses.

A second component of the study aimed to develop and validate the *Nurse Caring Patient Scale* (NCPS) that resulted in a reliable and valid instrument with adult acute in-patients. This instrument can be used to identify patient perceptions of feeling cared for by nurses that extends current measures by considering hidden, uncounted nursing acts that include the sense of the nurse's presence, concern for the other; knowledgeable, competent care; and respect for the person. This scale with its three subscales can provide impetus for further development of the ontology of nurse caring.

*Implications for Theory Development*

A theoretical implication of this study was the addition to the body of caring knowledge a new mid-range theory of *nurse caring* containing three attributes. The attributes (*Presence, Concern for the Other, Knowledgeable, Competent Care,* and *Respect for the Person)* portrayed nurses, students and patients' descriptors of caring, and seemed to more fully express the art and science of the nurse-patient encounter. It was in the complex interplay of the attributes (see Figure 1) that nurse caring occurred. Caring was not just being there for the patient. Nurses needed to intentionally enter the patient encounter honoring the person, showing personal interest and performing functions expertly. It was the patient perceptions of nurse caring that reformed the sense of the nursing theoretical ideas on caring by stressing competency of care, and respect of the person in addition to connecting with the nurse. These perceptions provided a missing component to caring knowledge, that led to more comprehensive, inductively derived definition of caring. Caring has been articulated as the art of nursing (American Nurses Association, 2004), and the essence of nursing (Watson, 2006). The mid-range theory of

nurse caring encompasses the art and science of nursing by intentionally emphasizing knowledgeable nursing expertise as an equal necessary component to presence and respect of the patient for caring to occur.

This new theory of nurse caring also created a way to evaluate patient perceptions of nurse caring. The second aim of this study was to use patient descriptors from the meta-synthesis to develop items for a new instrument the *Nurse Caring Patient Scale*. Psychometric analysis resulted in a valid reliable instrument with three factors containing items that mirrored the mid-range theory attributes from which they were drawn. The analysis of this instrument provided initial support for the mid-range theory of *nurse caring*. NCPS as a valid reliable instrument may be helpful in making nurse caring more objective and visible by providing a measure for nursing care that is presently hidden and unmeasured. NCPS might also serve as an indicator of perceived nursing care, and may be a means for better understanding the theory of *nurse caring*.

As a final component of this study, participants were asked to describe in writing an encounter with a nurse. Validation and extending a theory are desirable outcomes of research because research findings can augment knowledge about the theory tested. In this case responses to the descriptive question reiterated similar experiences to those studies reviewed in the meta-synthesis, further supporting the results of previous research and validating the synthesized mid-range theory of *nurse caring*. Additionally participant' descriptors offered no new insights for items that might added to the NCPS, thus validating those items populating the instrument. Further in-depth analysis of the

descriptive question responses may provide new data that validates and extends the mid-range theory, thus adding to what is known about nurse caring.

*Implications for Nursing Practice*

There is a call for nursing to practice patient–centric, evidence-based care (American Nurses Credentialing Center, 2008; Institute of Medicine, 2003). Evidence is often interpreted as the outcomes of assessment and intervention skills that nurses execute. Institutions also use patient satisfaction as a guide for quality and excellence. Not well documented is the experience of the nurse-patient encounter particularly from the patient's viewpoint, yet there is an acknowledgement in the literature that patients' perspectives determine their sense of quality health care (Kaiser Family Foundation et al., 2004). Nursing scholars have also recognized the inability to clearly define the ontology of nurse caring due to the lack of patient perceptions of feeling cared for (Morse et al., 1990; Paley, 2001). Nelson & Gordon (2006) noted that nursing's new Cartesianism has discounted and downplayed the medical, technical and physical care of the nurse while emphasizing the psychosocial and emotional. This observation of what nurses value when queried may partially explain the differing views of nurses and patients on important nursing care activities.

The mid-range theory of *nurse caring* provides nurses with a comprehensive model for nursing practice that portrays the complex interaction of the technical and physical care of the patient with the psychosocial and emotional. Nurses need not discount one aspect of nursing care in favor of another. Nurses need to recognize that caring for the patient includes all components of their expertise. The model of nurse

caring (Figure 1) provides clinical nurses with a practical vision of how each aspect of care, being present, being technically competent, and having respectful consideration for the patient intersect in the ideal as nurse caring. Nurses that deny components of *nurse caring* as important may generate uncaring behaviors and negative consequences in the course of care delivery that affects both the nurse and the patient. It is in the provision of bodily care (from bathing to complex interventions) that the intimate relationships between nurse and patient are formed, and when nurses pick up vital clues about the patient's physical, mental, and spiritual condition (Nelson & Gordon, 2006). Each nursing act whether teaching, monitoring, physical care, technological interventions, or communicating and being with the patient is integral to the whole of nursing care. These nursing acts which consider the whole patient fit the current call for patient-centric care.

The meta-synthesis is the first attempt to define *nurse caring* by including the patient's perspective. *Nurse caring* provides a practical framework for nurses to prepare for, and enter into an encounter with the patient. Indices listed as prerequisites for *nurse caring* give nurses a meter to measure their preparedness to interact with the patient. The model of *nurse caring*, with its three component parts, illustrates the expectations of nurses, students, and patients for a positive nurse-patient encounter. Effects, particularly on the patients, are a reminder to the nurse of the impact nurse caring has on the lives of others.

Hospitals, however, are interested in enhanced patient outcomes, and the most economical bottom line. If compassion or caring counts, it must be measurable. From patient's point of view caring comprises technical competency, individual respect, and a

sense that the nurse is focused on his/her care. NCPS is the first attempt to provide a valid reliable instrument developed from patient descriptors of the nurse-patient encounter that emerged from a meta-synthesis of qualitative studies. NCPS provides insight into nursing functions that are not recorded or captured by other data-collection systems. This valid reliable instrument enhances the body of instruments measuring quality and satisfaction by providing nurses and administrators with more comprehensive objective data of the nurse-patient encounter than provided by current quality and outcome indicators due to its use of the patient perceptions of care. Employing NCPS may also lead to between group comparisons of patient-perceived nurse caring by age, gender, ethnicity, education and socioeconomic status thus lending further insight into health care disparities.

*Implications for Nursing Education*

A caring environment in schools of nursing is critical for teaching students how to approach the care of the patient, and for providing a milieu for unifying faculty and students (Beck, 2001). Students need to experience caring before being able to apply it to patient care. A faculty modeled environment is conducive to setting the stage for caring behaviors of students in clinical practice. *Nurse caring,* as derived from the meta-synthesis, illustrates that the art and science of nursing is caring; since it requires the interplay of presence, concern for the other; knowledgeable, competent care with respect for the person to constitute caring. This theory and its model (Figure 1) can provide faculty with a framework for understanding and articulating the complex relationship between each of the *nurse caring* attributes as a means to construct an environment of

caring. Students in this environment will be able to personally experience and learn what steps to take in order to provide the ideal caring experience for the patient.

Nursing educators incorporate into curricula, coursework that will foster knowledge of the arts and sciences, technical competence, critical thinking, medical ethical knowledge, and a sense of relationship with the patient that results in a knowing connection. Some schools of nursing have faculty that are unable to agree on a meta-theory to guide the philosophy of nursing education (K. Gramling, personal communication, March 19, 2008). *Nurse caring* may provide a tangible theoretical framework for guiding those schools of nursing whose faculty desire to institute a caring environment as a learning mechanism for student nurses.

The NCPS may provide nursing educators with a means of evaluating students in the clinical environment. Although using this instrument is impractical in many instances, since students often serve patients for one short clinical day. NCPS might be of practical use to objectively measure student clinical performance, from the patient's perspective, during the culmination or synthesis of undergraduate or graduate studies. Results of this measurement might provide validation for current course content, or provide objective data to drive modification of curricula. Additionally application of NCPS with students may enhance the understanding of components of the *nurse caring* theory such as what patients mean when they describe the nurse as competent.

### *Recommendations for Further Research*

#### *Mid-range Theory of Nurse Caring*

While the mid-range theory and model (Figure 1) of nurse caring contributes to the epistemology of the concept of caring with a new definition that includes the patients' perceptions of nurse caring, questions also arise. For instance, patients have reported that nursing competence is the most important component of nursing care as revealed in studies using Larson's (1981) CARE-Q instrument (Gooding et al, 1993; Larson, 1984;1986; Widmark-Petersson, 1996; 2000). Patients express competence most commonly with descriptors such as "knowing how to" or able to enact skills (Gramling, 2004; Miller et al, 1992; Paternoster, 1988), "helping" (Lovegren et al, 1996; Collins et al, 1994), providing information (Hogan, 2000; Lemmer, 1991; Swanson-Kauffman, 1988). Other descriptors of knowledgeable competence including "doing extra things" (Gramling, 2004), "persistence" (Hinds, 1988), "protective" (Bowers, 1987), "anticipated needs" (Clayton et al, 1991), and nurses "maintaining belief" in the patient throughout the healthcare experience (Swanson, 1986; 1988).

What does the patient really mean when using the descriptor "competence?" Is it similar or the same as nurses view of technical competence in that there is a proficiency in completing a technical intervention, or is it a more comprehensive concept that might include the nurse's approach, confidence, physical presence, as well as being able to meet patient expectations technically? Further research is warranted to explore and better understand this antecedent concept of *nurse caring*.

The meta-synthesis included 90 qualitative studies conducted in eight countries that explored the perceptions of nurses, students and patients regarding the nurse-patient encounter. A mid-range theory of nurse caring emerged from the data with three

attributes derived from the descriptions of nursing care given by participants in the reviewed studies. Despite the large number of studies reviewed, not all cultures and ethnicities were included. Future qualitative studies asking nurses, students, and patients about the nurse-patient experience needs to be conducted in Africa, Asia, South America, and the Pacific islands in order to have a comprehensive definition of *nurse caring*. Is a comprehensive definition possible, given the differences in cultural norms across the world?

There seems to be an indication that patients and nurses may have similar descriptions of nurse caring despite cultural differences. For example Holroyd et al (1998) used Larson's (1981) CARE-Q instrument with nurses and patients in Hong Kong. Results of this revised Chinese translation of the CARE-Q instrument were the similar to other studies using the CARE-Q in that nurses and patients disagreed on the most important aspect of nursing care. Nurses viewed psychosocial aspects of care delivery most important but did include competency as part of the 10 most important behaviors, and patients reported competency and respect as most important. The investigators of this study (Holroyd et al) stated that nurses needed to communicate with patients so that they could judge more accurately what patients considered important in feeling cared for. This example was a single study. No qualitative studies from Hong Kong or other Asian nations were found in a review of the literature to determine whether nurses, students and patients in Asian cultures have views about nurse caring that are similar to those who participated in the reviewed studies.

*The Nurse Caring Patient Scale*

Further research is required to confirm the reliability and validity of the *Nurse Caring Patient Scale*. Initial reliability and validity has been established using factor analysis in one sample. A second study using a contrasting group of larger sample size is suggested for further testing reliability and validity of the resulting 23-item NCPS.

Another approach would be to test NCPS with a different population. In this study women comprised 68.6% of the sample and 76.1% of the participants were self-identified as Caucasian/white/European descent. Neither the gender, nor the ethnicity of the sampled subjects is reflective of the general population in the United States. Likewise the education level and socio-economic status of this sample were not reflective of the general population. A more stratified sample might yield a different response, and add to the knowledge of caring. Since the meta-synthesis was gleaned from studies done across several countries and included many cultures, a cross-cultural sample might begin to confirm or refute the idea that nurse caring is viewed differently by peoples of different cultures.

Analysis of between group differences using this valid, reliable instrument may reveal differences in perceived care by patients of different age groups, ethnicities, genders, socio-economic status and hospital in-patient unit. Recognizing and ending health disparities is a key issue in today's quest for quality care. The NCPS may highlight disparities perceived by patients in an institution using this instrument. Further research using the NCPS may provide a useful instrument for health care organizations in rooting out disparate care. Similarly, NCPS might be a means of benchmarking perceived nursing care between units within a hospital, and between hospitals across the country.

In the literature, caring instruments that measure nurses or patient perceptions of care have been linked to quality of care (Wolf et al, 2004) and patient satisfaction (Larrabee et al, 2004; Yaekel et al, 2003). Future research is indicated to compare NCPS to valid and reliable satisfaction and quality instruments. Since NCPS incorporates patient perceptions of nursing care that are hidden and unmeasured, NCPS may be found as a positive adjunct to currently used measures for quality and satisfaction.

*Summary*

This study had two aims, a meta-synthesis of qualitative studies of nurses, students and patients' perceptions of nursing care to result in a new definition of caring and the development and psychometric analysis of a new instrument the *Nurse Caring Patient Scale* (NCPS). A meta-synthesis of qualitative studies seeking responses from nurses, students and patients about the nurse-patient encounter resulted in a mid-range theory of n*urse caring* with three attributes. Nurses and student contributions to the model mirrored nursing theoretical ideas about nurse caring (see Appendix D). Patient perceptions of feeling cared for by nurses (see Appendix E) changed the initially synthesized model from one that had a fourth attribute concerning the spiritual/metaphysical to the model's final three attributes: *Presence, Concern for the Other, Knowledgeable Competent Care, and Respect for the Person* (see Appendix A). The model of nurse caring (Figure 1) provides nurses and students a practical framework for research, clinical practice and academic learning.

The second aim of the study was the development and testing of a new instrument that measured patient perceptions of feeling cared for by nurses. Items for the NCPS were

derived from descriptors of nurse-patient encounters by patients (Appendix E). A team of experienced clinical nurses, and one experienced nursing theorist examined the initial NCPS for relevance to the concept of *Nurse Caring*, clarity, readability, understandability, conciseness, and any missing items from the descriptor list. Adjustments were made to the instrument to improve its readability and understandability; and statements were added for those descriptors that were missing from the model. The resulting NCPS had 50 items and a single Likert response scale. A review of instrument content validity was performed by "expert" patients who had been hospitalized, and experienced nursing care during their hospitalization. This expert panel reviewed the NCPS for clarity, readability, understandability, and for any missing items. Two items were changed, but no items were dropped nor were any new descriptors added by the expert panel that would lead to additional items being added to NCPS.

