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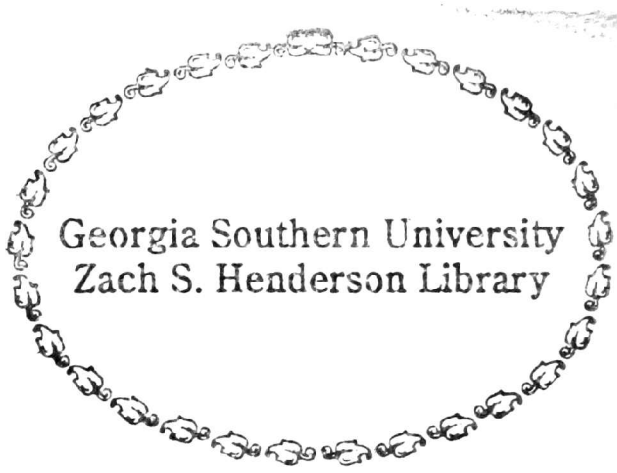
HOME CARE NURSES AND HOME CARE PATIENTS: DIFFERENCES IN PERCEPTIONS OF NURSE CARING BEHAVIORS

Sara K. Welsh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ABSTRACT

Caring has been identified as the essence of nursing. Leininger (1988b, p. 3) even stated that "caring is nursing and nursing is caring." Caring has been studied from many different perspectives. Throughout the history of nursing the caring aspect has grown from a primarily caregiver role, to having a caring intersubjective relationship with the patient. Various studies have been conducted to try and identify which nursing behaviors make patients feel cared for. The purpose of this exploratory study was twofold: (a) to determine what were the most important nurse caring behaviors as perceived by both home care nurses and patients; and (b) to determine if there was a difference between the perceptions of nurses and patients regarding the most important nurse caring behaviors. A scaled questionnaire format of Larson's CARE-Q was utilized for this study. Demographic data was also collected on all participants. The subjects included 61 home care nurses and 52 home care patients. Descriptive statistics were used to analyze the results. The results of this study indicated that both nurses and patients included both expressive and instrumental behaviors as most important. Nurses reported an expressive behavior, "listens to the patient," as the most important behavior while patients reported an

instrumental behavior, "knows when to call the doctor," as most important. Within the top 10 most important nurse caring behaviors nurses (70%) and patients (80%) listed mostly expressive types of behaviors. Between the top 10 nurse caring behaviors for nurses and patients there were six behaviors common to both groups. Both nurses and patients ranked the category of "monitors and follows through" as the most important. Nurses and patients also shared seven of the ten (70%) least important nurse caring behaviors. Conclusions based on these results and recommendations for further research were suggested.

HOME CARE NURSES AND HOME CARE PATIENTS: DIFFERENCES IN PERCEPTIONS OF NURSE CARING BEHAVIORS

by

Sara K. Welsh

A Thesis Submitted to the Faculty

of the College of Graduate Studies

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in Partial Fulfillment of the

Requirements of the Degree

Master of Nursing

Statesboro, Georgia

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HOME CARE NURSES AND HOME CARE PATIENTS:

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Chapter I: Introduction

Caring for self and others is one of the oldest forms of human expression. Caring has been identified as a vital factor for human growth, health maintenance, and survival. Human caring and human relationships are closely interrelated. Human relationships and the maintenance of health have been closely linked to caring behaviors and processes (Leininger, 1979).

Caring has also been identified as an essential component of nursing (Leininger, 1988a; Watson, 1979). The phenomenon of caring as related to nursing has undergone an evolutionary process of transformation. Initially, caring referred only to the physical dimensions of care provided to or for individuals by nurses. Today, the concept of caring not only relates to the provision of physical care, but also encompasses the intersubjective human relationship that exists between the nurse and the recipient of the care (Morse, Solberg, Neander, Botteroff, & Johnson, 1990; Watson, 1979). The concept of caring has been utilized as the basic tenet upon which several nursing theorists have developed their theories of nursing (Leininger, 1978, 1988a, 1988b, 1991; Orem, 1980, 1985; Watson, 1979, 1985). The various theories differ to some degree with regard to the relationship that exists between the nurse and

the individual receiving or participating in the caring process.

Statement of the Problem

The concept of caring has been associated with nursing since the time of Florence Nightingale (1980). However, there has been much confusion as to what caring means within the context of nursing. Even today, use of the words care, caring, and nursing care have not been defined within the various domains of nursing (Morse et al., 1990).

If caring is to continue to be regarded as the essence of nursing, the concept of caring must be further studied and defined. Caring can be studied using either quantitative (objective) data or qualitative (subjective) data. Both subjective and objective outcomes of caring have been demonstrated in the nursing literature (Morse et al., 1990). Subjective outcomes refer to patients' feelings about the care received, while objective outcomes refer to physical responses to the care process (Morse et al., 1990; Watson, 1981).

Significance

In America's health care system of the 1990's, indicators of care are often being restricted to such things as morbidity and mortality statistics. These indicators are derived from analyses which depict the ability of an individual or that of an organization to meet certain prescribed indicators of care. These pre-determined quality

of care determinants or indicators have generally been developed by government agencies, regulatory or accreditation agencies, peer review organizations, fiscal intermediaries, and even some professional organizations. The statistical results of these studies refer only to aggregate data. These quantitative quality indicator studies are limited to measuring objective data. The impact on the individual receiving the care has not been addressed. In reality, on an interpersonal level, the value of the care given to an individual, regardless of the outcome, can only be judged by the individual receiving the care. The patients' perceptions about the care received are recognized as legitimate outcomes of care (Duffy, 1992).

Nursing care represents the highest percentage in both time and intensity of patient care contacts. Therefore, nurses have the greatest potential of any group of health care providers to exert an impact on the health care beliefs, perceptions, or practices of their patients (Becker & Naiman, 1981). In view of the current financial status of the health care industry, most health care agencies will avow to promote high quality patient care; however, to survive they will in fact have to deliver this high quality care at a competitive price.

The delivery of quality nursing care is vital to the delivery of high quality health care. In other words, this

author proposes that without high quality nursing care, high quality health care is not possible.

To provide high quality patient care, nurses must meet the needs and expectations of the recipients of their care. The only way to meet the needs and expectations of patients is to know what the patients' needs and expectations are prior to implementation of the care.

Caring processes are inherent to the therapeutic relationship that exists between the nurse and the patient (Peplau, 1991). Therefore, the concept of caring presents itself as a suitable construct with which to study the perceptions of patients and nurses with regard to the importance of specific nurse caring behaviors. The information gained from this study will help nurses to gain insight into home care patients' perceptions of what caring means to them as individuals. Nurses will be able to utilize the information obtained from this study to assist them in providing nursing care that is focused around the unique, holistic needs of their patients (Duffy, 1992).

Purpose

The purpose of this study was twofold: (a) to identify the most important nurse caring behaviors as indicated by both home care nurses and patients; and (b) to determine if there were differences between home care nurses' and patients' perceptions of nurse caring behaviors.

Watson's Philosophy and Science of Caring (1979) was utilized to provide the theoretical framework for exploring the importance of nurse caring behaviors. Watson views nursing as the Philosophy and Science of Caring (Watson, 1979; Wolf, 1986). The importance of the patient experiencing a sense of his or her own unique being in the process of care is a vital component of Watson's theory. Watson defines nursing as a therapeutic, interpersonal process in which carative factors are used in the nurse-patient relationship to bring about therapeutic responses (1979). The carative factors include both personal characteristics and actions by the nurse (Watson, 1979). Larson's Caring Assessment Instrument (CARE-Q) was utilized as the tool for purposes of this study (Larson, 1981; 1984). Larson's CARE-Q instrument utilizes both personal characteristics and actions by the nurse to identify important nurse caring behaviors. The theoretical constructs for both Watson's philosophy of caring and Larson's CARE-Q provided a consistent framework within which the concept of caring could be further explored.

Research Questions

The following research questions guided this study.

1. What are the most important nurse caring behaviors of nurses as perceived by home care nurses?
2. What are the most important nurse caring behaviors of nurses as perceived by home care patients?

3. Are there differences in the perceptions of the most important nurse caring behaviors between home care nurses and patients?

Definition of Terms

For the purpose of this study, the following operational definitions were used.

1. **Nurse Caring Behaviors** are those actions or behaviors which nurses perform or exhibit that communicate a sense of attention and well-being.
2. **Caring** is defined as the combination of both the objective and subjective behaviors that invoke a sense of well-being in the recipient. Caring is viewed as an intersubjective experience (Watson, 1979; 1985).
3. **Perceptions** refers to an individual's feelings about a particular subject, in this case, feelings of being cared for.
4. **Home Care Patient** means an individual who is the recipient of nursing care at home.
5. **Home Care Nurse** refers to a licensed nurse who is employed by a home care agency to provide care to patients in the home.

Assumptions

There were four assumptions used for this study.

1. The Caring Assessment Instrument (CARE-Q) tool accurately identifies nurse caring behaviors in the home care setting.

2. The caring behaviors of nurses do make patients feel a sense of security and contentment.
3. Caring is viewed as an important component of the nursing process.
4. Study participants will answer the questions in an honest manner.

Limitations

1. The generalizability of the findings of this study is limited due to the fact that the data collection involved only nurses and patients associated with one home care agency in southeast Georgia.
2. Respondents may have had difficulty interpreting some of the questions as related to the home environment.
3. There may have been other variables which may have affected a patient's perceptions about nurse caring behaviors which were not addressed in this research study.

Caring has been identified as the essence of nursing. This author has defined the purpose of this study and identified specific research questions to be answered. Definition of terms, assumptions, and limitations of this study have been presented.

Chapter II: Review of the Literature

Introduction

To present an understanding of the importance of caring behaviors to nursing practice, a deductive strategy will be utilized. First, the philosophical, moral, and social context of caring behaviors will be presented. Next, the historical development of caring behaviors within the nursing profession will be addressed. Specific nursing theories, which utilize caring as a central theme, will be presented. The theoretical framework for this author's study was Watson's Philosophy and Science of Caring (1979). An in-depth review of Watson's theory will be presented. A summation of the theoretical views discussed and their significance to this study will be provided.

Caring

Care has been postulated to be an essential human need, upon which the personal development, health maintenance, and survival of humanity depends (Leininger, 1988a, 1988b). Philosophically, caring for others and helping them grow has been viewed as the means to self-fulfillment (Mayerhoff, 1971). Caring is viewed as a process by which developmental changes take place in both the recipient and the caregiver (Mayerhoff, 1971). Pellegrino proposed that caring is the moral obligation of all health care professionals (1985).

Caring in Nursing - Historical Perspectives

"Caring is nursing and nursing is caring" (Leininger, 1988a, p. 83). Since its inception, nursing beliefs and practices have been firmly rooted in the value of care (Leininger, 1988a). Caring, likewise, has been viewed as a vital component of nursing (Leininger, 1988a).

Florence Nightingale's philosophy of nursing focused on the actions or nursing care that the nurse performed to assist an individual or group of individuals in the "reparative" process, or in the prevention of disease (Nightingale, 1980). Historically, nursing literature focused primarily on the role of the nurse in the provision of physical care to individuals or groups of individuals. The interpersonal significance of the nurse-patient relationship began to be explored after World War II. Peplau (1991) described nursing as an interpersonal process and stated that the nurse portrayed an essential role in the patients' process of changing health related behaviors, by forming a therapeutic relationship with the patient.

Care/caring is a focal theme in Leininger's (1978) Transcultural Theory of Nursing. Leininger stated that care is a universal human phenomenon, but that caring patterns did vary between cultures (Leininger, 1978). Leininger believed that caring is unique to nursing and distinguishes it from other disciplines. Leininger proposed that there were significant differences between curing and caring.

She went on to say that "there can be no curing without caring, but there can be caring without curing" (Leininger, 1988a, p. 83).

Prior to 1975, there had been little interest in the study of the nature and essence of caring as the foundation upon which nursing theory and practice were developed (Gaut, 1991). According to the American Nurses Association (ANA) Social Policy Statement (1980), "nurses are guided by a humanistic philosophy, having caring coupled with understanding and purpose as its central feature" (ANA, p. 18). This statement conveyed the belief that caring was an important aspect of all nurse-patient interactions. This statement supported Gaut's assertion that caring was accomplished indirectly through the performance of many activities and therefore no single activity of nursing could be designated as the caring act of nursing practice (Gaut, 1991).

Caring in nursing was viewed as the totality of service delivered by means of the nurse-patient interaction (Gustafson, 1988). Benner (1984) spoke about the power associated with the concept of caring. Benner stated that if the nurse-patient relationship was not founded upon mutual trust and genuine caring, then no intervention would be successful (Benner, 1984). Caring was attributed as the factor which made an expert nurse effective (Benner, 1989).

Orem stated that care was a general term which encompassed the commonalities of interpersonal helping and regulation. Orem (1980) also stated that care, itself, was not unique to nursing. Orem (1985) did propose however that the concept of self-care was a concept unique to nursing. Orem's theoretical model of nursing was based upon the premise that all people require self-care in order to maintain health and life. Nursing care is viewed as necessary if and when individuals are unable to meet their self-care needs (Orem, 1980). Orem's (1985) theory also proposed that human beings need both continuous self-care maintenance and self-regulation, which are achieved and maintained through self-care actions. Since an individual's ability to meet these needs may vary from time to time, caregivers may need to assist individuals in achieving their self-care requisites (Orem, 1985).

Watson's Philosophy and Science of Caring (1979) emphasized the "psychologic, emotional, and spiritual dimensions of care" (Morse, et al., 1990, p. 7). Watson saw caring as a process comprised of both physical acts and expressive behaviors (Watson, 1981). According to Watson (1979), caring is the moral ideal of nursing, whereby the end is protection, enhancement, and preservation of human dignity.

Watson's Philosophy and Science of Caring

The central theme of Watson's theory proposes that caring processes are intrinsic to therapeutic interpersonal

relationships between the nurse and patient (Watson, 1979). All of human caring is related to intersubjective human responses to health-illness conditions (Watson, 1985). Human care and caring consists of transpersonal, human to human attempts to protect, enhance, and preserve humanity by helping others to find meaning in illness, suffering, pain, and existence; to help others gain self-knowledge, control, and self-healing, wherein a sense of self-harmony is restored regardless of external conditions (Watson, 1979, 1985). Caring is viewed as a combination of humanistic, altruistic feelings and acts which promote the best professional care and the most mature social contributions (Watson, 1979, p.12). Watson outlined seven basic assumptions for the "science of caring in nursing". These seven assumptions are:

1. Caring can be effectively demonstrated and practiced only interpersonally.
2. Caring consists of carative factors that result in the satisfaction of central human needs.
3. Effective caring promotes health and individual or family growth.
4. Caring responses accept a person not only as he or she is now but as what he or she may become.
5. A caring environment is one that offers the development of potential while allowing the person

to choose the best action for himself or herself at a given point in time.

6. Caring is more "healthogenic" than is curing. The practice of caring integrates biophysical knowledge with knowledge of human behavior to generate or promote health and to provide ministrations to those who are ill. A science of caring is therefore complementary to the science of curing.
7. The practice of caring is central to nursing. (Watson, 1979, pp. 8 & 9; & Appendix F).

Overview of the Carative Factors

There are 10 primary carative factors that form a structure for studying and understanding nursing as the science of caring. These carative factors are:

1. The formation of a humanistic-altruistic system of values.
2. The instillation of faith-hope.
3. The cultivation of sensitivity to one's self and to others.
4. The development of a helping-trust relationship.
5. The promotion and acceptance of the expression of positive and negative feelings.
6. The systematic use of the scientific problem-solving method for decision making.
7. The promotion of interpersonal teaching-learning.

8. The provision for a supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment.
9. Assistance with the gratification of human needs.
10. The allowance for existential-phenomenological forces (Watson, 1979, p. 9 & 10; 1992, & Appendix F).

Through utilization of these 10 carative factors, Watson developed the philosophy of caring as an expressive art and a science that could be practiced (Watson, 1979). The practice of nursing in accordance with Watson's theory of human care "becomes both a transpersonal and metaphysical experience" (Watson, 1985, p. 54).

Empirical Studies on Caring Perceptions in Nursing

Henry (1975) identified and described behaviors perceived by home care patients (n=50) to be indicative of caring by a nurse. Henry utilized open-ended questions to elicit patients' perceptions of important nurse caring behaviors. There were three major categories of care identified in this study. Responses of caring behaviors included what the nurse does, how the nurse does it, and how much the nurse does. The most frequent responses were: "doing extra things," "showing interest in the patient," "enacting skills" such as taking blood pressure, and "showing patience toward the patient."

Brown (1981) researched hospitalized patients' perceptions of nursing care. Brown's study population consisted of medical surgical patients (n=80) at a Denver hospital. Brown utilized a critical analysis incident technique to have patients identify, describe, and classify nurse caring behaviors. The most frequently identified categories of caring behaviors were: attention to physical well-being, recognition and use of the patients' knowledge of self in providing care, and attention to the well-being of the patient. Both what the nurse does and how the nurse does it influenced the patients' perceptions of care (Brown, 1981).