The 50-item NCPS was administered to a convenience sample of 341 acute in-patients in an urban teaching medical center in the northeastern United States. Eighty-one percent of the subjects completed the study materials. The final sample was n= 297. Standardized alpha for NCPS was extremely reliable at .92. Out of this sample some of the items had "not applicable" or no response. "Not applicable" was treated as no response, so eight items were deleted. Five items had an item-total correlation of less than .300 so they were also dropped from NCPS.

A 37-item NCPS was subjected to factor analysis. Principle components analysis, varimax rotation and Kaiser normalization with a cut-off point of .300 identified a three factor solution. All 37 items had an item correlation of at least .300. Items were retained

or discarded from a component based on hypothesized component structure. The resulting NCPS was a 23-item instrument with a high reliability of .91, and three component factors labeled *Presence, Concern for the Other* (11 items, alpha .89); *Knowledgeable, Competent Care* (5-items, alpha .77); and *Respect for the Person* (7-items, alpha .73). Figure 2 illustrates the steps in the development and psychometric evaluation of the Nurse Caring Patient Scale.

A descriptive question asked participants to relate an experience with a nurse in writing. Those who responded to the request wrote about caring and uncaring experiences with nurses. Descriptors used by the participants validated findings in the meta-synthesis of qualitative studies, thus validating the defined attributes of the mid-range theory of *nurse caring*. No new descriptors were conveyed within this sample of responses so no additional items needed to be added to NCPS.

*Nurse caring* is the art and science of the practice of nursing. NCPS was developed from the mid-range theory of *nurse caring* which extended the concept of caring by including the patient's perspective. This new instrument then provided an objective means to measure seen and unseen aspects of nursing care. The NCPS, a reliable valid instrument, may provide a means for measuring unseen aspects of nursing care as an adjunct to current measures for quality and satisfaction, and it may provide a cross-cultural comparison for disparities thus providing a response to the call for evidence-based practice and patient-centric care. NCPS may also provide a more comprehensive evaluation of patient satisfaction with nursing care by assessing patient perceptions of nurse caring that are currently hidden, and unmeasured.

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APPENDIX A

Nurse Caring Defined by Nurses, Students and Patients

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| being friendly, kind, sense of humor (Fareed, 1996; Hogan, 2000; Jenny & Logan, 1996; Lovegren et al., 1996; Pound et al., 1995; Propst et al., 1994; Raudonis, 1993; Ray, 1987; Sherwood, 1991) | dignity (Beauchamp, 1993; Lovegren et al, 1996) | meeting needs (Euwas, 1993; Raudonis, 1993) |
| giving of self (Beck, 1991; Chipman, 1991; Clarke & Wheeler, 1992; Davies & O'Berle, 1990; Hughes, 1993a) | individuality (Cara, 2001; Collins et al, 1994; Gramling, 2004; Jensen et al, 1996; Lemmer, 1991; Raudonis, 1993; Tanner et al, 1993) | doing extra things, intuitive (Gramling, 2004; Lovegren et al, 1996; Nelms, 1996 Propst et al, 1994) |
| open to the moment (Dietrich, 1992) | consistency (Steeves et al., 1994; Williams, 1992) | touching (Beauchamp, 1993; Hinds, 1988; Mullaney, 2000, Swanson – Kauffman, 1986; 1988) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| comforts (Beck, 1991; Bottorff, 1993; Boyd & Munhall, 1989; Clayton et al., 1991; Collins et al., 1994; Nelms, 1996; Paternoster, 1988; Peterson, 1985; Pound et al., 1995; Ray, 1984, 1987; Schaefer, 2003; Sherwood, 1991; Spangler, 1993; Swanson-Kauffman, 1986) | personally valued, being known (Hogan, 2000; Jenny & Logan, 1996; Lovegren et al, 1996; Sherwood, 1991; Swanson-Kauffman, 1988; Tanner et al, 1993) | advocates (Back-Petersson & Jensen, 1993; Clayton, 1989; Davies & O'Berle, 1990; Jensen et al, 1993; Kahn & Steeves, 1988; Kosowski, 1995; McNamera, 1995; Peterson, 1985; Ray, 1987; Steeves et al, 1994) |
| open to the moment (Dietrich, 1992) | commitment, fidelity (Burns, 1994; Grigsby & Megel, 1995; Jensen et al, 1993; Schaefer, 2003; Swanson, 1990) | helps, enables (Clayton, 1989; Girot, 1993; Green-Hernandez, 191; M. D. Hanson, 2004; L. Hanson & Smith, 1996; Hughes, 1993a; Ray, 1984; Raudonis, 1993; Swanson, 1990) |
| is calm (Clayton et al., 1991) | acceptance (Mullaney, 2000) | attention, attentive (Spangler, 1993) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| connection/ interconnected (Back-Pettersson & Jensen, 1993; Bottorff, 1993; Burns, 1994; Clayton, 1989; Davies & O'Berle, 1990; Fareed, 1996; Girot, 1993; Gramling, 2004; Green-Hernandez, 1991; Grigsby & Megel, 1995; Halldorsdottir & Hamrin, 1997; L. Hanson & Smith, 1996; Jensen et al., 1993; Kahn & Steeves, 1988; Kosowski, 1995; Miller et al., 1992; Milne & McWilliam, 1996; Montgomery, 1992; Nelms, 1996; Raudonis, 1993; Ray, 1984; Schaefer, 2003) | respect (Beauchamp, 1993; Beeby, 2000b; Bunkers, 2004; Bush, 1988; Clayton et al., 1991; Collins et al., 1994; Davies & O'Berle, 1990; Forrest, 1989; Gramling, 2004; Halldorsdottir, 1989; Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996; Jensen et al., 1993, 1996; Lovegren et al., 1996; Parker, 1994; Poole & Rowat, 1994; Spangler, 1993; Wolf et al., 2003a) | knows how to do … (competent, knowledgeable) (Clayton et al, 1991; Collins et al, 1994; Cooper, 1993; Coulon, 1996; Donoghue, 1993; Engebretson, 2000; Fareed, 1996; Finn, 1993; Gramling, 2004; Green-Hernandez, 1991; Halldorsdottir, 1989; Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996; Hogan, 2000; Jensen et al, 1996; Kosowski, 1995; Lemmer, 1991; Lenners, 1993; Lovegren et al, 1996; Miller et al, 1992; Parker, 1984; Paternoster, 1988; |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| Swanson-Kauffman, 1988; Williams, 1992) | family/caregivers respected (Powell-Cope, 1994; Winters et al, 1994) | Propst et al, 1994; Raudonis, 1993; Raudonis & Kirschling, 1996; Ray, 1984; 1987; Schaefer, 2003; Sherwood, 1991) |
| reassurance, encouraged (Lemmer, 1991; Winters et al., 1994) | accessible, available (Fareed, 1996) | pain relief (Collins et al, 1994; Gramling, 2004; Lovegren et al, 1996) |
| concern, caring (Donoghue, 1993; Drew, 1986; Halldorsdottir, 1989; Halldorsdottir & Hamrin, 1997; Jensen et al., 1993, 1996; McNamara, 1995; Paternoster, 1988; Poole & Rowat, 1994; Pound et al., 1995; Raudonis & Kirschling, 1996; Schaefer, 2003; Williams, 1992) | listens (Cara, 2001; Clarke & Wheeler, 1992; Clayton et al., 1991; Collins et al., 1994; Donoghue, 1993; Fareed, 1996; Green-Hernandez, 1991; Jensen et al., 1993; Kahn & Steeves, 1988; Lovegren et al., 1996; Poole & Rowat, 1994; Ray, 1987; Williams, 1992; Wolf et al., 2003a) | problem-solves (Ray, 1984) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| trust (Clarke & Wheeler, 1992; Euwas, 1993; Fareed, 1996; Girot, 1993; Gramling, 2004; Halldorsdottir & Hamrin, 1997; Mullaney, 2000; Powell-Cope, 1994; Ray, 1987; Winters et al., 1994) | sensitive (Beauchamp, 1993; Finn, 1993; Mullaney, 2000) | facilitates integration of services (Hogan, 2000; Milne & McWilliam, 1996; Poole & Rowat, 1994) |
| love (Beauchamp, 1993; Engebretson, 2000; Jensen et al., 1996; Montgomery, 1992; Ray, 1984) | supportive, encouraging (Beck, 1992a, 1993, 1994; Fareed, 1996; Green-Hernandez, 1991; L. Hanson & Smith, 1996; Hughes, 1993a; Peterson, 1985; Poole & Rowat, 1994; Steeves et al., 1994; Swanson, 1990; Williams, 1992) | surveillance/monitors (L. Brown, 1986; Burfitt et al, 1993; Gramling, 2004; Hinds, 1988; Miller et al, 1992; Ray, 1984; Sherwood, 1991;Steeves et al, 1994; Winters et al, 1994; ) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| sharing (Davies & O'Berle, 1990; Kosowski, 1995; Ray, 1984) | allowed to have situational control (Gramling, 2004; Jensen et al, 1996; Lemmer, 1991; Lovegren et al, 1996; Williams, 1992) | protecting, protective (Bowers, 1987; Swanson-Kauffman, 1986) |
| anticipates needs (Coulon et al., 1996; Montgomery, 1992) | showing patience ( Clayton, 1989; Pool & Rowat, 1994) | teaches (Forrest, 1989; Ray, 1984; Steeves et al, 1994; Williams, 1992; Wolf et al, 2003a) |
| spiritual union (Bush, 1988; McNamara, 1995) | dependable (Steeves et al, 1994) | helping (Collins et al, 1994; Jenny & Logan, 1996; Lovegren et al, 1996) |
| transcendence (Montgomery, 1992) | consideration (Clayton et al., 1991; Davies & O'Berle, 1990; Parker, 1994; Raudonis & Kirschling, 1996; Wolf et al., 2003a) | responsive, responds quickly ( L. Hanson & Smith, 1996; Hughes, 1993a; McNamera, 1995; Ray, 1984; Wolf et al, 2003a) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| being present, being there (Beauchamp, 1993; Beck, 1991, 1992a, 1992b, 1993, 1994; Beeby, 2000b; Boyd & Munhall, 1989; J. Brown & Ritchie, 1989; Bunkers, 2004; Bush, 1988; Clarke & Wheeler, 1992; Collins et al., 1994; Drew, 1986; Engebretson, 2000; Euwas, 1993; Fareed, 1996; Finn, 1993; Green-Hernandez, 1991; L. Hanson & Smith, 1996; Hughes, 1993a; Jensen et al., 1993; Miller et al., 1992; Nelms, 1996) | empathy (Clayton et al., 1991; Donoghue, 1993; Finn, 1993; Forrest, 1989; Green-Hernandez, 1991; L. Hanson & Smith, 1996; Jensen et al., 1993; Kahn & Steeves, 1988; McNamara, 1995; Parker, 1994; Powell-Cope, 1994; Ray, 1984; Williams, 1992; Winters et al., 1994; Wolf et al., 2003a) | communicates, provides information (Bush, 1988; Cara, 2001; Clarke & Wheeler, 1992; Coulton et al, 1996; Davies & O'Berle; Euwas, 1993; Fareed, 1996; Green-Hernandez, 1991; Hogan, 2000; Hughes, 1992; 1993a; Jenny & Logan, 1996; Jensen et al, 1996; Kahn & Steeves,1988; Lemmer, 1991; Lovegren et al, 1996; McNamera, 1995; Poole & Rowat, 1994; Powell-Cope, 1994; Ray, 1987;Schaefer, 2003; Swanson, 1990; Swanson-Kauffman, 1988) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| Poole & Rowat, 1994; Propst et al, 1994; Steeves et al, 1994; Swanson-Kauffman, 1986; Swanson, 1990; Williams, 1992; Winman & Wikblad, 2004; winters et al, 1994) | compassion (Halldorsdottir & Hamrin, 1997) | attends (touch) (Chipman, 1991; Clarke & Wheeler, 1992; Coulton et al, 1996; Finn, 1993; Green-Hernandez, 1991; L. Hanson & Smith, 1996; Kosowski, 1995; McNamera, 1995; Ray, 1984; 1987; Schaefer, 2003) |
| perceives/ insight/ comprehension (Beck, 1992a, 1992b; Burns, 1994; Donoghue, 1993; Engebretson, 2000; Forrest, 1989; Halldorsdottir, 1989; Hughes, 1993a; Leners, 1993; Swanson, 1990) | other regarding/ supports (maintaining belief) (Clayton et al., 1991; Kahn & Steeves, 1988; Parker, 1994; Schaefer, 2003) | enacting skills/practices (Bunkers, 2004; L. Brown, 1986; Clayton et al, 1991; Jensen et al, 1996; Milne & Mc William, 1996; Poole & Rowat, 1994; Pound et al, 1995; Sherwood, 1991; Swanson, 1990; Swanson-Kauffman, 1986; |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| Uncaring | | |
| lack of or disconnection (Halldorsdottir & Hamrin, 1997; Parker, 1994) | insensitive, cold (Drew, 1986; Halldorsdottir & Karlsdottir, 1996; Hinds, 1988; Winman &Wikblad, 2004 | not meeting needs timely (Chipman, 1991) |
| lack of concern (Halldorsdottir, 1989) | disinterested (Drew, 1986; Halldorsdottir & Karlsdottir, 1996; Winman & Wikblad, 2004) | incompetence (Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996) |
| indifference (Burfitt et al., 1993; Drew, 1986; Halldorsdottir & Hamrin, 1997; Lovegren et al., 1996) | disrespectful, treated as object (Burfitt et al, 1993; Finn, 1993; Lovegren et al, 1996; Parker, 1994; Swanson-Kauffman, 1988; Winman & Wikblad, 2004) | rough (Reimen, 1986) |
| | inhumanity (Winman & Wikblad, 2004) | |

| Uncaring | | |
|---|---|---|
| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
| minimally present, remote (Finn, 1993; Parker, 1994; Solberg & Morse, 1991) | impatient, inconsiderate (Drew, 1986; Reiman, 1986) | withholding contact/ignored (Finn, 1993; Reimen, 1986; Swanson-Kauffman, 1988) |
| no comfort (Chipman, 1991; Solberg & Morse, 1991) | dismissive, belittled (Drew, 1986; Finn, 1993; Halldorsdottir & Karlsdottir, 1996; Lovegren et al, 1996; Winman & Wikblad, 2004) | detachment, only doing a job (Burfitt et al., 1993; Chipman, 1991; Hinds, 1988; Kahn & Steeves, 1988; Lovegren et al., 1996; Reimen, 1986) |
| animosity (Kahn & Steeves, 1988) | | |
| unkind (Halldorsdottir & Karlsdottir, 1996) | | |

APPENDIX B

Caring Instruments Developed 1984-2005

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/ Psychometrics |
|---|---|---|---|---|
| Caring Assessment Instrument (CARE-Q) | Larson, P. (1984) | Perceptions of nurse caring behaviors | A priori development form observation of cancer patient needs | Expert nursing panel test-retest for content and face validity |
| CARE-SAT, revision of CARE-Q | Larson, P. & Ferketich, S. (1993) | Patient satisfaction of nursing care | Adaptation of Larson's original work | Cronbach's alpha .94. Three scales with alpha>.80 |
| CARE-Q revised – Swedish version | von Essen, L. & Sjödén, P. O. (1991a) | Perceptions of nurse caring behaviors | Translation of CARE-Q tool to Swedish | Cross-cultural validity – similar results to English version |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Caring Behaviors Inventory (CBI), | Wolf, Z. (1986) | Words, phrases in nursing literature that represent caring | Nursing literature and based on Watson's theory of Human Caring (1988) | Content validity from literature sources |
| CBI revised | Wolf, Z., Giardino, E. R., Osborne, P. A., Ambrose, M. S. (1994) | Process of caring | Adaptations from original work | Test-retest reliability .96; content & construct validity from expert panel; in retest Cronbach's alpha .98 |
| CBI revised, | Wu, Y., Larrabee, J.H., Putman, H. P.(2006) | Process of nurse caring in a less burdensome way | Adaptations from original work | Cronbach's alpha .96, four factors with alphas >.80 |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| CBI-E, CBI for elders | Wolf, Z., Zuzelo, P. R., Costello, R., Cattilico, D. Cooper, K. A., Crothers, R. et al. (2004) Wolf, Z., Zuzelo, P. R., Goldberg, E., Crothers, R., Jacobson, N. (2004, 2006) | Perception of nurse caring (in assisted living, independent living and adult day-care) | Adaptations from original work | Cronbach's alpha .94, elders - .93, caregivers - .82. Five factors - .65-.93 with one factor containing only one item. |
| Caring Behavior Assessment (CBA) | Cronin, S. & Harrison, B. (1988) | Patients' perception of nurse caring behaviors | Watson's Theory of Human Caring (1988) | Cronbach alpha for 7 subscales .66-.90, face and content validity |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| CBA | Stanfield, M. H.(1991) | Patients' perceptions of caring | Retest of original instrument | Cronbach's alpha .96, subscales: .78-.89 |
| CBA revised, | Parson, E., Kee, C., Gray, P. (1993) | Patients' perceptions of nurse caring behaviors | Revised instrument – 8 items eliminated as not relevant to patient population | None reported for revised instrument |
| CBA revised | Huggins, K., Gandy, W., Kohut, C. (1993) | Patients' perceptions of nurse caring behaviors | Revised instrument for emergency department patients | None reported for revised instrument |
| Caring Behaviors of Nurses Scale (CBNS) | Hinds, P.S. (1988) | Caring behaviors of nurses within subjective human relationships | Existential-humanistic nursing and inductive studies of nurse-adolescent interactions | Cronbach's alpha .86, face and content validity |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Professional Caring Behaviors (PCB), developed 1989, 1991 (J. Watson, 2002) | Developed by Horner, S.D. (published in later testing by Harrison, E.) (1995) | Perceptions of nurse caring behaviors | None stated, but refers to caring literature. Published study – concern with families' perception of nurse caring. | Cronbach's alpha .92 & .94, test-retest .81 |
| Nyberg Caring Attributes Scale | Nyberg, J. (1990) | Caring attributes of nurses | Watson's Theory of Human Caring (1988), Gaut (1983), Noddings (1986), Mayeroff (1971) | Cronbach's alpha .87-.98 ( included Nyberg's caring attributes, and Larson's CARE-Q) |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Caring Ability Inventory (CAI) | Nkongho, N.O. (1990) | One's ability to care in a relationship | Caring literature, Mayeroff's (1971) eight critical elements of caring | Cronbach's alpha for subscales: .71-.84, Content validity with experts, correlation with Tennessee Self-Concept Scale. |
| Caring Behaviors Checklist (CBC) | McDaniel, M. (1990) | Caring process (observed) | Caring literature, interest in caring about and caring for with students | Inter-rater reliability .92, Content validity index .80 |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Client Perception of Caring Scale (CPC) | McDaniel, M. (1990) | Clients' perception of nurse caring (detects caring and non-caring behaviors) designed for use with CBC | Caring literature, conceptual model of caring process to guide instrument development | Content validity index 1.00, Cronbach's alpha .81 Construct validity not significant after correction with empathy scale |
| Caring Assessment Tool (CAT) | Duffy, J. (1990, 1992) | Patients' perception of nurse caring behaviors | Watson's Theory of Human Caring (1988) and carative factors | Cronbach's alpha .978, high correlations between CAT and CARE-Q, r = .79. CAT positive significant ($p<.0005$) correlation with satisfaction |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Caring Assessment Tool (administrator form) | Duffy, J. (1993) | CAT- modified for nurses' perceptions of managers' caring behaviors | Watson's Theory of Human Caring (1988) and carative factors | None noted |
| CAT – Edu | Duffy, J. (2001) | Educational version of CAT focusing on student perceptions of faculty caring behaviors | Watson's Theory of Human Caring (1988) and carative factors | Validity established, Cronbach's alpha .98 |
| Peer Group Caring Interaction Scale | Hughes, L. (1993a, 1998) | Organizational climate of caring perceived by nursing students with peers | Informed by caring literature, Noddings (1986), and Bevis & Watson (1989) | Cronbach's alpha .91 for each subscale |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Organizational Climate for Caring Questionnaire (OCCQ) | Hughes, L. (1993b) | Designed to measure student perceived organizational climate for caring with context of faculty-student interactions | Nodding's (1986) | Cronbach's alpha .88-.92 in three pilot studies |
| Caring Efficacy Scale, 1992, (J. Watson, 2002) | Coates, C. (1997) | To assess one's ability to develop caring relationships and express a caring orientation | Bandura's social psychology, Watson's (1988) Theory of Human Caring | Cronbach's alpha .84-.85 – three versions |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Holistic Caring Inventory, 1988, | Latham, C. P. (1996) | Patient perceptions of caring | Holistic and humanistic caring theory | Content validity nursing experts, Cronbach's alpha for subscales: .89-.91 |
| Caring Dimensions Inventory (CDI) | Watson, R. & Lea, A. (1997) | Nurses' perceptions of caring | Caring theory influential, but used empirical approach | Cronbach's alpha - .91 |
| Caring Attributes Professional Self-Concept-Technological Influence (CAPSTI) | Arthur, D., Pang, S. Wong, T. Alexander, M.F., Drury, J. et al (1999) | Consumer's perspective of practice relationship with health care providers | Swanson's Middle Range Caring Theory, empirically derived | Cronbach's alpha subscales: advanced practice nurses - .74-.96, nurses-.97, physicians - .96 |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Methodist Health Care System Nurse Caring Instrument (MHCSNCI), unpublished (J. Watson, 2002) | Shepherd, M. | Nurse caring as related to patient satisfaction and outcome based research on nurse caring | Empirically derived from caring literature | Content validity with nurses, intra-class correlation .98. |
| Nurse Caring Behaviours (NCB) | Hegedus, K. S. (1999) | Nurses and patients ranking of caring behaviors. | Derived from the caring literature, interviews with nurses, and clinical observation | no psychometric data available. |

| Instrument | Researcher | Developed to measure | Source of Development | Validity & Reliability/Psychometrics |
|---|---|---|---|---|
| Oncology Patients' Perceptions of the Quality of Nursing Care Scale (OPPQNCS), unpublished (personal communication) | Radwin, L.E. (2005) | Patients' perceptions of cancer nursing care quality | Derived from qualitative study of cancer patients' perceptions that yielded a middle-range theory of attributes of excellent cancer nursing care. | Content validity from expert panel. Cronbach's alpha - .95, subscales - .69-.81 on short form, alpha .96, and subscales; .93-.95 on long form |

APPENDIX C

Caring Qualitative Studies of Nurses, Students & Patients

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Bäck-Pettersson, S., & Jensen, K. P. (1993) | nurses, Sweden | n =32 | 3 subthemes from overall theme: she dares Courageous when: connecting with people in crisis, practicing advocacy, and coping with stressful situations. |
| Beauchamp, C. J. (1993) | patients (HIV-AIDS) | n=1 | Themes: dignity, love, security, presence, respect, sensitivity |
| Beck, C. T. (1991) | students | n = 47 | Themes: attentive presence (focusing attention, senses), sharing of selves (giving, nonjudgmental, shares self), consequences (student feels respected as individual, experience energizes student, student is able to reach out) |