Larson's studies (1981, 1984, 1986, 1987) have focused on both the oncology nurses' and patients' perceptions of important nurse caring behaviors. Larson utilized the CARE-Q instrument to have cancer patients (n=57) identify important nurse caring behaviors (1984). In this study, the patients ranked the category of "monitors and follows through" as most significant. This category includes such behaviors as "knows how to give shots" and "how to manage equipment." Larson (1986) also utilized the CARE-Q instrument to study cancer nurses' perceptions of caring (n=57). Nurses identified the behaviors of listening, touching, talking, and individually giving patient care as the most important behaviors. Larson (1981) compared the perceptions of important nurse caring behaviors of both

hospitalized oncology patients (n=57) and oncology nurses (n=57). In this study, patients' and nurses' perceptions varied greatly. Patients perceived nurse behaviors that demonstrated being accessible, or monitoring and following through as most caring. Nurses perceived comforting and trusting relationships as being the most important caring behaviors.

Mayer (1986) replicated Larson's study to compare oncology nurses' (n=28) and oncology patients' (n=54) perceptions of the most important nurse caring behaviors. Mayer's findings supported Larson's previous results (1987). Even though there was significant correlation between the nurses' and patients' perceptions, there were also significant differences. Nurses ranked "listens to the patient" as the most important caring behavior. Patients rated "knows how to give shots and IV's, etc." as the most important behavior.

Wolf (1986) utilized the Caring Behavior Inventory as a tool to have registered nurses (n=97) in the Philadelphia area rank order nurse caring behaviors. Nurses ranked listening, comforting, honesty, patience, responsibility, providing information, touch, sensitivity, respect, and individualizing care as the most important behaviors.

Von Essen and Sjoden (1991) utilized a Swedish version of the CARE-Q to identify both cancer patients' (n=127) and nursing staffs' (n=104) perceptions of caring behaviors.

Most important patient ranked behaviors were: knows when to call the doctor, knows how to give shots and IV's, is honest with the patient, puts the patient first, and tells the patient what is important. Nurses listed listens, puts the patient first, touches the patient, talks to the patient, and tells the patient what is important, as the most important caring behaviors.

In England, Farrell (1991) studied how accurately nurses (n=27) perceived patients' (n=30) needs. The clinical settings for this study included both general nursing units and psychiatric units. The results of Farrell's study showed that individual nurses were not able to accurately assess their patients' needs. The nurses tended to overestimate both the emotional and physical needs of the patients.

A recent study done in the home care setting (Smit & Spoelstra, 1991) identified the most important nurse caring behaviors of patients and nurses (n=28). This study utilized Larson's CARE-Q instrument. Nurses ranked listens to the patient, touches the patient when he/she needs comforting, puts the patient first no matter what, talks to the patient, and allows the patient to express feelings as the most important caring behaviors. Patients listed behaviors such as knows when to call the doctor, listens to the patient, talks to the patient, gives treatments and medications on time, and puts the patient first no matter

what, as most important. Nurses' and patients' perceptions were fairly congruent in this study.

Summary

In this section a review of the literature related to caring as a philosophical construct, moral obligation, and intersubjective experience has been presented. Caring as a central, unifying theme throughout nursing's history, has been explored even though the interpretations of what caring means has not reached consensus among nurses.

Three different theories that utilize caring as a central theme have been reviewed. These include the theories of Leininger, Orem, and Watson. An in-depth description of the components of Watson's Philosophy and Science of Caring (1979) was presented. Finally, a review of significant clinical research studies, that utilized caring as the central focus, was discussed.

In summary, historical data confirm that the concept of care or caring has been associated with nursing since its inception. The outcomes of the various studies presented indicate that patients do generally perceive nursing care behaviors differently than do nurses. The results of the research studies do have some similar trends, but the researchers conclude that more research should be conducted to increase the data available and that the studies should be performed throughout all practice settings.

Chapter III: Methodology

Organization

An exploratory design was utilized to identify both home care nurses' and patients' perceptions about which nurse caring behaviors make patients feel cared for. According to Wilson (1989) an exploratory study is utilized to gain information or familiarity with a phenomenon. The population studied, as well as the design, instrumentation, protection of human rights, data collection, and data analysis will be presented.

Sample

The sample consisted of home care nurses and patients who were affiliated with one home health agency in southeast Georgia. Participants included patients and nurses affiliated with eight different branches of the agency. Nurse criteria for inclusion in the study were: (a) registered nurse or licensed practical nurse currently employed by the agency; and (b) employed by the agency for a minimum of six months. Patient criteria for inclusion in the study were: (a) currently receiving nursing services by the agency; and (b) have received a minimum of four skilled nursing visits.

Design

An exploratory research design was utilized. Information regarding which specific nurse caring behaviors,

as well as which category of behaviors was perceived as most important by both home care nurses and patients were obtained. The 10 individual behaviors which received the highest mean scores for each group were identified as the most important behaviors. Likewise, the 10 individual behaviors which received the lowest mean scores for each group were identified as the least important behaviors. The category which received the highest summed mean score for each group was identified as the most important category of nurse caring behaviors.

Instrumentation

Data was collected by self-response questionnaires. Data collection tools included: demographic data sheets for nurses (Appendix A) and for patients (Appendix B), and Larson's Caring Assessment Instrument (Appendix C). Demographic information obtained on the nurses included: age, gender, race, nursing degree, type of nursing education, number of years of nursing experience, number of years of home health experience, job category, and job status. Patient information obtained included: age, gender, race, years of education obtained, whether the patient lived alone or with someone, medical diagnosis, payor source, and the length of time the patient had been receiving home health services.

The Caring Assessment Instrument consists of 50 nurse caring behaviors. The 50 items are subdivided into six

major categories. The six categories include: accessible, explains and facilitates, comforts, anticipates, trusting relationship, and monitors and follows through.

Face and content validity of the CARE-Q were previously established by Larson (1981, 1984) through the use of an expert panel of nurses and a psychometrician. Test-retest reliability was established by administering the CARE-Q to a random sampling of 115 oncology nurses (Larson, 1981, 1984). Larson (1981, 1984, 1986, 1987) utilized the Q-sort methodology developed by Stephenson (1953) to have study participants rank the fifty caring behaviors in order of importance. The Q-sort methodology provides identification of the most important caring behaviors as the measure of priority (Larson, 1984). Larson (1984, 1986, 1987) utilized this forced choice distribution selection process. Participants were required to select a pre-determined number of items for each of seven priority categories. The CARE-Q instrument was utilized by von Essen and Sjoden (1991) in a Swedish study. These authors also compared the Q-sort technique with a questionnaire listing of the CARE-Q's 50 caring behaviors. The participants who completed the questionnaire ranked each of the 50 questions individually, using a scale of seven to one. Seven being the highest rating and one being the lowest rating. Comparisons of the results between the Q-sort technique and the scaled questionnaire technique demonstrated that the overall

results were in agreement. The Spearman rank correlation between the 50 items in the CARE-Q and questionnaire was r=0.83 for patients and 0.82 for staff (von Essen and Sjoden, 1991). For purposes of this author's study, the scaled questionnaire format developed by von Essen and Sjoden (1991) was utilized. Scoring for this study consisted of a likert scale of seven (7) to one (1).

Protection of Human Rights

Approval from the Institutional Review Boards of Georgia Southern University and Memorial Medical Center Incorporated was obtained prior to implementation of the study. Subjects were assured that their participation was voluntary and that individual confidentiality would be maintained. The participants completed and returned a study consent form. A copy of the consent form was given to each participant.

Collection of Data

Participant packets included both the demographic information sheet and the Caring Assessment Instrument. Data was collected by the researcher or by nurses who had attended a one hour training session. Completed questionnaires were placed in an envelope and sealed to maintain confidentiality. Participants who requested a copy of the study results signified this by filling their name and address in the designated area on the bottom of the consent form. Study results were mailed to all participants who requested this information.

Analysis of Data

Returned questionnaires were reviewed for completeness and then coded for computer entry. Incomplete questionnaires were not included in the data analysis. Descriptive data analysis techniques were utilized. Descriptive statistics were run on the demographic data. Frequencies are presented in table form.

Summary

In this chapter, the investigator has outlined the methodology utilized in this study. Information regarding the population of study, data collection procedures, protection of human rights, instrumentation, design, and data analysis techniques have been presented.

Chapter IV: Analysis and Findings

Sample

Completed questionnaires were returned by 122 subjects. This number consisted of 64 nurse surveys and 58 patient surveys. Nine questionnaires were rejected due to incomplete data. The final number of completed surveys consisted of 61 nurse surveys and 52 patient surveys. Analysis of the data was conducted by means of descriptive statistics. Summary information regarding the various statistics are presented in tables. A copy of the questionnaire is included in the Appendices.