| *Author(s)* | *Focus* | *Subjects* | *Themes* |
|---|---|---|---|
| Beck, C. T. (1992a) | Students (faculty) | n = 53 | Themes: authentic presencing ( sensed , listened, understood, there for me, recognized), selfless sharing (sacrificed time, shared knowledge and expertise, stayed with me), |
| Beck, C. T. (1992b) | Students (with children) | n = 31 | Themes: authentic presencing (reached inside, experienced her uniqueness), physical connectedness (touched, held), reciprocal sharing (shared, enjoyed each other, laughed together), delightful merriment (smiled, feeling of joy), bolstered self-esteem (permitted child to do on his own), unanticipated self-transformation ( I changed). |
| Beck, C. T. (1993) | students | n = 22 | Themes: authentic presence, competence, emotional support, physical comforting, and positive consequences |
| Beck, C. T.(1994) | nurse faculty, students | n = 17<br>n = 136 | Constituents of caring experience: authentic presencing, unconditional support, spontaneous sharing, and uplifting consequences (of caring) |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Beeby, J. P. (2000b) | nurses in ICU, England | n = 9 | Themes:<br>• being involved - being there, being close, respecting the person, having feelings for the patient, involving family<br>• sustaining - being supportive, having experience, having expertise, positive feelings for work, having resources<br>• having frustrations - rigors of work, constraints on resources, difficulties with the team |
| Bottorff, J. L.(1993) | patients (Acute Care Oncology), Canada | n = 8 | Observed types of touch as caring: comforting, connecting, working, orienting, and social |
| Bowers, B. J. (1987) | 27 parents/patients & 33 offspring/caregivers | n = 60) | Categories:<br>Anticipatory caregiving, preventative caregiving, supervisory caregiving, protective caregiving, instrumental caregiving (doing for, assisting) |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Boyd, C. O., Munhall, P. L.(1989) | students | n = 15 | Reassurance : person-environment cues via distress, types of situations, nursing actions/aims: giving information, physical comfort, supporting autonomy, being present, acting confidently and calmly, crying with patient |
| Brown, L. (1986) | patients pediatric | n = 50 | Care themes: recognition of individual qualities and needs, reassuring presence, provision of information, demonstration of professional knowledge and skill, assistance with pain, amount of time spent, promotion of autonomy, surveillance |
| Brown, J. & Ritchie, J. A. (1989) | nurses, pediatric, Canada | n=25 | • Reciprocal relationship – nurse to family<br>• Adversarial relationship – interpersonal conflict<br>• Negotiated relationship – honest communication<br>Asynchronous relationship – discrepancies; perceived need verses assessed need |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Brown, J. & Ritchie, J. A. (1989) | | | • Ineffective relationship – nurse dissatisfied |
| Bunkers, S. S.(2004) | patients, female outpatients | n = 10 | Caring themes: contentment with intimate affiliations (presence), salutary endeavors (action), honoring uniqueness amid adversity (fostering human wellbeing, respect). |
| Burfitt, S. N. , Greiner, D. S., Miers, L. J., Kinney, M. R., Branyon, M. E. (1993) | Patients - ICU | n = 13 | Patterns of caring: vigilance, mutuality (a reciprocal process, healing)<br>Noncaring behavior:<br>• direct – attitude, indifference, treating patient as object.<br>• indirect – low effort, just a job.<br>• contradictory – no privacy because never alone |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Burns, M.(1994) | nurses, pediatric | n=8 | • Making connection – becoming aware of the person<br>• Perceiving the need of the other – developing the relationship<br>• A sense of investment – unfolding from commitment<br>• Remaining distant – choosing not to engage |
| Bush, H. A.(1988) * | nursing students (doctoral) | n=14 | Spirituality<br>Sensitivity<br>Presence<br>Communication with the other<br>Respect<br>Organization of teaching – learning |
| Cara, C. M. (2001) | Nurses, Canada | n=6 | Two themes: Natural caring, professional caring<br>Natural caring – sociocultural background, values and beliefs and personal knowledge |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Cara, C. M. (2001) | | | • Professional caring – Learning from theoretical education, role modeling, clinical experience, and work environment. |
| Chipman, Y. (1991) | students | n = 26 | Caring – giving of self, meeting patients' needs in a timely fashion, providing comfort measures for patients and their families, Noncaring behaviors – not giving of self, not meeting patients' needs in a timely fashion, not providing comfort measures for patients and their families. |
| Clarke, J. B. & Wheeler, S. J. (1992) | nurses, medical-surgical, England | n=6 | Being supportive – concern, valuing people, respect, trust, giving of self, awareness of others needs<br>Communicating – talking, listening, touching, presence<br>Pressure – as a consequence of nursing<br>Caring ability – considered innate and instinctive, coping |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Clayton, G. M. (1989) | nurse/patient dyads | n = 4 | Themes: heightened sensitivity to own feelings prior to and during caring interaction, sensitivity to self and other, helping trusting environment (eye contact, patience, calm attitude, nurse liked work) ,and environment supportive, protective and permissive, (patients were free to be themselves). |
| Clayton, G. M., Murray, J. P., Horner, S. D., Greene, P. E. (1991) | patients | n = 70 | Five themes:<br>• environmental broker - advocate, attending to details, participates in policy-making, provides administrative leadership, volunteers in community<br>• expert knowing -anticipates needs, expert knowledge, competent, high standards<br>• facilitating factors -encourages independence and expression of emotions; helps; empathetic; listens; provides comfort, emotional support and encouragement, recognizes uniqueness |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Clayton, G. M., Murray, J. P., Horner, S. D., Greene, P. E. (1991) | | | and wholeness of other<br>• personal being -balances professional and personal life, high moral character, positive attitude, cheerful, compassionate, dedicated, humane, open, assertive, courageous, intuitive, shows concern, smiles<br>• connecting -awareness of individual and changes, unconditional regard, involves patient/family in decision-making, participates in discovery of meaning in illness experience (p.159) |
| Collins, B. A., McCoy, S. A., Sale, S., Weber, S. E. (1994) | patients, postpartum, England | n = 36 | • Attributes of comfort – resolution of pain, resolution of fatigue, satiation of hunger, resolution of individual irritants, relaxation<br>• Interventions for comfort – standard therapy, supportive presence, caring nursing approach<br>• Personal modifiers of comfort – individualized comfort |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| | | | patterns, environmental ease, maternal concern<br>• Most predominant theme – caring nursing approach – cheerful, listen, tell you what's going on, cared, treated as unique person, respect, confident, helped, being there, attention |
| Cooper, M. C. (1993) | nurses (ICU) | n = 9 | Technology – competence, for patients an obstacle to human interaction. To be competent is to be set apart or caring cannot occur. |
| Coulon, L., Mok, M., Krause, K., Anderson, M. (1996) | students and nurses, Australia | n = 156 | Themes:<br>• Professionalism – best (academically, physically, professionally, and spiritually), proficient, efficient, consistent<br>• Holistic care – attending to mental, physical, social and spiritual needs of patient<br>• Practice – proficient, competent, dedicated expert, successful, sharing information, educating patients, keeping abreast of |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Coulon, L., Mok, M., Krause, K., Anderson, M. (1996) | | | new knowledge, efficient, has initiative, organized<br>• Humanism – respect of individual without prejudice, being aware of unvoiced needs, providing comfort without being asked, being able to read between the lines, treating the patient as a person, providing autonomy, enabling patients to self-care, communicating, advocating |
| Davies, B. & Oberle, K. (1990) | nurse (described 10 cases), Canada | n=1 | Valuing – respect for patient's inherent worth, individual qualities<br>Connecting – making connection, sustaining connection – being available, spending time, sharing secrets, giving of self, breaking connection<br>Empowering – facilitating, encouraging, defusing, mending, giving information<br>Doing for – taking charge, team playing<br>Finding meaning – focus on living, acknowledging death |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Davies, B. & Oberle, K. (1990) | | | Preserving own integrity – looking inward, valuing self, acknowledging own reaction |
| Dietrich, L. (1992) | nurses | n=5 | Nurse to nurse caring themes: being sensitive, offering help, being open, being understanding, acknowledgement, being supportive, and camaraderie<br>Nurse to nurse noncaring themes: lack of respect, lack of acknowledgement, lack of camaraderie |
| Donoghue, J. (1993) | Nurses in public hospitals | n = 107 | Attributes of a caring nurse: empathy, listening skills, understanding, sympathy/concern, and being knowledgeable. |
| Drew, N. (1986) | patients, surgical and OB/GYN | n = 35 | Experiences with caregivers:<br>• Experience of exclusion – lacking emotional warmth, cold, |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Drew, N. (1986) | | | stiff, mechanical, indifferent, bored, impatient, irritated, flip, close-minded, superior, disinterested, dismissive, insensitive, and preoccupied<br>• Experience of confirmation – sense of energy expended on their behalf, wanting to be there, caring liking their work, having personality, not in a hurry, relaxed, willing to share their lives, touch, tone of voice<br>• Effects of exclusion – added stress, uses up energy, coped by – seeking family support, excusing caregivers, expressing anger<br>Effects of confirmation – relaxed, confident, stronger, more in control |
| Duffy, J. R.(1993) | doctoral nursing students | n = 2 | Expressions of caring: treating, understanding, helping, letting (the other person become)<br>Process of caring: commitment (potential, reciprocal, genuine), |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Duffy, J. R.(1993) | | | involvement (personal, spiritual, holistic, freedom to express self), and belonging (reassuring, comforting, knowing, connected). |
| Engbretson, J.(2000) | student nurse | n=1 | Presence – physical, psychological, therapeutic (centering, intentionality, intuitive knowing, commenting, loving) |
| Euswas, P. (1993) | nurses & patients, New Zealand | n = 62 | Actualized caring moment:<br>• Preconditions – ready to be in contact, nurse brings qualities of caring, benevolence, commitment and clinical competency; patient brings personal uniqueness<br>• Situated context – place and time<br>• Ongoing interaction (caring process) – being there, being mindfully having a trusting relationship, participating in meeting needs, having empathetic communication, and balancing knowledge-energy-time |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Fareed, A. (1996) | patients, acute care, England | n = 8 | Themes of reassurance:<br>• Being with – in tune with, empathy<br>• Receiving information and knowledge of facts<br>• Interpersonal skills – tone of voice, smile<br>• Being there – always there, near you<br>• Communication skills – verbally, touch<br>• Trusting relationship –made me feel secure<br>• Being cared for – supportive, concern, anything you wanted they come and do, sympathetic, reassured, at ease<br>• Assertion of optimism - encouraged<br>• Humanistic traits of nurses – kindness, cheerful |
| Finn, J. (1993) | patients/ spouses (OB) | n = 3 | Caring themes – knowledgeable, considerate, nursing was calling not a job, used touch/contact, constant presence, empathy communicated. Uncaring themes – cold, patient viewed as an object, minimally |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Finn, J. (1993) | | | present, physical contact withheld, and remote. |
| Forrest, D. (1989) | Nurses, Canada | n=17 | Caring Themes:<br>Involvement – being there, respect, feeling with and for, closeness<br>Interacting – touching and holding, picking up cues, being firm, teaching, knowing them well |
| Girot, E. A. (1993) | nurses | n = 10 | Attributes of competence:<br>• Trust – trust/safety of skills<br>• Caring – a helping-trust relationship<br>• Communication skills<br>• Knowledge/adaptability |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Gramling, K. L. (2004) | Patients | n = 10, ICU | Perpetual presence: always there, in my room more than out, right there all the time, instrumental, mattered, well taken care of, in good hands, vigilance, monitoring<br>Knowing the other: knowing, respect that I'm different, going out of their way, goes the extra step, remembered to do personal things<br>Intimacy in agony: being with, being human, being caring, timely response, more than just talk, don't treat me as a nonentity, timeliness<br>Deep detail: human touches<br>Honoring the body: "heart" in the nurses' touch, manipulated, reducing exposure, promoting privacy, reducing discomfort, requesting permission, providing forewarning, information, choice and active participation |
| Green-Hernandez, C. (1991) | nurses | n = 20 | Natural caring themes: being there, touching, social support, reciprocity, time/extra effort, and empathy. |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Green-Hernandez, C. (1991) | | | Professional caring themes: holistic, touching, technical competence, communication, listening, being there, professional experience, empathy, social support, involvement, time, formal and informal learning, and helping |
| Grigsby, K. A. & Megel, M. E. (1995) | nurse educators | n = 7 | Two themes: caring is connection – with colleagues, students, administrators. Caring is a process of establishing and maintaining relationships |
| Halldórsdóttir, S. (1989) | former students (BSN, MSN), Iceland | n = 9 | Professional caring teacher approach:<br>• Professional competence – knowledge, experience, professional presentation of content, high standards, academic fairness<br>• Genuine concern – concern, respect, faith in students, giving professional confrontation, being interested in student<br>Positive personality – being honest, genuine, sharing and giving of self, attentiveness, flexibility, humor |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Halldórsdóttir, S. (1989) | | | • Professional commitment – enthusiasm for subject, sense of vision, high regard for nurses and nursing, professional activity, search for excellence<br>Mutual trust<br>Working relationship (six phases)<br>• Effective communication and reaching out<br>• Mutual acknowledgement of personhood – mutual self-disclosure, acceptance<br>• Professional intimacy<br>• Negotiation of learning outcomes – dialoguing, negotiating, and concluding<br>• Understanding of student<br>• Termination of relationship<br>Student responses to professional caring |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Halldórsdóttir, S.<br><br>(1989) | | | • Sense of acceptance and worth<br>• Personal and professional growth and motivation<br>• Appreciation and role-modeling<br>• Long-term gratitude and respect<br><br>Lack of professional caring<br><br>• Lack of professional competence<br>• Lack of concern<br>• Demand for control and power<br>• Destructive behavior – manipulation, showing contempt, disrespect, ignored, ridiculed<br><br>Student response to lack of professional caring<br><br>• Affective – at first hope for the best, puzzlement and disbelief, resentment and anger, loss of respect<br><br>Coping strategies and resources – personal strength, supportive |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Halldórsdóttir, S. (1989) | | | family and friends, caring teachers, classmates<br>• Specific reactions – wasted time and energy, feeling ashamed belonging to a profession that offers such teachers, sense of pity, discouragement, uneasiness, feeling manipulated, fear, negative self-image, despair, helplessness |
| Halldórsdóttir, S.(1991) | 9 patients, 9 nurses | n = 18, | Five modes of being with another - from caring to uncaring<br>• Life-giving – biogenic<br>• Life-sustaining – bioactive<br>• Life-neutral – biopassive<br>• Life-restraining – biostatic<br>• Life-destroying - biocidic |
| Halldórsdóttir, S., & Hamrin, E. (1997) | patients oncology, Iceland | n=9 | Caring themes: connection, competent, respect, compassion, mutual trust, gave sense of empowerment<br>Uncaring themes: perceived as incompetent, indifferent, perception of |