Descriptive Analysis

Descriptive statistics were run on the demographic data. Frequencies are presented for the nurses and patients in Tables 1 and 2.

The frequency data (see Table 1) indicated that the majority (69.1%) of the patients were age 70 or greater. Patients between the ages of 70 and 79 (28.8%) represented the age group with the largest number of participants. Two of the patients (3.8%) were age 90 or older. The range was 29 to 95 with a mean age of 71.33 years. Females represented a majority (81%) of the population. The most dominant race of participants was Caucasian (73%). There were variations in the educational level of the patients.

Most patients (42.3%) had completed high school. However, a minority of patients (5.8%) fell into the category of six years or less of education. The same percentage (5.8%) of patients had obtained a college degree. Cardiovascular (27%) and orthopedic (31%) conditions comprised the majority (58%) of the medical diagnoses of the patients. Most of the patients (90%) had Medicare either as the only payor source (43%) or in combination (47%) with other payor sources. A small minority (6%) of the patients had Medicaid as the only payor source. One patient (2%) had been receiving home care services between 5 and 10 years. The remaining patients (98%) had received services for up to three years. The patients receiving care for between one and three years, represented the largest group (41%) in this category.

Table 1

Summary of Demographic Data - Patients

Variables	Frequency	Percent
Age		
20-29	1	2.0
30-39	3	5.8
40-49	0	0.0
50-59	3	5.8
60-69	9	17.3
70-79	19	36.5
80-89	15	28.8
90-99	2	3.8
Sex		
Female	42	81.0
Male	10	19.0
Race		
African American	14	27.0
Caucasian	38	73.0
Years of Education		
0-6	3	5.8
7-11	15	28.8
12	22	42.3
12, plus	9	17.3
College Degree	3	5.8
Living Arrangements		
Alone	22	42.0
With Someone	30	58.0
Medical Diagnosis		
Orthopedic	16	31.0
Cardio-vascular	14	27.0
Cancer	4	7.5
Psychiatric	4	7.5
Endocrine	4	7.5
Pulmonary	4	7.5
Skin	2	4.0
Renal	1	2.0
Neurology	1	2.0
Genito-urinary	1	2.0
Other	1	2.0

(table continues)

Variables	Frequency	Percent
Payor		
Medicare	22	43.0
Medicaid	3	6.0
Private Insurance	2	4.0
Other	0	0.0
Medicare & Medicaid	10	19.0
Medicare & Private	10	19.0
Medicare & Other	1	2.0
Medicare, Medicaid, Private	2	4.0
Medicare, Private, Other	1	2.0
Medicare, Medicaid, Other	1	2.0
Length of time of Home Health Services		
0-6 mos.	18	34.0
6-12 mos.	12	23.0
1-3 yrs.	21	41.0
3-5 yrs.	0	0.0
5-10 yrs.	1	2.0

N=52

The frequency data for nurses (see Table 2) indicated that a significant number (45%) of the nurses were between the ages of 30 and 39. The range was 25 to 57 years. The mean age of the nurses was 39.28 years. All nurses who participated were female. The nursing population consisted of more races than did the patient population. The majority of the nurses (80%) were Caucasian and were registered nurses (87%). The educational level of the registered nurses varied from diploma graduate (11%) to a master's degree (3%). The majority of the nurses (43%) had an associate's degree in nursing. Most of the nurses who participated had been in nursing for a long period of time.

A majority (81%) of the nurses had five years or more of nursing experience. Forty percent had greater than 15 years of nursing experience. The mean number of years experience was 13.68. Home health experience among the nurses was varied. A majority of the nurses (59%) had between six months to three years experience. The nurses who had between 3 to 10 years experience accounted for 22 (36%) of the nurses. The mean number of years of home health experience was 3.28. Staff nurses accounted for the largest (47%) category of nurses. Fifteen percent listed "other" as their category. The majority (72%) of the nurses worked full-time. Part-time (15%) nurses and casual (13%) nurses were almost equally represented in the population.

Table 2

Summary of Demographic Data - Nurses

Variables	Frequency	Percent
Age		
20-29	6	9.0
30-39	28	45.0
40-49	18	30.0
50-59	9	15.0
Sex		
Female	61	100.0
Male	0	0.0
Race		
Caucasian	49	80.0
African American	8	13.0
Hispanic	3	5.0
Other	1	2.0
Nursing Education		
LPN	8	13.0
Diploma	7	11.0
ADN	26	43.0
BSN	18	30.0
MSN	2	3.0
Years Nursing Experience		
1-3 yrs.	8	13.0
3-5 yrs.	4	6.0
5-10 yrs.	14	23.0
10-15 yrs.	11	18.0
15-20 yrs.	12	20.0
20+ yrs.	12	20.0
Years Home Health Experience		
0-6 mos.	2	3.0
6-12 mos.	22	36.0
1-3 yrs.	14	23.0
3-5 yrs.	11	18.0
5-10 yrs.	11	18.0
10-15 yrs.	1	2.0
Job Category		
Staff Nurse	29	47.0
Patient Care Coordinator	9	15.0
Manager/Administrator	14	23.0
Other	9	15.0
Job Status		
Full-time	44	72.0
Part-time	9	15.0
Casual	8	13.0

N=61

After the demographic data had been analyzed, the next step was to organize and analyze the data which had been collected by nurses and patients from the Caring Assessment Instrument. Means and standard deviations were computed for each of the 50 items on the Caring Assessment Instrument. The Statistical Package for the Social Sciences (SPSS) (1991), was utilized to generate this information. Next, the data for each group, nurses and patients, were rank ordered to display the individual items from most to least important. The 10 items receiving the highest mean scores are reported as the most important nurse caring behaviors (items 1 to 10) for each group. The 10 items receiving the lowest mean scores are reported as the least important nurse caring behaviors for each group (items 41 to 50).

To obtain mean scores for each of the six CARE-Q subscales/categories, the mean scores for all items belonging to that subscale/category were summed and then divided by the number of items within that specific subscale/category. The specific CARE-Q subscale was also identified for each of the 10 behaviors listed as most important or least important by both nurses and patients.

Table 3 lists the most important nurse caring behaviors as reported by nurses. The nurses reported "listens to the patient" ($\underline{M}$=6.79) as the most important nurse caring behavior. This item belongs to the CARE-Q's "comforts" category. The nurses rated "knows when to call the doctor"

($\underline{M}$=6.69) as the second most important behavior. This item belongs to the CARE-Q's "monitors and follows through" category. The 10 most important behaviors as scored by nurses included a combination of both expressive and instrumental behaviors. Watson (1979) defined expressive activities as: establishing relationships that are characterized by trust, hope, sensitivity, compassion, warmth, genuineness; and offering support, which may include nurturance, surveillance, comfort, protection, and respecting and accommodating privacy and territorial needs. Instrumental activities include: physical, action-oriented, helping behaviors, such as assistance with gratification of human needs, administering procedures and medications, specific stress alleviation through various modalities, and maintenance of physical environment; and cognitively-oriented helping behaviors, such as conducting specific teaching regimens, instructing, advising, and problem-solving (Watson, 1979).

The nurses' top 10 scoring behaviors included seven expressive and three instrumental behaviors. Utilizing Larson's (1981; 1984) six CARE-Q sub-scales/categories these 10 behaviors represent the following categories: three "monitors and follows through," three "trusting relationship," two "comforts," and one each for the "accessible" and "explains and facilitates." None of the top 10 behaviors belong to the "anticipates" category.

Table 3

Ten Most Important Nurse Caring Behaviors as Reported by Nurses

Ranking	Behavior	Mean	S.D.	Item #	Behavior Category
1	Listens to the patient.	6.79	.45	19	III Comforts
2	Knows when to call the doctor.	6.69	.65	50	VI Monitors & Follows Through
3	Allows patient to express feelings & treats information as confidential.	6.66	.54	38	V Trusting Relationship
3	Talks to the patient.	6.66	.60	20	III Comforts
5	Knows how to give shots, IV's.	6.64	.84	46	VI Monitors & Follows Through
6	Introduces self to patient.	6.61	.59	42	V Trusting Relationship
7	Gives good physical care.	6.59	.64	48	VI Monitors & Follows Through
8	Gives a quick response to the patient's calls.	6.57	.62	5	I Accessible
9	Tells patient in understandable language what is important to know.	6.46	.79	9	II Explains & Facilitates
10	Encourages patient to ask questions.	6.44	.74	35	V Trusting Relationship

Next, the 10 most important nurse caring behaviors as reported by patients will be presented. Table 4 lists these behaviors. Patients reported "knows when to call the doctor" ($\underline{M}$=6.92) as the most important nurse caring behavior. The second most important behavior was "gives good physical care" ($\underline{M}$=6.79). Even though these top two items represented instrumental behaviors, the remaining top eight behaviors were all expressive type behaviors. The patients' 10 most important nurse caring behaviors belong to the following CARE-Q subscales: four "explains and facilitates," three "monitors and follows through," and one each from the "accessible," "comforts," and "trusting relationship."