| *Author(s)* | *Focus* | *Subjects* | *Themes* |
|---|---|---|---|
| Halldórsdóttir, S., & Hamrin, E. (1997) | | | distrust and disconnection, gave sense of discouragement |
| Halldórsdóttir, S. & Karlsdóttir, S. I. (1996) | patients, OB, Iceland | n=10 | Four themes<br>Caring: competence, genuine concern and respect, positive mental attitude<br>Uncaring: Lack of competence, lack of genuine concern, negative character traits (gloomy, brusque, cold, unkind or harsh) |
| Hanson, L. E., & Smith, M. J. (1996) | students | n = 32 | Recognition – attending, initiating, responding<br>Connection – connecting, empathizing<br>Confirmation/affirmation – affirming, motivating |
| Hanson, M. D. (2004) | nurses (critical care) | n = 30 | Themes: being there, unconditional support for loved-one, personal situation (for nurse), unconditional help, promoting self-care |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Hinds, P. S. (1988) | adolescents, psychiatry | n = 25 | Categories that have a negative influence on adolescent hopefulness: being alone, trying, nurse monitoring and intrusion, nurses only doing a job, nurses consider adolescent as having an attitudinal problem, nurses harass and distort, negativity of others, not getting along with others, disappointment at difficulty of adhering totreatment, unsure about future, false expectations of satisfaction with self, using(drugs) again, family scrutiny, unstructured time<br>Positive influence: help from others, doing something (self activity), observing others, self encouragement, nurses facilitate progress (helping us get through), being off drugs, getting along with nurses, nurses persisted, change in perception that things will work out, staying sober, getting help from others, necessary one-time use of drugs to strengthen commitment to abstinence. |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Hogan, B. (2000) | surgical patients, Australia | n = 6 | Characteristics of a good nurse: personality (pleasant, shows personal interest in the patient), good communicator, competent, facilitator |
| Hughes, L. (1992) | BSN students | n = 10 | Climate of caring: modeling – show oneself to another as caring<br>Dialogue – reciprocal and open communication<br>Practice – provision of opportunities |
| Hughes, L. (1993a) | students (data from 1992 study) | n = 10 BSN | Climate of caring – caring behaviors: willingness to help, sensitivity, presence, supportiveness, sharing of information, sharing of ideas, sharing of self |
| Jenny, J. & Logan, J. (1996) | patients (ICU – ventilated), Canada | n = 20 | Metaphors of caring: Physical discomfort (wearing a hole, dry mouth, suction-kind of destruction, porcupine in my throat) nurse caring (friend, talked, forgot the personal side, made me feel human, took care, attitude) altered self (seemed to be in a TV movie, a zombie, something not part of myself) and patient work (hard time, despondent, |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Jenny, J. & Logan, J. (1996) | | | trying to breathe, no sense of time – everything dragging, communication-key) |
| Jensen, K. P., Bäck-Pettersson, S., Segesten, K. (1993) | nurses, Sweden | n = 16 | Caring themes: competence (knowledge, skills, self-confidence, being totally present, uses empathy, preservation of patients' autonomy), compassion (committed and interested, honest, generous, respect for patient, listening, being there), and courage (connecting with people in crisis by practicing advocacy, go beyond conventional limits, acknowledge the power of religion) |
| Jensen, K. P., Bäck-Pettersson, S., Segesten, K. (1996) | Danish women (cancer), Sweden | n = 19 | Excellent nurse – competent (gives relevant information, technical skill, uses timing, preserves autonomy, holistic view) compassionate (positive approach, altruistic love, respect, genuine concern), courageous (infuses hope and meaning by daring, faces death together, is present in chaos), and concordant (obtains sense of congruity, |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Jensen, K. P., Bäck-Pettersson, S., Segesten, K. (1996) | | | inspires confidence acts according to patient preferences, connectedness, trustful relationship) |
| Kahn, D. L. & Steeves, R. H. (1988) | RN – MSN students | n = 25 | Four themes of nurse-patient caring relationship Ideological – persons as unique, compassion, empathy, therapeutic relationships, objectivity Liking – 'fitting' with someone, friendship, reciprocated personal recognition, absence of caring – animosity Praxis – physical and nonphysical nursing actions, communication, being an |
| Kahn, D. L. & Steeves, R. H. (1988) | nurses | n=25 | advocate, listening, absence of caring – performing in routine way Attributions of caring – elicited when patients are in dire circumstances, have multiple problems, rely on nurse, are alert and |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Kahn, D. L. & Steeves, R. H. (1988) | | | personable, and nurse can make a temporal investment. Care is limited by temporal circumstances, patient's poor self-image, unwillingness to communicate, and actions that cause problems. |
| Kosowski, M. M. R. (1995) | students | n = 18 | Creative caring – 7 themes: connecting, sharing, being holistic, touching, advocating, being competent, and feeling good. Learning caring – five themes: role modeling, reversing (observed uncaring behaviors), imagining, sensing, and constructing |
| Lemmer, C. M.(1991) | couples after stillbirth or neonatal death | n = 15 | Two categories of caring:<br>Taking care – expert care, providing information<br>Caring for or about – providing emotional support, individualized family-centered care, acting as surrogate parent, facilitating the creation of memories, respecting the rights of parents |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Leners, D. W.(1993) | nurses | n = 40 | Intuition is the process of caring<br>Intuition domains and themes:<br>Process of intuition – looking at the patient, putting yourself on the line<br>Intuition mediation variables – recognizing, sensing, identifying, and listening to<br>intuition (confidence in intuition came with experience)<br>Environment variables – less distraction promoted intuition, people variables – patients more critically ill elicit more intuition experiences<br>Significance of intuition – enhance the tuning in process, cannot nurse without it |
| Lövgren, G., Engström, B., Norberg, A. (1996) | 80 patients, 12 relatives (hospital and primary care), Sweden | n= 92 | Themes: Positive care episodes – general aspects (getting good help, staff recognizing needs, getting adequate care), relationship aspects (being respected, listened to, taken seriously, being trusted, being believed, friendliness, supportive, consoled, cared about, having |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Lövgren, G., Engström, B., Norberg, A. (1996) | | | opportunity to make own decisions), task aspects (no wait, swift and competent assessment, adequate pain relief, clean bed, good food |
| Lövgren, G., Engström, B., Norberg, A. (1996) | | | good information), extra aspects (staff arranging amusements and activities) |
| | | | Negative care episodes – relationship aspect (not being listened to, not taken seriously, being mistrusted, not being involved in one's own care, not being understood, not being treated as a whole human being, no support, being treated as on a conveyor belt, being forgotten, treated with indifference), task aspects (treatment failure, poor pain relief, having to wait, incomprehensible information, misjudgments and inflexible routines) |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| McNamara, S. A.(1995) | Nurses (perioperative) | n = 5 | Practice of caring elements: showing concern for patients as unique human beings, communicating, using touch, being aware of and sensitive to patients' experiences and feelings, providing support, protection and safety, praying and facilitating patients' contacts with support systems |
| Miller, B. K., Haber, J., Bryne, M. W. (1992) | 15 patients, 15 nurses | n = 30 | Themes: Holistic understanding, connectedness/shared humanity, presence, anticipating and monitoring needs, and beyond the mechanical (know which of your needs to meet first – talking, physical care, etc.) |
| Milne, H. A. & McWilliam, C. L. (1996) | patients, neurological, Canada | n=6 | Elements of caring time:<br>being with - sharing humanness, connecting<br>doing for- being technical, integrating services<br>Overarching structure: spending time, struggle with time, inadequate time |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Montgomery, C. L. (1992) | nurses | n = 35 | Theme: spiritual transcendence. Three subthemes – receptivity, source of energy for nurse, aesthetic form of caring |
| Mullaney, J. B.(2000) | female patients (depressed) | n = 11 | Five Themes (organized according to Watson's carative factors)<br>Helping/trusting, and actual caring occasion<br>Faith/hope<br>Sensitivity to oneself and others<br>Expressed feelings of acceptance despite expressing negative feelings<br>Adoption of positive feelings, health behaviors and coping |
| Nelms, T. P. (1996) | nurses | n = 5 | Caring as a presencing of being themes:<br>• Timelessness and spacelessness of caring – gathering of what endures, recalling nearness of the far<br>• Creating home – making a home for patients, creating home for self (feelings manifested to nurse and moved her to action)<br>• Call to care as a call of conscience – call to our innermost |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Nelms, T. P. (1996) | | | potentiality of being ourselves instead of inauthentic (force of habit) modes of being, unshakeable joy and purpose that comes from resoluteness and authenticity |
| Parker, M. E. (1994) | nurses | n = 45 | Nursing values: Expressed values – caring, respect, compassion, competence, excellence in practice, inner harmony, accountability Conflicts in nursing practice – disrespect, dishonesty, disconnected, distanced distrust |
| Paternoster, J.(1988) | patients, acute care | n=12 | Nurses who cared: solicitous, dependable, cognizant of patients' comfort needs, having a positive effect. Patient feelings associated with experience: feeling good, secure, connected, validated. |
| Peterson, B. H. (1985) | nurse observation of one patient (OB-GYN) | n = 1 | Caring themes: support, comfort (including spiritual care), protective |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Poole, G. & Rowat, K. (1994) | Elderly patients, Canada | n=5 (Home care) | Caring behaviors: attributes of nurse – good mood, understanding, genuineness, patience, respect. Giving emotional support – listening, giving hope/encouragement |
| Poole, G. & Rowat, K. (1994) | | | spending time. Giving physical support – doing physical tasks, giving information/advice, coordinating services |
| Pound, P., Bury, M., Gompertz, P. Ebrahim, S. (1995) | Stroke patients, England | n = 40 | Patients valued: all actions necessary to ensure survival, provision of comfort and human warmth, feeling cared for, technical care |
| Powell-Cope, G. M. (1994) | family/caregivers | n = 12 | Negotiating partnership – conveying information, knowing (recognition as a significant person, feeling understood, striving to know or understand caregiver's perspective), being accessible ( was |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Powell-Cope, G. M. (1994) | | | predicated on knowing), and maintaining belief (in the specific case of caregiving) |
| Propst, M. G., Schenk, L. K., Clairain, S. (1994) | patients (primagravidas – OB) | n=9 | Themes of caring – techniques of professional (skillful), constant presence, need to be in company (facilitated maternal-newborn attachment), going beyond the limit, nurse's positive manner/being |
| Rankin, J. M. (2003) | patient, Canada | n=1 | Information (in satisfaction surveys) becomes part of a dominant consumer oriented healthcare discourse that subordinates concerns about what actually happened. |
| Raudonis, B. M. (1993) | patients, hospice | n =14 | Empathetic relationship – reciprocal sharing, revealing of personhood. Meaning of empathetic nurse-patient relationship: affirmation as a person (friendship – subcategory) |
| Raudonis, B. M. & Kirshling, M. (1996) | family/caregivers (6 months post hospice care) | n = 9 | Themes: Part of family – respect, kindness, caring for the patients and families, clinical expertise |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Raudonis, B. M. & Kirshling, M. (1996) | | | Presence of the nurse<br>Hospice program – integrated entity |
| Ray, M. A. (1984) | hospital employees ( nurses predominate) | n = 192 | Characteristics of caring:<br>Physiologic –<br>• Feeling – empathy, concern, feeling, loving, compassion, givingnesss<br>• Knowing – teaching, meeting needs, knowledge observation (watch over), decisions, assessment, evaluation<br>• competition, safety, charting Technical – skill, equipment |
| Ray, M. A. (1984) | | | Practical –<br>• Social – economic, organization coordination, time, legal, presence, political |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Ray, M. A. (1984) | | | Interactional –<br>• Physical – comfort, physical touch<br>Social – communication, interact, listen, help, involve, reassure |
| Ray, M. A. (1987) | nurses (critical care) | n = 8 | Five themes of human caring experiences in ICU:<br>A process of personal growth<br>Technical achievement, technical competence<br>Giving and receiving is the bonding process (touch, emotional investment, bonding, compassion, making patient feel safe, meeting fears, comfort, sense of humor)<br>Communication and community (keeping family informed, collegiality, support from each other, establishing rapport)<br>Judgment/ethics (understanding human suffering, patient trust, right decisions, choice for patients/families, economics) |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Ray, M. A. (1989) | respondents in acute care setting | n = 200 | Themes of caring bureaucracy: Social, political, economic, spiritual/religious, ethical, technical/physiological, educational, legal |
| Reiman, D. J. (1986) | patient | n = 1 | Noncaring behaviors – being in a hurry and efficient, doing a job, being rough and belittling, not responding, treating patients as objects |
| Schaefer, K. M. (2003) | nursing students | n = 68 | Themes: physical care, communicating, providing comfort, knowing (cognitive knowing), unconditional acceptance, being present, touching (concern and commitment), work with others, providing encouragement |
| Sherwood, G. (1991) * | patients, surgical | n =10 | Caring themes: assessing needs , planning care (knowledgeable), intervening nursing actions, encouraged to return to self-care), validating (of effectiveness of interventions), interacting (empathy, kindness, comfort, and personal regard) |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Sherwood, G. (1993) | patients, post-anesthesia recovery | n = 10 | Responses to caring: positive mental attitude, movement towards recovery (alleviated anxiety, satisfied mental/emotional needs), physical comfort, gratitude (felt protected, safe, had skillful nurse action), reassurance (felt existential presence), dignity and acceptance (respected, treated like a person), trust, and satisfaction (being and doing of nurse). |
| Solberg, S. & Morse, J. M. (1991) * | nurses, neonatal, Canada | n=4 | Absence of comforting by touch or vocalization<br>Lack of proactive comforting<br>Kinds of comforting observed same as those used for normal infants |
| Spangler, Z. (1993) * | Anglo-American nurses<br>Filipino nurses | n = 22,<br>n = 28 | Anglo-American care values – promotion of autonomy, patient education, expectation that patients will comply, personal control of situations<br>Filipino care values – dedication to work (duty, conscience, vocation), attentiveness to patient comfort, respect, patience |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Steeves, R., Cohen, M. Z., Wise, C. T. (1994) | nurses | n=38 | Nursing roles: Maintaining goals and values of health care – monitoring, acting, protecting; helping to understand, cope Participating in patients' experiences – being there, being with the dying patient, becoming part of the patient's family Reconciling healthcare values and the experiences of patients –telling the truth, teaching |
| Swanson, K. M. (1990) | MD, nurses, parents in NICU | n= 19 | Themes: caring – knowing, being with, doing for, enabling, maintaining belief; attaching – communicating, performing; managing responsibilities – taking on, maintaining, letting go; avoiding bad outcomes – directing action, inhibiting action. |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Swanson-Kauffman, K. M.(1988)* | patients, OB-GYN | n = 20 | Caring needs:<br>• knowing - treating as object, treated as unique<br>• being with – (beyond knowing) understanding, not involved<br>• enabling – keeping informed, being honest, explaining<br>• doing for – helping<br>• maintaining belief |
| Swanson – Kauffman, K. M. (1986) | patients, OB | n = 20 | Caring in miscarriage:<br>Knowing – personalized care, comforting, supportive, healing, desire to understand intentionally<br>Being with – feeling with (the woman), entering into emotion-laden, person-to-person relationship<br>Doing for – comfort, health maintenance acts, helping, protecting, restoring, succor Enabling – facilitating woman's capacity to grieve, giving information to validate their right to grieve |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Swanson – Kauffman, K. M. (1986) | | | Maintaining belief – believe in her capacity to get through loss |
| Tanner, C. A., Benner, P., Chesla, C., Gordon, D. R. (1993) | observed patients<br>interviewed patients | n = 130<br>n = 48 | Knowing the patient:<br>• in depth knowledge of the patient's patterns of responses – to therapeutics, routines and habits, coping, physical capabilities and endurance, and body topology<br>• knowing the patient as a person<br>Knowing the patient is central to skilled clinical judgment, a practical nursing discourse, creates the possibility of advocacy, and sets up learning about patient populations<br>Knowing the patient as the skill of involvement is learned through experience. |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Williams, H. A. (1992) | parents, health care professionals | n = 13<br>n=33 | Definition of support:<br>Parents: caring, being there, listening, easy to talk to<br>Professionals: support (being available, caring, being knowledgeable).<br>Enacted support -<br>Parents: information, household management, parent-to-parent networks<br>Professionals: caring (being available, being consistent, being supportive, empathetic, understanding, and support parent role), offering education, and assisting with needed resources<br>Factors impeding support -<br>Parents: failure of staff to see them as experts in their children's care<br>Professionals: lack of nursing staff, lack of communication from physician to staff, inconsistency of staff, medical bureaucracy |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Winman, E. & Wikblad, K. (2004) | Patient episodes observed, Iceland | n =5 | Caring themes: being open and perceptive of others, being genuinely concerned, being morally responsible, being truly present (attentive to the moment, present physically and emotionally). Being dedicated and having courage.<br>Uncaring themes: instrumental behavior (lack of emotional involvement), disinterest, insensitivity, coldness, inhumanity. |
| Winters, G., Miller, C., Maracich, L., Compton, K., Haberman, M. R. (1994) | patients, cancer | n= 23 | Discovering the lived reality – patient demands, patient characteristics, family demands, environment<br>Managing the flow – being with, giving reassurance, normalizing (providing assurance), empowering<br>Emerging awareness – nurse's developing intuitive understanding of interpersonal dynamics<br>Keeping watch – monitoring patient and family |

| Author(s) | Focus | Subjects | Themes |
|---|---|---|---|
| Winters, G., Miller, C., Maracich, L., Compton, K., Haberman, M. R. (1994) | | | Behind closed doors – interactions between nurse and patient that do not get fully documented including building trust, family conferences, dying and negotiating |
| Wolf, Z.R., Miller, M., Freshwater, D., Patronis Jones, R. A., Sherwood, G. (2003a) | nurses Round 1, Round 2, Round 3 | n=72 n= 5 , n=75 | Four standards for caring<br>Approach client with intention of enhancing welfare – courteous, compassionate, sensitive, respectful, encourages, supportive, teaches<br>Monitors and keeps vigilant – available, provide safe environment, address issues, follow up<br>Learn client's story, situation and context – pay attention, act promptly<br>Encourage client to express feelings – listen and support, respond, respect |