Table 4

Ten Most Important Nurse Caring Behaviors as Reported by Patients

Ranking	Behavior	Mean	S.D.	Item #	Behavior Category
1	Knows when to call the doctor.	6.92	0.27	50	VI Monitors & Follows Through
2	Gives good physical care.	6.79	0.46	48	VI Monitors & Follows Through
3	Encourages the patient to call.	6.71	0.57	6	I Accessible
4	Tells patient in understandable language what is important to know.	6.69	0.61	9	II Explains & Facilitates
5	Helps patient not feel dumb by giving adequate information.	6.62	0.72	8	II Explains & Facilitates
5	Gives a quick response to patient's calls.	6.62	0.87	5	I Accessible
7	Is honest with patient regarding his medical condition.	6.60	.93	12	II Explains & Facilitates
8	Is calm.	6.58	.78	47	VI Monitors & Follows Through
9	Allows patient to express feelings & treats information as confidential.	6.56	.73	38	V Trusting Relationship
9	Listens to the patient.	6.56	.78	19	III Comforts

Table 5 shows how the nurses and patients ranked the categories of behaviors according to the CARE-Q subscales. The 10 highest scoring behaviors for both nurses and patients belong to the following CARE-Q subscales: six "monitors and follows through," five "explains and facilitates," four "trusting relationship," three "comforts," and two "accessible." None of the top 10 behaviors belong to the "anticipates" subscale.

In comparing the 10 most important behaviors as reported by patients and nurses, six of the items are common to both groups (Table 6). These common behaviors are: "listens to the patient," "knows when to call the doctor," "allows patient to express feelings and treats the information as confidential," "gives good physical care," "gives a quick response to the patient's call," and "tells the patient in understandable language what is important to know about the disease and treatment." These behaviors represent four expressive and two instrumental behaviors.

Table 5

Ranking of CARE-Q Categories of Behaviors as Reported by Nurses & Patients

	Nurses' Mean	Category / Behavior		Patients' Mean
1	6.36	VI	Monitors & Follows Through	#1 6.51
2	6.18	III	Comforts	#3 6.15
3	6.13	V	Trusting Relationship	#5 6.08
4	6.11	II	Explains & Facilitates	#2 6.27
5	6.08	IV	Anticipates	#6 5.87
6	6.01	I	Accessible	#4 6.11

Table 6

Ten Most Important Nurse Caring Behaviors as Reported by Nurses & Patients

Nurses			Item		Category	Patients		
Rank	Mean	S.D.	No.	Behaviors	No.	Rank	Mean	S.D.
1	6.79	.45	19	Listens to the patient.	III	9	6.56	.78
2	6.69	.65	50	Knows when to call M.D.	VI	1	6.92	.27
3	6.66	.54	38	Allows patient to express feelings.	V	9	6.56	.73
3	6.66	.60	20	Talks to the patient.	III	12.5	6.52	.78
5	6.64	.84	46	Knows how to give shots.	VI	11	6.54	1.11
6	6.61	.59	42	Introduces self to patient.	V	17	6.42	1.04
7	6.59	.64	48	Gives good physical care.	VI	2	6.79	.46
8	6.57	.62	5	Gives a quick response.	I	5	6.62	.85
9	6.46	.79	9	Tells patient in understandable language.	III	4	6.69	.61

(table continues)

Nurses			Item		Category	Patients		
Rank	Mean	S.D.	No.	Behaviors	No.	Rank	Mean	S.D.
10	6.44	.74	35	Encourages patient to ask questions.	V	20.5	6.37	.91
15	6.38	.82	6	Encourages patient to call.	I	3	6.71	.57
21	6.30	.74	8	Helps patient not feel dumb by giving information.	I	5	6.62	.72
27	6.13	.92	12	Is honest with patient.	II	7	6.6	.93
22.5	6.28	.73	47	Is calm.	VI	8	6.58	.78

Next, the lowest scoring nurse caring behaviors as reported by both nurses and patients will be presented. Table 7 lists the 10 lowest nurse caring behaviors as reported by nurses. The item scored lowest by the nurses was "volunteers to do little things for the patient" ($\underline{M}$=5.23). The behavior receiving the second lowest score is "approaches the patient first, offering to do little things" ($\underline{M}$=5.49). These two behaviors belong to the CARE-Q's "accessible" category. The 10 least important behaviors consist of seven expressive and three instrumental type behaviors. These 10 behaviors belong to the following CARE-Q subscales: four "trusting relationship," two "accessible" and "explains and facilitates," and one each from "comforts" and "anticipates." None of the 10 behaviors belong to the "monitors and follows through" subscale.

Table 7

Ten Least Important Nurse Caring Behaviors as Reported by Nurses

Ranking	Behavior	Mean	S.D.	Item #	Behavior Category
41	Helps patient clarify thinking about disease and treatment.	5.82	1.01	33	V Trusting Relationship
42	Sits down with the patient.	5.77	1.07	17	III Comforts
43	Asks patient what name he/she prefers to be called.	5.72	1.23	39	V Trusting Relationship
44	Tells patient of support systems available.	5.70	.92	7	II Explains & Facilitates
44	Offers reasonable alternatives to schedule.	5.70	1.04	29	V Trusting Relationship.
46	Suggests questions for patient to ask the doctor.	5.69	.92	11	II Explains & Facilitates
47	Checks out with patient the best time to talk.	5.61	1.02	31	V Trusting Relationship
48	Realizes the nights are the most difficult time.	5.56	1.28	22	IV Anticipates
49	Approaches patient first offering to do little things.	5.49	.91	1	I Accessible
50	Volunteers to do little things for the patient.	5.23	1.17	2	I Accessible

Table 8 displays the least important behaviors as reported by patients. Patients reported "asks patient what name he/she prefers to be called" ($\underline{M}$=3.81) as the least important nurse caring behavior. This behavior belongs to the CARE-Q's "trusting relationship" subscale. The behavior receiving the next lowest score was "volunteers to do little things for the patient" ($\underline{M}$=5.0). This behavior belongs to the CARE-Q's "accessible" category. The 10 least important behaviors belong to the following CARE-Q subscales: three "explains and facilitates," two "accessible," two "anticipates," two "trusting relationship," and one "comforts." None of the least important behaviors belong to the "monitors and follows through" subscale. The patients rated three instrumental and seven expressive behaviors as least important.

Table 8

Ten Least Important Nurse Caring Behaviors as Reported by Patients

Ranking	Behavior	Mean	S.D.	Item #	Behavior Category
41	Provides basic comfort measures.	5.71	1.55	13	II Explains & Facilitates
41	Suggests questions for the patient to ask the doctor.	5.71	1.70	11	II Explains & Facilitates
43	Involves patient's family in the care.	5.63	1.60	21	III Comforts
44	Tells patient of support systems available.	5.62	1.67	7	II Explains & Facilitates
45	Knows when the patient has had enough and acts accordingly.	5.58	1.59	24	IV Anticipates
45	Realizes the nights are the most difficult time.	5.58	1.70	22	IV Anticipates
47	Approaches patient first, offering to do little things.	5.56	1.72	1	I Accessible
48	Checks out with patient the best time to talk.	5.54	1.49	31	V Trusting Relationship
49	Volunteers to do little things for the patient.	5.0	1.97	2	I Accessible
50	Ask patient what name he/she prefers to be called.	3.81	2.00	39	V Trusting Relationship

Table 9 displays the 10 least important behaviors as reported by nurses and patients. These behaviors represent 14 expressive type behaviors and six instrumental type behaviors. These 10 lowest scoring behaviors for both groups belong to the following CARE-Q subscales: six "trusting relationship," five "accessible," five "explains and facilitates," two "comforts," and two "anticipates." None of the lowest scoring behaviors belong to the "monitors and follows through" subscale. In analyzing the 10 least important nurse caring behaviors as reported by nurses and patients, seven of the items reported are common to both groups. The seven common behaviors include: "asks patient what name he/she prefers to be called," "volunteers to do little things for the patient," "checks out with the patient the best time to talk," "approaches the patient first offering to do little things," "realizes the nights are the most difficult times," "tells the patient of support systems available," and "suggests questions for the patient to ask the doctor." These behaviors represent five expressive and two instrumental type behaviors. Also of interest, is the fact that the two groups share four out of five (80%) of the five least important nurse caring behaviors. None of the 10 behaviors reported by nurses as most important were reported in the patient's 10 least important behaviors. Likewise, none of the top 10 behaviors as reported by patients were reported in the nurses' 10 least important nurse caring behaviors.