APPENDIX D

Attributes of Nurse Caring from Nurses and Student Nurses

| Presence | Respect | Competent Care | Spiritual/Metaphysical |
|---|---|---|---|
| being present (Beck, 1991,1992a, 1992b, 1993, 1994; Beeby, 2000b; Boyd & Munhall, 1989; J. Brown & Ritchie, 1989: Bush, 1988; Clarke & Wheeler, 1992; Engebretson, 2000; Euwas, 1993; Green- Hernandez, 1993; L. Hanson & Smith, 1996; Hughes, 1993a; Jensen et al, 1993; Miller et al, 1992; Nelms, 1996; Steeves et al, 1994; | human dignity, consideration, respect (Beeby, 2000b; Bush, 1988; Clayton et al, 1991; Davies & O'Berle, 1990; Forrest, 1989; Halldorsdottir, 1989; Jensen et al, 1993;Parker, 1994; Spangler, 1993; Wolf et al, 2003a) | knowledgeable (Clayton et al, 1991; Coulon, 1996; Donoghue, 1993; Engbretson, 2000; Girot, 1993; Halldorsdottir, 1989; Kosowski, 1995; Schaefer, 2003;) | love (Engebretson, 2000; Montgomery, 1993; Ray, 1984) |

| Presence | Respect | Competent Care | Spiritual/Metaphysical |
|---|---|---|---|
| Swanson, 1990; Swanson-Kauffman, 1986); | maintaining belief (Swanson, 1990) | problem-solves (Ray, 1984) | spiritual union (Bush, 1988; Montgomery, 1993; McNamara, 1995) |
| connection, relationally connecting (Bach-Pettersson, & Jensen, 1993; Bottorff, 1993; Burns, 1994; Clayton, 1989; Davies & O'Berle, 1990; Girot, 1993; Green-Hernandez, 1991; Grigsby & Megel, 1995; Jensen et al, 1993L. Hanson-Smith, 1996; Kahn & Steeves, 1988; Kosowski, 1995; Montgomery, | empathy (Clayton et al, 1991; Donoghue, 1993; Forrest, 1989; Green-Hernandez; L. Hanson & Smith, 1996; Jensen et al, 1993; Kahn & Steeves, 1988; McNamera, 1995; Nelms, 1996; Parker, 1993; Ray, 1984; Williams, 1992; Wolf et al, 1991) | responsive, acting promptly (L. Hanson & Smith, 1996; Hughes, 1993a; McNamara, 1995; Ray, 1984; Wolf et al, 2003a) | giving of self giving back of self (Beck, 1991; Chipman, 1991; Clarke & Wheeler, 1992; Davies & O'Berle, 1990; Hughes, 1993a) |

| Presence | Respect | Competent Care | Spiritual/Metaphysical |
|---|---|---|---|
| 1993; Nelms, 1996; Ray, 1984; Scahefer, 2003) | consistency (Williams, 1992) | competent (Green-Hernandez, 1991; Leners, 1993; Parker, 1984; Ray, 1984; 1987) | faith/hope transcendence (Montgomery, 1992) |
| belonging (Steeves et al, 1994) | dependable (Steeves et al, 1994) | affirm/ motivate (L. Hanson & Smith, 1996) | |
| knowing, perceives/ insight (Beck, 1992a, 1992b; Burns, 1994; Donoghue, 1993; Engbretson, 2000; Forrest, 1989; Halldorsdottir, 1989; Hughes, 1993a; Lenners, 1993; Montgomery, 1993; Swanson, 1990) | listening (Cara, 2001; Clarke & Wheeler, 1992; Donoghue, 1993; Green-Hernandez, 1993; Jensen et al, 1993; Kahn & Steeves, 1988; Ray, 1987; Wolf et al, 2003a) | advocates (Back-Pettersson, & Jensen, 1993; Clayton, 1989; Davies & O'Berle, 1990; Jensen et al, 1993; Kahn & Steeves, 1988; Kosowski, 1995; Montgomery, 1993) | |

| Presence | Respect | Competent Care | Spiritual/Metaphysical |
|---|---|---|---|
| sharing (Davies & O'Berle, 1990; Kosowski, 1995; Ray, 1984) | needs anticipated (Coulon et al, 1996, Nelms, 1996) | enabling (L. Hanson & Smith, 1996) | |
| concern (Donoghue, 1993; Halldorsdottir, 1989; McNamera, 1995; Schaefer, 2003; | supportive (Beck, 1992a, 1993, 1994; Clarke & Wheeler, 1992; Dietrich, 1992; Green-Hernandez, 1991; L. Hanson & Smith, 1996; Hughes, 1993a; McNamera, 1995; Peterson, 1985; Ray, 1984; Steeves et al, 1994; Williams, 1992; Wolf et al, 2003a) | protecting (McNamara, 1995; Peterson, 1985; Ray, 1987; Steeves et al, 1994) | |

| Presence | Respect | Nursing Action | Spiritual/Metaphysical |
|---|---|---|---|
| comfort (Beck, 1991; Bottorff, 1993; Boyd & Munhall, 1989; Nelms, 1996; Peterson, 1985; Ray, 1984, 1987; Schaefer, 2003; Spangler, 1993) | other regarding (Clayton et al, 1991; Kahn & Steeves, 1988; Parker, 1994; Schaefer, 2003) | helps (Clayton, 1989; Girot, 1993; Green-Hernandez, 191; M. D. Hanson, 2004; Hughes, 1993a; Ray, 1984; Swanson, 1990) | |
| trust (Clarke & Wheeler, 1992; Euwas, 1993; Girot, 1993; Ray, 1987) | | monitors (Ray, 1984; Steeves et al, 1994) | |
| sense of humor (Ray, 1987) | | doing for, meet needs (Euwas, 1993) | |
| open to the moment (Dietrich, 1992) | | attention with patience (Spangler, 1993) | |

Uncaring

| Presence | Respect | Nursing Action | Spiritual/Metaphysical |
|---|---|---|---|
| indifference, lack of concern (Burfitt et al, 1993; Halldorsdottir, 1989) | disrespectful/ treated as an object (Burfitt et al, 1993; Parker, 1994) | | |
| insensitive/ just a job (Burfitt et al, 1993; Kahn & Steeves) | inhumanity (Winman & Wikblad, 2004) | | |
| distant/ no engagement (Parker, 1994, Solberg & Morse, 1991) | | | |
| detached/ disconnected (Parker, 1994) | | | |
| dishonest (Parker, 1994) | | | |
| no comfort (Chipman, 1991, Solberg & Morse) | | | |

APPENDIX E

Patient Definitions of Nurse Caring Attributes

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| being there (Beauchamp, 1993; Bunkers, 2004; Collins et al, 1994; Drew, 1986; Fareed, 1996; Finn, 1993; Poole & Rowat, 1994; Propst et al, 1994; Swanson-Kauffman, 1986; Williams, 1992; Winman & Wikblad, 2004; Winters et al, 1994) | dignity, respect (Beauchamp, 1993; Collins et al, 1994; Bunkers, 2004; Gramling, 2004; Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996; Jensen et al, 1996; Lovegren et al, 1996; Mullaney, 2000; Poole & Rowat, 1994; Raudonis & Kirschling, 1996) | knows how to do … competent, knowledgeable (Collins et al, 1994; Cooper, 1993; Fareed, 1996; Finn, 1993; Gramling, 2004; Halldorsdottir & Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996; Hogan, 2000; Jensen et al, 1996; Lemmer, 1991; Lovegren et al, 1996; Miller et al, 1992; Paternoster, 1988; Poole & Rowat, 1994; Propst et al, 1994; Raudonis, 1993; Raudonis & Kirschling, 1996; Sherwood, 1991) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| reassurance and empowerment (Lemmer, 1991; Winters et al, 1994) | showing patience (Clayton, 1989; Poole & Rowat, 1994) | persistence (Hinds, 1988) |
| comforts (Clayton et al, 1991; Collins et al, 1994; Paternoster, 1988; Pound et al, 1995; Sherwood, 1991; Swanson-Kauffman, 1986) | individuality (Collins et al, 1994; Gramling, 2004; Jensen et al, 1996; Lemmer, 1991; Raudonis, 1993; Tanner et al, 1993) | facilitated integration of services (Hogan, 2000; Milne & McWilliam, 1996; Poole & Rowat, 1994) |
| is calm (Clayton, 1989) | sensitivity (Beauchamp, 1993; Finn, 1993; Mullaney, 2000) | doing extra things (Gramling, 2004; Lovegren et al, 1996; Propst et al, 1994) |
| love (Beauchamp, 1993, Jensen et al, 1996) | empathy, compassion (Finn, 1993; Halldorsdottir & Hamrin, 1997; Powell-Cope, 1994;; Winters et al, 1994) | pain relief (Collins et al, 1994; Gramling, 2004; Lovegren et al, 1996; Raudonis, 1993) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| caring, genuine concern (Drew, 1986; Halldorsdottir & Hamrin, 1997; Jensen et al, 1993; Jensen et al, 1996; Paternoster, 1988; Pound et al, 1995; Poole & Rowat, 1994; Raudonis & Kirschling, 1996; Williams, 1992) | accessible, available (Fareed, 1996) | enacting skills/ facilitates (L. Brown, 1986; Bunkers, 2004; Clayton et al, 1991; Jensen et al, 1996; Milne & McWilliam, 1996; Poole & Rowat, 1994; Pound et al, 1995; Sherwood, 1991; Swanson, 1990; Swanson-Kauffman, 1986; |
| being friendly, kind (Fareed, 1996; Hogan, 2000; Jenny & Logan, 1996; Lovegren et al, 1996; Pound et al, 1995;Propst et al, 1994; Raudonis & Kirschling, 1996; Sherwood, 1991) | personally valued, known, accepted (Hogan, 2000; Jenny & Logan, 1996; Lovegren et al, 1996; Sherwood, 1991; Swanson-Kauffman, 1988; Tanner et al, 1993) | surveillance, monitoring (L. Brown, 1986; Burfitt et al, 1993; Gramling, 2004; Hinds, 1988; Miller et al, 1992; Sherwood, 1991; Winters et al, 1994) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| trust, in good hands (Fareed, 1996Gramling, 2004; Halldorsdottir & Hamrin, 1997; Mullaney, 2000; Powell-Cope, 1994; Winters et al, 1994) | family/caregivers respected (Powell-Cope, 1994; Winters et al, 1994) | helps, assisting (Beauchamp, 1993; Collins et al, 1994; Hinds, 1988; Lovegren et al, 1996; Mullaney, 2000; Raudonis, 1993; Swanson-Kauffman, 1986, 1988) |
| connection (Fareed, 1996; Gramling, 2004; Halldorsdottir & Hamrin, 1997; Miller et al, 1992; Milne & McWilliam, 1996; Raudonis, 1993; Swanson-Kauffman, 1988; Williams, 1992) | encourages (Fareed, 1996; Poole & Rowat, 1994) | protective (Bowers, 1987; Swanson – Kauffman, 1986) |
| | allowed to have situational control (Gramling, 2004; Jensen et al, 1996; Lemmer, 1991; Lovegren et al, 1996; Williams, 1992) | provides information/ communicates (Fareed, 1996; Hogan, 2000; Jenny & Logan, 1996; Jensen et al, 1996; Lemmer, 1991; Lovegren et al, 1996; |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| | is honest about medical condition (Sherwood, 1993: Swanson-Kauffman, 1988) | Poole & Rowat, 1994; Powell-Cope, 1994; Swanson, 1990; Swanson-Kauffman, 1988) |
| | listens (Clayton et al, 1991; Collins et al, 1994; Fareed, 1996; Lovegren et al, 1996; Poole & Rowat, 1994; Williams, 1992) | |
| | anticipates needs (Clayton et al, 1991) | |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| *Uncaring* | | |
| lack of trust (Halldorsdottir & Hamrin, 1997) | inconsiderate, impatient, rushed (Drew, 1986; Halldorsdottir & Karlsdottir, 1996; Hinds, 1988; Winman & Wikblad, 2004) | incompetence (Halldorsdottir 7 Hamrin, 1997; Halldorsdottir & Karlsdottir, 1996) |
| indifference (Drew, 1986, Halldorsdottir 7 Hamrin, 1997 Lovegren et al, 1996) | Insensitive, cold, only doing a job (Drew, 1986; Finn, 1993; Halldorsdottir & Karlsdottir, 1996; Winman & Wikblad, 2004) | withholding contact/ignored (Finn, 1993; Reimen, 1986; Swanson-Kauffman, 1988) |
| only doing a job (Hinds, 1988; Lovegren et al, 1996; Reiman, 1986) | disrespectful, treated as an object (Finn, 1993; Lovegren et al, 1996; Reiman, 1986; Swanson, Kauffman, 1988; Winman & Wikblad, 2004) | rough (Reiman, 1986) |

| Presence, Concern for the Other | Respect for the Person | Knowledgeable, Competent Care |
|---|---|---|
| Uncaring | | |
| disconnection (Halldorsdottir & Hamrin, 1977) | unconcerned, disinterested (Drew, 1986; Halldorsdottir & Karlsdottir, 1996; Winman & Wikblad, 2004) | needs not met timely (Chipman, 1991) |
| Detachment, minimally present, remote (Finn, 1993) | dismissive (Drew, 1986; Lovegren et al, 1996) | |
| unkind (Halldorsdottir & Karlsdottir, 1996) | belittling (Reiman, 1986) | |

APPENDIX F
Nurse Caring Patient Scale and Instructions

**Directions to the Participant:**

On the following pages is a survey about nursing care given to patients. Please read each statement on the ***Nurse Caring Patient Scale***, and answer the question: How much of the time did it happen (to me)? Circle the number on the scale that best represents your experience in the hospital. A sample of the statements is below.

SAMPLE:
1. The nurses gave me help when I needed it.

How much of the time did it happen?

| all | most | some | few | rarely | none |
|---|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 | 0 |

The second part of the survey has one question. Please answer it in a short paragraph.

The third part of the survey asks some personal questions. Please fill in the blank or check the correct answer. These questions help the researcher to summarize the group of people who volunteered to participate. The information also allows the investigator to analyze the survey answers by different groupings of people (such as by age, ethnicity, income, and education).

This survey is anonymous. Once you place it in the envelope and seal it, only the investigator will see it. A summary of all the surveys will be given to the hospital and the nurses on your hospital unit once the study is completed and all the data is analyzed. No names will ever be revealed to the hospital management or staff.

---

## *The Nurse Caring Patient Scale*

Circle the number that best answers the question.

How much of the time did it happen?

| | all | most | some | few | rarely | none |
|---|---|---|---|---|---|---|
| 1. The nurses knew what I needed. | 5 | 4 | 3 | 2 | 1 | 0 |
| 2. The nurses made me feel like an object instead of a person. | 5 | 4 | 3 | 2 | 1 | 0 |
| 3. The nurses treated me with respect. | 5 | 4 | 3 | 2 | 1 | 0 |
| 4. The nurses watched me closely in the hospital. | 5 | 4 | 3 | 2 | 1 | 0 |
| 5. I could trust the nurses who cared for me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 6. The nurses treated me as a person rather than an illness. | 5 | 4 | 3 | 2 | 1 | 0 |
| 7. The nurses ignored me, when other patients seemed to get help. | 5 | 4 | 3 | 2 | 1 | 0 |
| 8. The nurse helped me to understand what was happening to me in the hospital. | 5 | 4 | 3 | 2 | 1 | 0 |
| 9. The nurses listened to me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 10. The nurses rushed with my care. | 5 | 4 | 3 | 2 | 1 | 0 |
| 11. The nurses gave me help when I needed it. | 5 | 4 | 3 | 2 | 1 | 0 |
| 12. The nurses were gentle when caring for me. | 5 | 4 | 3 | 2 | 1 | 0 |

Circle the number that best answers the question.