Table 9

Ten Least Important Nurse Caring Behaviors as Reported by Nurses & Patients

Nurses			Item		Category	Patients		
Rank	Mean	S.D.	No.	Behaviors	No.	Rank	Mean	S.D.
41	5.82	1.01	33	Helps patient clarify thinking about disease.	V	25.5	6.31	1.16
42	5.77	1.07	17	Sits down with patient.	III	37.5	5.96	1.19
43	5.72	1.23	39	Asks patient what name he/she prefers.	V	50	3.81	2.00
44	5.70	.92	7	Tells patient of support systems available.	II	44	5.62	1.67
44	5.70	1.04	29	Offers reasonable alternatives to schedule.	V	40	5.77	1.50
46	5.69	.92	11	Suggests questions for patient to ask M.D.	II	41	5.71	1.70
47	5.61	1.02	31	Checks out with patient best time to talk.	V	48	5.54	1.49
48	5.56	1.28	22	Realizes the nights are the most difficult time.	IV	46	5.58	1.70

(table continues)

Nurses			Item		Category	Patients		
Rank	Mean	S.D.	No.	Behaviors	No.	Rank	Mean	S.D.
49	5.49	.91	1	Approaches patient, first, offering to do little things.	I	47	5.56	1.72
50	5.23	1.17	2	Volunteers to do little things.	I	49	5.0	1.97
38	5.09	1.10	13	Provides basic comfort measures for the patient.	III	41	5.71	1.55
15	6.38	.82	21	Involves patient's significant other in care.	III	43	5.63	1.60
31	6.08	1.02	24	Knows when patient has had "enough" & acts accordingly.	IV	45	5.58	1.59

Chapter V: Summary, Conclusions, and Recommendations

Overview

Even though caring has been identified as the primary component of the nursing process, there is still much confusion about what constitutes caring by nurses; therefore, the need for this study of home health nurses' and patients' perceptions of nurse caring behaviors. Caring has been studied from various nursing perspectives, but little caring research has been conducted in the home care environment.

The provision of home health nursing care has increased significantly in both scope and volume of services over the last 10 years. To meet the special needs of the home care patients, nurses must have knowledge regarding which nurse caring behaviors are valued by patients in the home environment.

The purposes of this study were to: (a) identify the most important nurse caring behaviors as identified by both home care nurses and patients; and (b) to determine if there was a difference between home care nurses' and patients' perceptions of the most important nurse caring behaviors.

Watson's Philosophy and Science of Caring (1979) was utilized as the theoretical framework for this study. According to Watson's theory, nursing is viewed as a

therapeutic, interpersonal process, which combines scientific and humanistic aspects to provide holistic patient care (Watson, 1979).

Larson's (1981; 1984) CARE-Q instrument was utilized by both nurses and patients to identify the most important nurse caring behaviors. This tool is further divided into six subscales or categories so that the most important category of nurse caring behaviors can also be identified. Demographic data was also generated by information collected on the participant data sheets, which were developed by this investigator. The review of the literature focused on the importance of caring in human relationships. A historical perspective on the evolution of humanistic nurse caring behaviors was presented.

Summary of Findings

The research questions presented for this study were:

1. What are the most important nurse caring behaviors as perceived by home care nurses?
2. What are the most important nurse caring behaviors as perceived by home care patients?
3. Is there a difference in the perceptions of the most important nurse caring behaviors between home care nurses and patients?

The population for this study consisted of home care nurses and patients, affiliated with a home health agency in southeast Georgia. Participants utilized a questionnaire

format of the CARE-Q to rate the importance of each of the 50 items contained in the instrument. Descriptive techniques were utilized to identify the most important and least important nurse caring behaviors. There was a total of 113 completed questionnaires, which were evaluable. Sixty-one of the questionnaires were from nurses and 52 were from patients.

Demographic data was presented in frequency distributions to describe participants' age, gender, race, and educational level. For nurses the type of nursing degree, years of nursing and home health experience, job title, and job status were also presented. Patient data also included primary diagnosis, whether the patient lived alone or with someone, payor source, and the length of time the patient had received home health care.

The 10 behaviors which received the highest mean scores by nurses and patients were identified as the "most important" nurse caring behaviors. The 10 behaviors receiving the lowest mean scores were identified as the "least important" nurse caring behaviors. Mean scores for each of the six categories of behaviors were also computed to rank order the categories of behaviors as to their importance to both nurses and patients. Statistical analysis was accomplished using SPSS (1991).

Discussion

In this section, a discussion of the findings of this study, as well as previous research studies will be presented. This discussion will be organized around the research questions. Question one asked, "What are the most important nurse caring behaviors as perceived by home care nurses?" Nurses in this study rated, "listens to the patient" as the most important nurse caring behavior. This behavior belongs to the "comforts" category. Within the 10 most important nurse caring behaviors, nurses reported seven expressive and three instrumental behaviors. This pattern is consistent with other nursing studies (Larson, 1984; Mayer, 1987; von Essen & Sjoden, 1991; Smit & Spoelstra, 1991) in that nurses rated more expressive behaviors as most important.

Question two asked, "What are the most important nurse caring behaviors as perceived by patients?" Patients rated "knows when to call the doctor" as the most important nurse caring behavior. This behavior belongs to the "monitors and follows through" subscale. The patients ranked two instrumental and eight expressive behaviors within the top 10. It is of interest that the patients' top two most important nurse caring behaviors were instrumental rather than expressive. This finding is consistent with previous research studies (Larson, 1981; 1984; Mayer, 1987; Smit & Spoelstra, 1991). This may be related to the environment in

which the care is delivered. Patients view nurses as their link to medical care and must trust the nurses to make accurate assessments of their conditions and to call their doctors as appropriate. However, it is also important to note that 8 out of 10 (80%) of the behaviors listed by patients as most important were expressive type behaviors. These two findings suggest that patients are concerned that the nurses provide competent, skilled care, but that the care be provided in a humanistic manner.

Question three asked, "Is there a difference in the perceptions of the most important nurse caring behaviors between home care nurses and patients?" In reviewing the 10 most important nurse caring behaviors as reported by nurses and patients it is significant to note that 6 of the 10 (60%) behaviors were common to both groups. These six behaviors represent four expressive and two instrumental behaviors. In comparison with other research studies, it is of interest to note that this study and Smit and Spoelstra's study (1991), which both studied home care nurses and patients, shared six common nurse caring behaviors. In other studies (Larson, 1981; 1984; von Essen & Sjoden, 1991) five most important nurse caring behaviors were shared between the nurses and patients. In Mayer's study (1987) none of the five most important nurse caring behaviors were shared by nurses and patients. These studies consisted of hospitalized or ambulatory clinic patients. In this

author's study, both nurses and patients rated "monitors and follows through" as the most important category of nurse caring behaviors. The behavior rated lowest by the nurses was "volunteers to do little things for the patient." This belongs to the "accessible" category. Overall, nurses rated seven expressive and three instrumental behaviors as the least important nurse caring behaviors. Patients rated "asks the patient what name he/she prefers to be called" as the least important behavior. This belongs to the "trusting relationship" category. Patients also rated seven expressive and three instrumental behaviors as least important. Neither patients nor nurses listed any behaviors from the "monitors and follows through" category as least important. This is important to note in that "monitors and follows through" ranked as the most important category for both nurses and patients. These findings demonstrate that there were some differences between the perceptions of home care nurses and patients regarding the most important nurse caring behaviors. However, there were more similarities between home care nurses and patients regarding the most important nurse caring behaviors.

To provide further analysis, the results of this study were compared to the results which had been obtained from those of four previous studies (Larson, 1981; 1984; Mayer, 1987; von Essen & Sjoden, 1991; Smit & Spoelstra, 1991). The study by von Essen and Sjoden (1991) actually reported

results obtained from the use of two types of the CARE-Q. Therefore, there are actually five previous research studies which will be utilized for analysis purposes.

Upon analyzing the results from all of these studies on caring, several interesting comments can be made. First of all, several differences in the demographic data were noted (Table 10). The mean ages of both nurses ($\underline{M}$=39.28) and patients ($\underline{M}$=71.33) reported in this researcher's study, were higher than in any of the other studies. Also of interest is the fact that the nurses in this study had more years of home health experience than did the nurses in Smit and Spoelstra's (1991) study. All of the nurses who participated in this study were female. The other studies were similar in that all or almost all of the nurses were female. The patients who participated in this study were 81% female, which is a higher percentage than in most of the previous studies (Table 11).

Table 10

Comparison of Nurse Demographics by Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

	1981 Larson	1987 Mayer	1991 von Essen & Sjoden	1991 Smit & Spoelstra	1993 Welsh
Nurses					
Mean Age	Unavailable	31.1	Unavailable	38.5	39.28
<30 years	28	16	Unavailable	Unavailable	6
>30 years	28	12	Unavailable	Unavailable	55
Sex					
Male	3	0	3	0	0
Female	54	28	70	38	61
Years Nursing Experience					
Mean	Unavailable	8.3		12.5	13.7
<5 yrs	28	5	Unavailable	Unavailable	12
>5 yrs.	16	23	Unavailable	Unavailable	49
Years Home Health Experience					
Mean	N/A	N/A	N/A	2.64	3.28
Nursing Education					
LPN	0	0	39 N/A	0	8
Diploma	14	10		7	7
Associates Degree	7	2		12	26
Bachelor of Science	33	3		16	18
Masters Degree	2	3		2	2
*Nursing Assistant	N/A	N/A	*34	N/A	

(N/A = Not Applicable)

Table 11

Comparison of Patient Demographics by Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

	1981 Larson	1987 Mayer	1991 von Essen & Sjoden	1991 Smit & Spoelstra	1993 Welsh
Patients					
Mean Age	42.2	53.8	Unavailable	66.9	71.33
Range	16-79	22-77	53>age 53	Unavailable	29-95
Sex					
Male	19	24	39	6	10
Female	38	30	47	20	42
Diagnosis					
Cancer	57	54	Unavailable	3	4
Cardiovascular	0	0	Unavailable	5	14
Endocrine	0	0	Unavailable	2	4
Genito-Urinary	0	0	Unavailable	0	1
Neurological	0	0	Unavailable	1	1
Orthopedic	0	0	Unavailable	5	16
Psychiatric	0	0	Unavailable	0	4
Pulmonary	0	0	Unavailable	3	1
Renal	0	0	Unavailable	0	1
Wound/Skin	0	0	Unavailable	0	1
Other	0	0	Unavailable	0	1

Next an analysis of the results of the various studies will be presented. Nurses in all of the studies reported "listens to the patient" as the most important nurse caring behavior (Table 12). Three other behaviors: "touches the patient when he/she needs comforting," "talks to the patient," and "allows the patient to express his feelings about his/her disease or treatment and treats the information as confidential" were listed in five of the six studies (83%). "Realizes that the patient knows himself best and whenever possible includes the patient in planning and management of his/her care" was reported in four of the six studies (67%). Two behaviors, "puts the patient first, no matter what" and "is perceptive of the patient's needs and plans and acts accordingly" was included in three of the six (50%) studies. Upon further analysis it was noted that the two home care studies, Smit and Spoelstra (1991) and this study, shared 6 of the 10 most important nurse caring behaviors. In comparing Mayer's (1987) top five behaviors with the top 10 as listed by Larson (1981), four common behaviors were noted. These studies were conducted in an oncology setting. However, in comparing Larson's (1981) findings with those of Smit and Spoelstra (1991) there were 6 of 10 (60%) common behaviors. In comparing Larson's (1981) results with this study there were 5 of 10 (50%) common behaviors. These findings demonstrate that nurses, across various clinical practice settings have similar views

as to what are the most important nurse caring behaviors. These findings also demonstrate that nurses rank expressive behaviors as the most important type of nurse caring behaviors.

Table 12

Ranking of Top 10 Nurse Caring Behaviors by Nurses According to Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

	1981 Larson	1987 Mayer	1991 von Essen & Sjoden Care-Q	1991 von Essen & Sjoden Questionnaire	1991 Smit & Spoelstra	1993 Welsh
1	19	19	19	19	19	19
2	18	38	18	20	18	50
3	38	34	36	47	36	38+20
4	41	18	9	50	20	
5	20	25	47	9	38	46
6	34	Not Available	34	16	34	42
7	25	Not Available	20	18	50	48
8	5	Not Available	50	46	46	5
9	36	Not Available	38,4, 15+17	17	10	9
10	48	Not Available		25	9	35

In comparing data available on the least important nurse caring behaviors, as reported by nurses, the following findings were identified (Table 13). Two behaviors, "asks the patient what name he/she prefers to be called," and "suggests questions for the patient to ask his/her doctor"

were included in the results of three previous studies (Larson, 1981; Mayer, 1987; Smit & Spoelstra, 1991) and also in this study. One item, "is professional in appearance-wears identifiable clothing and identification" was common to three of the four (75%) studies. In comparing Smit and Spoelstra's (1991) results with this study, there were 7 of 10 (70%) common least important nurse caring behaviors.

Table 13

Ranking of 10 Least Important Nurse Caring Behaviors by Nurses According to Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

1981 Larson	1987 Mayer	1991 von Essen & Sjoden	1991 Smit & Spoelstra	1993 Welsh
*Not Available		Not Available		
41	Not Available		31	33
42	Not Available		33	17
43	Not Available		2	39
44	Not Available		44	7+29
45	Not Available		39	
46	16*		11	11
47	2*		29	31
48	11*		22	22
49	39*		31	1
50	43*		43	2

* These items were also included in Larson's lowest ranked behaviors as discussed by Mayer (1987), but individual rankings were not available.

In comparing the top 10 nurse caring behaviors (Table 14) as reported by patients the following results were

noted. "Knows when to call the doctor" was included in this study as well as in the results of four (83%) other studies Larson (1981), von Essen and Sjoden (1991) in both the CARE-Q and questionnaire format, and in Smit and Spoelstra (1991). "Knows how to give shots" was reported in five of the six (83%) studies (Larson, 1981; Mayer, 1987; von Essen & Sjoden, 1991; Smit & Spoelstra, 1991). "Listens to the patient" was also common to five out of the six (83%) studies (Larson, 1981; von Essen & Sjoden, 1991; Smit & Spoelstra, 1991). In comparing the results of Larson (1981) with Smit and Spoelstra (1991) there were eight (80%) common least important behaviors. In comparing the results of this study with the results of Smit and Spoelstra (1991), five (50%) common behaviors were noted.

Table 14

Ranking of Top 10 Nurse Caring Behaviors by Patients According to Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

	1981 Larson	1987 Mayer	1991 von Essen & Sjoden Care-Q	1991 von Essen & Sjoden Questionnaire	1991 Smit & Spoelstra	1993 Welsh
1	46	46	12	12	50	50
2	50	16	46	50	19	48
3	5	6	9	33	20	6
4	48	36	19	9	3	9
5	3	26	36	46	36	8
6	36		33	16	46	5
7	19		50	19	5	12
8	20		16	14	48	47
9	4+45		14	47	12	38
10			15	3	9	19

Data on the patients' 10 least important nurse caring behaviors was not available on some of the studies. Von Essen and Sjoden (1991) did not report these findings. Mayer (1987) only reported the five least important behaviors. Larson (1981) did not include the least important behaviors. However, Mayer (1987) reported which least important behaviors were common to both hers and Larson's (1981) studies. This information was included so

that data on five of Larson's (1981) least important behaviors could be included for discussion. Therefore, some data for analysis was available from three previous studies (Larson, 1981; Mayer, 1987; Smit & Spoelstra, 1991).

In comparing the least important nurse caring behaviors as listed by patients (Table 15), it was noted that "asks the patient what name he/she prefers to be called" was reported in all four studies. Two behaviors were included in three of the four (75%) studies. These included: "helps the patient establish realistic goals" and "suggests questions for the patient to ask the M.D." Two other behaviors were common to Larson (1981) and Mayer (1987): "is professional in appearance-wears appropriate identifiable clothing and identification" and "makes sure others know how to care for the patient."

Table 15

Ranking of 10 Least Important Nurse Caring Behaviors by Patients According to Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

1981 Larson	1987 Mayer	1991 von Essen & Sjoden	1991 Smit & Spoelstra	1993 Welsh
*Not Available		Not Available		
41	Not Available		22	13+11
42	Not Available		17	
43	Not Available		7	21
44	Not Available		29	7
45	Not Available		23	24+22
46	30*		2	
47	49*		18	1
48	11*		8	31
49	39*		39	2
50	43*		30	39

* These items were also included in Larson's lowest ranked behaviors, but individual rankings were not available. Mayer (1987) included a discussion of the least important behaviors that were common to both her study and Larson's (1981).

To compare nurses' and patients' perceptions the following findings are presented. Nurses and patients included "listens to the patient" as a most important nurse caring behavior in all of the studies except one of the

patient groups (Mayer, 1987). Nurses and patients in three previous studies (von Essen & Sjoden - two versions, 1991; Smit & Spoelstra, 1991) and this study included "knows when to call the doctor" as a most important nurse caring behavior.