How much of the time did it happen?

| | all | most | some | few | rarely | none |
|---|---|---|---|---|---|---|
| 13. The nurses were unconcerned about me as a person. | 5 | 4 | 3 | 2 | 1 | 0 |
| 14. The nurses spent the time to tell me about procedures I would have in the hospital. | 5 | 4 | 3 | 2 | 1 | 0 |
| 15. My nurses treated the machines in my room instead of me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 16. My nurses were there when I really needed a nurse. | 5 | 4 | 3 | 2 | 1 | 0 |
| 17. The nurses were concerned about what I was going through as a patient. | 5 | 4 | 3 | 2 | 1 | 0 |
| 18. My nurses saw the needs of my family as important to my care. | 5 | 4 | 3 | 2 | 1 | 0 |
| 19. The nurses helped me to understand how to manage my care when I got home. | 5 | 4 | 3 | 2 | 1 | 0 |
| 20. The nurses were unkind to me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 21. The nurses knew when to call the doctor. | 5 | 4 | 3 | 2 | 1 | 0 |
| 22. I could talk with the nurse when I needed to. | 5 | 4 | 3 | 2 | 1 | 0 |
| 23. The nurses worked to see my pain was relieved. | 5 | 4 | 3 | 2 | 1 | 0 |
| 24. The nurses were unfeeling when they came into my room. | 5 | 4 | 3 | 2 | 1 | 0 |

Circle the number that best answers the question.

How much of the time did it happen?

| | all | most | some | few | rarely | none |
|---|---|---|---|---|---|---|
| 25. My nurses connected with me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 26. The nurses respected my choices in health care. | 5 | 4 | 3 | 2 | 1 | 0 |
| 27. The nurses were knowledgeable about my care. | 5 | 4 | 3 | 2 | 1 | 0 |
| 28. I had little contact with my nurses. | 5 | 4 | 3 | 2 | 1 | 0 |
| 29. My nurses were available whenever I called for a nurse. | 5 | 4 | 3 | 2 | 1 | 0 |
| 30.The nurses knew when I needed cheering up. | 5 | 4 | 3 | 2 | 1 | 0 |
| 31. The nurses talked over me or about me but ignored me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 32. The nurses treated me with dignity. | 5 | 4 | 3 | 2 | 1 | 0 |
| 33. I had faith in the nurses' abilities. | 5 | 4 | 3 | 2 | 1 | 0 |
| 34. The nurses were incompetent with my care. | 5 | 4 | 3 | 2 | 1 | 0 |
| 35. The nurses gave me ideas on how to get help or health information after I was discharged. | 5 | 4 | 3 | 2 | 1 | 0 |
| 36. The nurses were available to do acts of kindness for me. | 5 | 4 | 3 | 2 | 1 | 0 |

Circle the number that best answers the question.

How much of the time did it happen?

| | all | most | some | few | rarely | none |
|---|---|---|---|---|---|---|
| 37. The nurses went beyond what I expected in my care. | 5 | 4 | 3 | 2 | 1 | 0 |
| 38. The nurses comforted me when I needed it. | 5 | 4 | 3 | 2 | 1 | 0 |
| 39. The nurses treated me as a unique person. | 5 | 4 | 3 | 2 | 1 | 0 |
| 41. Nurses were there to hold my hand when I needed it. | 5 | 4 | 3 | 2 | 1 | 0 |
| 42. The nurses allowed me to make my own health care choices. | 5 | 4 | 3 | 2 | 1 | 0 |
| 43. The nurses talked over me rather than to me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 44. The nurses were reassuring. | 5 | 4 | 3 | 2 | 1 | 0 |
| 45. The nurses helped me get what I needed. | 5 | 4 | 3 | 2 | 1 | 0 |
| 46. The nurses ignored me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 47. The nurses always put my needs first. | 5 | 4 | 3 | 2 | 1 | 0 |
| 48. The nurses were patient with me. | 5 | 4 | 3 | 2 | 1 | 0 |
| 49. The nurses were friendly. | 5 | 4 | 3 | 2 | 1 | 0 |

Circle the number that best answers the question.

50. The nurses were honest with me.

How much of the time did it happen?

| all | most | some | few | rarely | none |
|---|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 | 0 |

APPENDIX G
Descriptive Question

## *Nurse Caring Patient Scale*

Tell me about an experience with a nurse during this hospitalization.

APPENDIX H
Demographic Data Sheet

Participant ID #

Please fill in the blank or check the circle that best answers the question.

1. Gender: Male ○ Female ○

2. What is your age in years? _____

3. Marital status?

Single ○ Unmarried partner ○

Married ○ Widowed ○ Divorced ○

4. With which ethnic group do you identify? _____

5. What is your estimated household income? _____

6. How many people live in your home? _____

7. What is the highest education level you reached? _____

8. This is my first experience with nurses as a hospitalized patient.

yes ○ no ○

APPENDIX I
Script for Participant Recruitment

**Script for Introducing the Patient's Perceptions of Feeling Cared for Study**

"Hello, my name is Nola Della-Monica. I am a doctoral nursing student conducting research at St. Elizabeth's Medical Center. My research is about patient perceptions of feeling cared for by nurses. I would like to know if you would be interested in participating. Being a part of this research means that you would be willing to fill out a survey that asks you to rate your experiences with nurses during your hospitalization here. You would also have an opportunity to write your own story about your experience."

"Do you think that, for the most part, you were cared for by Registered Nurses?" Yes/No (I will collect data from all who consent, but since my scale was based on the epistemology of nurse caring, I need to know what the patient thinks. The responses to this question will enable me to separate the data, and perhaps compare the resulting statistics.)

"Would you be interested in participating?" Yes/No

"Before you fill out any forms for me, I would like to tell you more about the study, so that you are fully informed." (Review the Consent Form).

Answer any questions the patient might have. Obtain written consent. Give the patient the packet containing the Nurse Caring Patient Survey, the Qualitative Question Sheet, and the Demographic Sheet. Review the patient instructions and answer any questions. "Are you willing to continue?" Yes/No. If yes, "I will return later today to pick up your materials. Is there a good time for me to return?" I will note any specific time and return then.

Return to collect the paperwork and review for missing items. "There are some items that you missed. Can I help you to fill them in?" Fill in any blanks that he/she consents to finish. "Thank you very much for participating. I am sealing the envelope now, and no one at the hospital will know what you have said." If there is any problem the patient wishes to take to hospital administration, I will facilitate that process with their verbal permission.

APPENDIX J
Subject Consent Form

Subject's Name: _____ Date: _____
Home Address:

Home Telephone: Date of Birth:

Research Study Title: Development and Psychometric Evaluation of the Nurse Caring Patient Scale

Principal Investigator: Nola Della-Monica PhD(c), RN

Study Sponsor(s): Nancy Hagen MS, RN, Vice President of Patient Care Services

The purpose of this consent form is to inform you about the nature of the Research Study so that you may make an informed decision as to whether you would like to participate. You are free to decline participation and, should you choose to participate, you are free to withdraw from the Study at any time without penalty or loss of benefits that you otherwise enjoy outside of the Research Study.

1. Invitation: **You are being asked to participate in a research study. Your participation is voluntary.**

2. Purpose: **What is the purpose of this research study?**

You are being asked to participate in a study to determine the reliability of a new instrument. The information you provide, may also allow for a secondary analysis of the data, not related to the scale's reliability. The tool is called the *Nurse Caring Patient Scale*. It is designed to measure patient perceptions of feeling cared for by nurses while in the hospital. This study meets part of the requirements for my Doctorate degree in Nursing (PhD).

Hospital patients are often sent satisfaction surveys by the hospital when they return home. These surveys measure many aspects of the hospital stay including some nursing care. Much of what nurses do for patients is not measured, or written in the chart. This *Nurse Caring Patient Scale* is an attempt to measure nursing care experiences by how often you thought they occurred. There is also a place for you to write your story about a positive or negative incident during your hospital stay. Your experiences as a hospital patient qualify you to rate the nurses who cared for you.

3. Duration:**How long will you be participating in this research study**? It will take you about 15-20 minutes to complete the survey materials. .

4. Procedures: **What will the research study involve?**

If you agree to be in the study, I will give you a packet of materials. In the packet are the *Nurse Caring Patient Scale,* a sheet of paper for you to tell your story, some personal questions (e.g. age, etc.), directions for filling out the survey, and a pen. Filling out the materials will take about 15-20 minutes.

You are to fill out the entire survey materials by yourself. You may have someone help you write down the answers, but they should be **your** answers. Once you finish, put the materials into the envelope. You may keep the pen. I will collect the envelope.

5. Risks, Discomforts, Side Effects and Inconveniences: **What are the risks involved with being enrolled in this study?**

This is a research study that poses no known or anticipated risks to you. No nurse in the hospital will see anything that you write down. If you become uncomfortable with any of the questions, you may choose not to answer the question. You may also withdraw your consent to participate at any time.

You may wish to speak to someone at the hospital regarding any incidents, you thought about while filling out the study. Please call Nola Della-Monica,

603-880-3465. With your permission, she will give your name to the Vice President of Patient Care Services who will then contact you.

If you tell about an event with a nurse that was harmful to you, then it must be reported to the Vice President of Patient Care Services, so that you may receive help. I will tell you if I must report a harmful event. No nurse or staff member on the unit will be notified of what you said.

6. Benefits: **Are there any benefits from participating in this study?**

There are no known personal benefits to participating in this study. You will, however, be helping me to learn whether this new tool effectively measures what nurses do. It may also help nurses to provide better care to their patients.

7. Alternatives: Therapy is available to you without enrolling in this study. The appropriate alternative procedures or courses of treatment include the following: There are no alternatives available for this study. If you decide not to participate, or withdraw from the study at any time, it will not affect your care or services in the hospital in any way.

8. Confidentiality:

> Confidential information contained in your medical record may not be given to anyone except to members of the research group and others who must be involved professionally to provide essential medical care. The study sponsor, the Research/Human Subjects Committee (IRB), and federal agencies protecting the welfare of the study participants may view study records.

9. Compensation: **Will you be paid to participate in this research study?**

☐ You will be compensated for participating in the research study. You will receive:

☒ You will not receive any sort of compensation for participating in the research study.

10.In Case of Injury.

If you become sick or injured by your direct participation in this research study, medical treatment will be provided to you including first aid; emergency treatment and follow-up care as needed. Caritas St. Elizabeth's Medical Center will bill your health insurance for the cost of such care. If your insurance does not pay for your care, or pays only a portion of the cost of such care, Caritas St. Elizabeth's Medical Center may bill you for any unpaid amounts. No special arrangements will be made for the compensation or for the payment of treatment solely because of your participation in this research study. Caritas St. Elizabeth's Medical Center and persons conducting this research study are not admitting fault for your injury or illness by providing or making available medical treatment for your injuries or illness. This paragraph is a statement of the Caritas St. Elizabeth's Medical Center policy and does not waive any of your legal rights.

**In case of injury contact: Nola Della-Monica 603-880-3465.**

11.Costs. **What charges will be paid by the Study Sponsor?**

There is no cost to you to participate in this study. The only compensation to you is the free pen.

12.New Findings**. New Information.**

If you would like to know the results of this study, tell the Principle Investigator, Nola R. Della-Monica 603-880-3465. She will send you the results by mail following the completion of the study.

13.Number of Subjects.

The number of subjects who will participate in the Research Study at Caritas St. Elizabeth's Medical Center is estimated to be 250-500 .

14. Termination as a study subject – N/A

15. Secondary Analysis. Some of the information you write down, may provide additional research information beyond the scope of this study. This may include analysis of the scale results by age, ethnicity, income level, diagnosis, or educational level. With your consent the researcher, Nola R. Della-Monica, will be able to conduct a second study on the information you provide by filling out the study materials.

Please initial if you consent to this secondary analysis of the data. _____

16.Contacts.

If at any time during this research study, you feel that you have not been adequately informed as to the risks, benefits, alternative procedures, or your rights as a research subject, or feel under duress to participate against your wishes, you can contact a member of the Research/Human Subjects Committee, who will be available to speak with you during normal working hours (8:30 a.m. to 5:00 p.m.) at:

Institutional Review Board (IRB) Research/Human Subjects Committee
Telephone: 617-789-2804
Address: 736 Cambridge Street
Boston, MA 02135

You may also contact the Principal Investigator **Nola Della-Monica 603-880-3465**
or Representative **Boston College IRB 617-552-4778** at any time during this Research study for questions and answers regarding the Research study.

The subject has been informed of the nature and purpose of the procedures described above including any risks involved in the research study's performance. The subject has been asked if any questions have arisen regarding these procedures and these questions have been answered to the best of the Caritas St. Elizabeth's Medical Center's ability. A signed copy of this informed consent has been provided to the subject.

Also, any new unforeseen information relevant to the patient that may develop during the course of this research activity will be provided to the subject and the Research/Human Subjects Committee (IRB).

_____

Investigator's Signature Date

I have been informed about the procedures, risks, and benefits of this Research Study and agree to participate. I know that I am free to withdraw my consent and to quit the Research Study at any time. My decision not to participate in this Research Study or my decision at any time to withdraw from this Research Study will not cause me any penalty or loss of benefits that I am otherwise entitled to.

I have read and understand the terms of this Consent Form and I have had an opportunity to ask questions about the Study and to discuss the Study with my doctor and other health care providers and my family and friends.

I hereby consent to my medical records relating to this research activity be made available to state and federal agencies (including but not limited to the Department of Health and Human Services' Food and Drug Administration (FDA)), which regulates medical research activity, including this experiment. I understand that while every effort will be made to keep my identity confidential, there may be occasions when my identity must be made known to state and federal agencies at their request.

I understand that the Research/Human Subjects Committee (IRB) of Caritas St. Elizabeth's Medical Center (CSEMC) has approved the solicitation of subjects to participate in this research activity.

_____

Signature of Subject Date

Printed Name

or Signature of Subject's Legal Representative

_____

Signature of Witness Date

Printed Name

**INVESTMENT DISCLOSURE**

*Nola R. Della-Monica*
*Principal Investigator*

☐ HOLDS

x DOES NOT HOLD

an equity interest in the sponsor of this investigational protocol and/or may share in certain royalty payments from any commercial development incident to this research protocol.

_____

Signature of Principal Investigator Date

Caritas St. Elizabeth's Medical Center ☐ HOLDS

x DOES NOT HOLD

an equity interest in the sponsor of this investigational protocol and/or may share in certain royalty payments from any commercial development incident to this research protocol.

_____

Signature of the Caritas St. Elizabeth's Medical Center Official
Date

_____

Printed Name of CSEMC Official

APPROVED:_____, 20__
EXPIRES:_____, 20__
PROTOCOL NO.:_____

# APPENDIX K
## Letter to Nurse Managers

Dear Nurse Manager,

My name is Nola Della-Monica PhD(c), RN, and I will be conducting recruitment of subjects for a nursing research study on your unit. This study, *Development and Psychometric Analysis of the Nurse Caring Patient Scale* is the validation of a new instrument designed to measure patient perceptions of nurse caring behaviors. Caring is described by scholars as the essence of nursing, yet much of what nurses do is unseen and unmeasured. Patient satisfaction surveys are a standard device used by hospitals to measure quality of care, yet few questions in the surveys reveal patient evaluation of nurse-patient interactions. A new instrument is needed that demonstrates the spectrum of nurse-patient encounters.

In qualitative studies over the past twenty years patients have described caring and uncaring encounters with nurses. These descriptions provided the framework for a definition of nurse caring, and the structure for the *Nurse Caring Patient Scale*. *Nurse Caring* (NC) is an intentional act by a nurse, praxis, that includes a presence with the patient/client, a respectful honoring of a unique individual (family/group/community), resulting in a spiritual connection or transcendence as the nurse partners with patient/client in actions that lead to enhanced well being and reciprocity. Three attributes must be present for NC to occur: presence in the moment described as interconnectedness, respect or honoring of human dignity, and competent nursing action. It is this ideal that describes the essence of nursing. Uncaring is the antithesis of the nurse

caring ideal, but it is also described by patients. The *Nurse Caring Patient Scale* captures the descriptions of both caring and uncaring nursing behaviors.

During my time on your unit, I will be recruiting adults who have been hospitalized for more than 24 hours, and who can read and write in English. This study will impact your unit staff minimally. One of the criteria for my study is a patient who is cognitively able to participate in the study by filling out the *Nurse Caring Patient Scale.* I will need to ask the assigned nurse about a potential participant's cognitive status. The nursing staff will not be involved in the study in any other way. I will also be collecting participants' medical diagnosis or surgical interventions from their medical record. I will attempt to collect this data from the chart when I collect completed materials from the participant.

Once the data is analyzed I will be sending a report of the findings to the hospital. If I collect a representative sample of data from your unit, I will also produce a report for the unit. If the instrument is validated by this sample population, it may provide insight into the care nurses provide at St. Elizabeth's Hospital.

I look forward to working with you in the next few months.

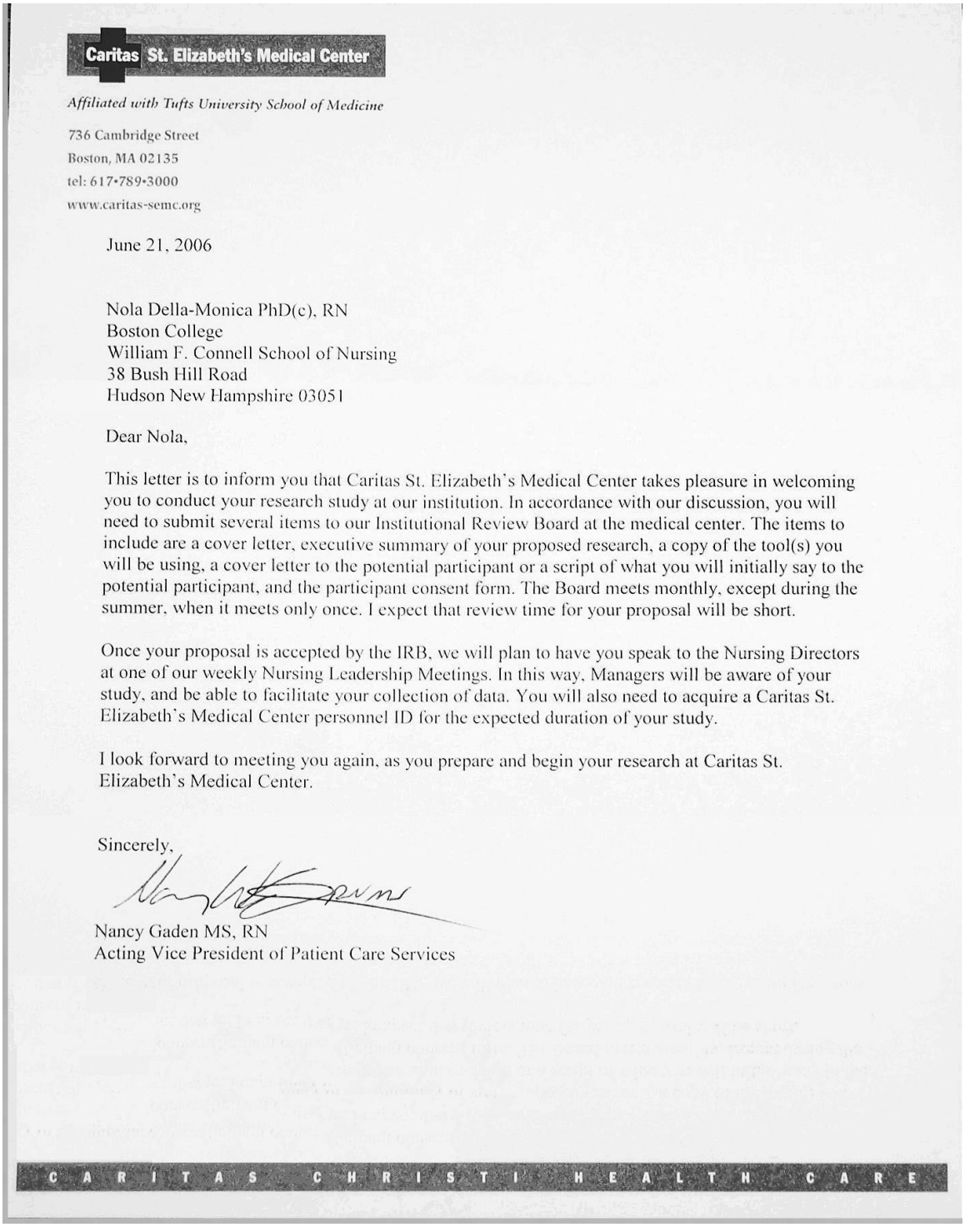
Sincerely,

Nola Della-Monica PhD(c), RN

Boston College Connell School of Nursing

# APPENDIX L

## Agency Letter of Approval



Caritas St. Elizabeth's Medical Center

*Affiliated with Tufts University School of Medicine*

736 Cambridge Street
Boston, MA 02135
tel: 617•789•3000
www.caritas-semc.org

June 21, 2006

Nola Della-Monica PhD(c), RN
Boston College
William F. Connell School of Nursing
38 Bush Hill Road
Hudson New Hampshire 03051

Dear Nola,

This letter is to inform you that Caritas St. Elizabeth's Medical Center takes pleasure in welcoming you to conduct your research study at our institution. In accordance with our discussion, you will need to submit several items to our Institutional Review Board at the medical center. The items to include are a cover letter, executive summary of your proposed research, a copy of the tool(s) you will be using, a cover letter to the potential participant or a script of what you will initially say to the potential participant, and the participant consent form. The Board meets monthly, except during the summer, when it meets only once. I expect that review time for your proposal will be short.

Once your proposal is accepted by the IRB, we will plan to have you speak to the Nursing Directors at one of our weekly Nursing Leadership Meetings. In this way, Managers will be aware of your study, and be able to facilitate your collection of data. You will also need to acquire a Caritas St. Elizabeth's Medical Center personnel ID for the expected duration of your study.

I look forward to meeting you again, as you prepare and begin your research at Caritas St. Elizabeth's Medical Center.

Sincerely,

Nancy Gaden MS, RN
Acting Vice President of Patient Care Services

CARITAS CHRISTI HEALTH CARE

APPENDIX M

Subject Descriptors of Caring/Uncaring Correlated with Descriptors from the Metasynthesis

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| Does not know who is caring for him/her | remote detachment, indifference | considerate | considerate | monitoring/vigilance | surveillance, monitoring |
| upbeat | friendly, kind | ready to listen | listens | competence (with anticipating and getting meds) | following through |
| connected on how much I'd been through | connection | understanding with me | personally valued | explained different tests/meds | providing information |
| got to know the nurses | connection | understanding with my wife (husband/family) | family respected | on her own time… | doing extra things |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| stayed with me | being there | patient | showing patience | took it on herself to help me out | doing extra things |
| reassuring | reassuring | treated me as a person | personally valued | remembered to observe me | monitoring, surveillance |
| sympathetic | caring or concern | rude | disrespectful | request was not answered until – (repeated calls) | incompetence |
| aware of my tension | perceives, insight | cold | insensitive | long wait | incompetence |
| calm/ calming | calm | insensitive | insensitive | attentive to my needs | assisting, doing for |
| warm | friendly, kind | understood my problem | personally valued | helped me , helpful | helps |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| understanding relationship | connection | disrespect | disrespectful | spent extra time | doing extra things |
| personal relationship | interconnected | interested in me | personally valued | explaining my care | providing information |
| will be here | being there | respectful | personally valued | explaining my care at home | providing information |
| | reassurance, encouraged | courteous | personally valued | treated the situation | enacting skills |
| let me use his cell phone | caring, genuine concern | related to me very well | empathy, compassion | nurse ‘multitasking” | enacting skills |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| the nurse caused good to me | kind | treated family with respect | family respected | let me know ways I could directly care for… | provided information |
| kind | kind | treated with dignity | dignity | competent | knows how to… |
| reassuring | reassurance | supportive | supportive* | professional care | competence |
| personable | friendly, kind | always asked if I had questions/concerns | personally valued | organized | knows how to… |
| very warm, friendly | friendly, kind | supported all my decisions | allowed situational control | warmed up my body lotion | doing extra things |
| heartwarming | friendly, kind | polite | considerate | attentive | attends |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Patient Response | Correlation | Patient Response |
| nice comic relief (joking decreased pt's stress) | comforts | inappropriate conversation about personal history rather than responding to patient's request for help | disinterested | made sure I was using… | monitoring, surveillance |
| did not want to give me a (prn) med – scowled at me | unkind | Nurse made assumptions about me, my children… | dismissive | responded quickly | responded quickly |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| courteous | kind | got my daughter and I something to eat | family respected | have to ask 2-3 hours before you get it | incompetence |
| not responsive | detachment, minimally present | held my hand | being there | called doctor | knows how to… |
| not friendly | disconnection | sensitive to me | sensitive | knowledgeable | knowledgeable |
| positive dispositions/smiling/happy | friendly, kind | able to work out a schedule | situational control | check on me | monitors |
| cheery | friendly, kind | experienced caring nurse truly thinking of how she treats people | considerate | informative/kept me informed | provides information |
| friendly | friendly, kind | thoughtfulness | considerate | gentle | gentle |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| comforting | comforts | nurse refused (patient request). It did not seem like a logical refusal | dismissive | explanations – great/ was able to understand them | provides information |
| caring | caring, genuine concern | no going beyond | insensitive (only doing a job) | got me… | following through |
| nursing was more than a job to her | caring, genuine concern | understanding | empathy | got all my needs (from the nurses) | enacting skills |
| pleasant | kind, friendly | made me feel as though I was the only patient | individuality | slow response to calls for pain meds | withholding |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| nice | kind, friendly | interested in my well being | personally valued | saw to it (that)… | assisting, doing for |
| made me comfortable | comforts | refused to listen | dismissive | prompt with meds | responds quickly |
| treated me with care | caring, genuine concern | made time (to help breast feed) | accessible, available | safe | protects |
| looked me right in the face | connection | compassionate | compassion | went above and beyond | doing extra things |
| anticipated my needs | anticipates needs | not rushed | considerate | taken care | assisting, doing for |
| soothed | comfort | introduced me to the next nurse | considerate | knowing my medical care was not compromised | knows how to… competent |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| trusted in nurse's knowledge | trust, in good hands | nurse interested in (her) life outside the hospital | personally valued | extra touch | touch |
| honorable | trust(y) | made the experience easier | supportive | performing duties with utmost professionalism and confidence | knows how to… competent |
| made sure I understood | empowerment | | | indicated nurse caused further dehydration and need for IVs | incompetent |
| had attitude problem | unkind | | | no monitoring | incompetent |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Correlation | Patient Response | Correlation |
| a joy to talk to/personal communications | connection | | | taught me so much | provides information |
| introduce themselves | friendly | | | paid extra attention | doing extra things |
| could talk to them about anything | connection | | | quick help | responds quickly |
| didn't have time for me | detachment, minimally present | | | hands on | helps/touch |
| helped me regain autonomy | empowerment | | | answers questions | provides information |
| proactive | anticipates | | | concern about pain level, control | pain relief |

| Presence, Concern for the Other | | Respect for the Authentic Self | | Knowledgeable, Competent Care | |
|---|---|---|---|---|---|
| Patient Response | Correlation | Patient Response | Patient Response | Correlation | Patient Response |
| | | | | efficient | knows how to…competent |
| | | | | refreshed drink, placed blankets, changed my room | doing extra things |
| Consequences | | | Comments about Hospital Conditions | | |
| made me feel helpless | made me feel isolated | made me feel guilty | poor communication -staff with poor English skills | connection difficult because different nurses all the time | |

| Consequences | | | Comments about Hospital Conditions | |
|---|---|---|---|---|
| felt helpless, frustrated, was crying a lot | made me feel as if I'd done something wrong | felt left alone more 11 (as versus another dept. L&D) | poor communication among medical staff to nursing. | poor communication (with MDs/nurses) re:condition |
| Put me at ease | on top of everything | felt – had no say in care of my child | | |
| made me feel like a family member | made a (the) difference , | made me feel uncomfortable | | |
| felt reprimanded | | | | |