Next, a comparison of the least important nurse caring behaviors as reported by nurses and patients was undertaken. One behavior, "asks the patient what name he/she prefers to be called" was common to both nurses and patients in all of the studies from which data was available. Of the lowest five behaviors listed for Mayer (1987) four of these were common to Larson's results (1981). There were three common behaviors noted between Smit and Spoelstra (1991) and this study.

Table 16 reports how nurses and patients ranked the overall categories of nurse caring behaviors for the various studies cited above. Nurses ranked "comforts" as the first or second most important nurse caring behaviors. Patients always ranked "monitors and follows through" as the first or second most important category of behaviors. All of the patients ranked "trusting relationship" as the fifth most important category.

Table 16

Ranking of Categories of Nurse Caring Behaviors by Nurses & Patients

According to Larson, Mayer, von Essen & Sjoden, Smit & Spoelstra, & Welsh

Category	1981 Larson P	1981 Larson N	1987 Mayer P	1987 Mayer N	1991 von Essen & Sjoden P	1991 von Essen & Sjoden N	1991 Smit & Spoelstra P	1991 Smit & Spoelstra N	1993 Welsh P	1993 Welsh N
Accessible	2	3	1	5	6	3	Unavailable		4	6
Explains & Facilitates	5	6	6	4	1	6	Unavailable		2	4
Comforts	4	1	3	2	4	1	Unavailable		3	2
Anticipates	3	2	4	1	3	2	Unavailable		6	5
Trusting Relationship	5	4	5	3	5	5	Unavailable		5	3
Monitors & Follows Through	1	5	2	6	2	4	Unavailable		1	1

P = Patients
N = Nurses

These comparisons show that nurses and patients across various practice settings share commonalities and differences in their perceptions of various nurse caring behaviors. Nurses, across all settings, reported comforting types of nurse caring behaviors as the first or second most important overall category. Patients usually reported monitors and follows through as the first or second most important category of nurse caring behaviors. Patients generally ranked an instrumental behavior as most important but also rated a majority of expressive behaviors as most important. Nurses generally rated expressive behaviors as the most important. Expressive behaviors usually accounted for the majority of the most important nurse caring behaviors as listed by patients. Nurses generally included several instrumental behaviors among their top 10 most important nurse caring behaviors. These findings support Watson's Philosophy and Science of Caring (1979) which views caring as a process of both physical acts and expressive behaviors. Both nurses and patients identified instrumental and expressive behaviors as the most important nurse caring behaviors. However, nurses and patients also included instrumental and expressive behaviors as the least important nurse caring behaviors. This fact suggests that patients have specific opinions as to what type of expressive and instrumental behaviors are important to them as individuals.

By developing holistic, interpersonal relationships with patients as proposed by Watson, nurses will be able to provide humanistic care that is based on the individual needs of each patient.

Limitations

This study was limited by use of a convenience sample. Therefore the sample may not be representative of the general population. There was a wide range in the age of patient participants (29 to 95 years). The mean age was 71.33. The majority of the patients were age 70 or greater (69.1%) and the majority were females (81%). Also, the majority of the patients were Caucasian (73%). The range of ages of the nurses was 25 to 57 years, with a mean of 39.28. The nursing population was all (100%) female. Caucasians accounted for the majority (80%) of this group. Other variations such as, the educational level of participants and the years of nursing experience could also have affected the results of this study.

Contributions to the Literature

Although there is much in the literature about caring and nurse caring behaviors, there is not a universal consensus as to what these terms mean in day-to-day nursing practice. To further identify what are the most important nurse caring behaviors and to apply Watson's Philosophy and Science of Caring (1979) into practice, application in all types of clinical settings are required.

The results provided by this research can assist nurses in providing care that is both scientific and humanistic. By reporting and comparing the caring needs of patients in various settings, nurses can be better prepared to provide care that meets the needs of the patients.

Implications

The results of this study demonstrate that nurses and patients view both instrumental and expressive behaviors as being indicative of nurse caring behaviors. The results also show that nurses and patients share some commonalities as to what types of behaviors are indicative of good nursing care. However, differences among the patients and nurses were also noted. To provide holistic, interpersonal care, nurses need to incorporate the patients' needs into the plans of care. As the health care environment changes due to social and financial factors, the importance of quality, caring, and effective nursing care will become even more important. Nurses who combine clinical expertise with a sense of caring and personal commitment to their patients, will be well prepared to meet the needs of their patients.

The results of this study for home health care suggest that home care patients value nursing care that incorporates the following behaviors: clinical competence, good communication and teaching skills, and respect for the individuality of each patient. Nurses should also respond to patient calls in a timely manner. These are skills that

all nurses should include in their daily practice, but sometimes overlook for various reasons. Home care orientation and in-service classes should address these areas. The patients' Bill of Rights (Department of Health & Human Services, 1991), which is a licensure requirement for home care patients, states that patients have the right to be involved in their care. Joint Commission on the Accreditation of Healthcare Organizations' (JCAHO, 1992) standards also state that nursing care plan goals should be mutually set between the nurse and the patient. Nurses often complain about unnecessary regulations and paperwork but these are two good examples of standards that were developed to promote the patients' participation in their care. Nurses should utilize Watson's Philosophy and Science of Caring (1979) to develop caring relationships with their patients so that appropriate, mutually agreed upon goals can be established.

To meet accreditation standards and to compete in today's environment home care agencies have quality improvement programs. Quality patient care and customer satisfaction are two integral components of any quality improvement program. This author would like to propose that Watson's Philosophy and Science of Caring (1979) offers home health administrators an appropriate theoretical framework upon which to develop a nursing care delivery system that would promote both quality patient care and customer

satisfaction. By adopting and promoting a philosophy of patient care based upon Watson's philosophy, quality patient care would be a realistic outcome. Home care agencies could develop their own practice models which incorporate caring behaviors and the nurse-patient relationship as the central components of the model. Once the theoretical framework is established, the standards of practice, patient outcomes, and nursing care plans would all be developed utilizing caring as a central concept. Continuous Quality Improvement (CQI) techniques are currently being adopted by many organizations to provide a framework for the provision of quality services and customer satisfaction. The CQI philosophy is congruent with Watson's Philosophy and Science of Caring (1979). Home care administrators can utilize CQI techniques to further identify and evaluate patient care needs on an on-going basis.

The findings of this study indicate the need for further research in the following areas.

1. Additional research is necessary to evaluate the needs of patients in all clinical areas. No studies were found which had addressed the needs of pediatric or obstetrical patients.
2. Follow-up research to refine the CARE-Q instrument so that it relates to nurse caring behaviors that are generic across all practice settings is needed. Also,

the language in some of the questions is suggestive of in-patient care.

3. Research should be conducted to compare the needs of patients with acute care versus chronic care needs.
4. Research to identify the significance of nurse caring behaviors as related to patient satisfaction and outcomes of care would be of value to both patients and care providers.
5. Research to identify how social factors influence caring needs, such as whether a person lives alone or has a care provider available, should be conducted.
6. Further research may be utilized to develop a clinical practice model for the delivery of home health nursing care based upon Watson's Philosophy and Science of Caring (1979) and CQI techniques.

Summary

In this section, the investigator has presented a summary of findings, conclusions, and recommendations. This study was conducted to investigate the most important nurse caring behaviors as identified by home care nurses and patients, and to determine if their perceptions differ. The results indicate that there are commonalities between home care nurses and patients, but that differences also exist. These findings demonstrate the importance for nurses to be aware of the needs of each individual patient and to incorporate the patient's needs in the plan of care.

Watson's Philosophy and Science of Caring (1979) offers nurses an effective theoretical framework upon which patient care can be practiced. By relating to patients on an interpersonal level, nurses will be more sensitive to the needs of each patient. The health care delivery system is currently undergoing many changes. Just as social, political, and economic factors will affect the delivery of health care, the delivery of nursing care will also be affected. Nurses must continue to provide clinically competent and safe care. However, nurses must also combine these clinical skills with effective interpersonal skills to best meet the needs of their patients.

The challenge for nurses today is to provide competent, humanistic nursing care in a health care environment that does not always value the humanistic needs of the patient.

REFERENCES

American Nurse Association. (1980). Nursing: A social policy statement. Kansas City, MO: author.

Becker, M., & Naiman, L. (1981). Strategies for enhancing patient compliance. Journal of Community Health, 6, 113-130.

Benner, P. (1984). From novice to expert. Menlo Park, CA: Addison Wesley.

Benner, P. (1989). The primacy of caring: Stress and coping in health and illness. Menlo Park, CA: Addison Wesley.

Brown, L. J. (1981). Behaviors of nurses perceived by hospitalized patients as indicators of care. (Doctoral Dissertation, University of Colorado, Boulder). Dissertation Abstracts International. 43:4361B (University Microfilms #DA8209803), 1982.

Brown, L. (1986). The experience of care: Patient perspectives. Journal of Advanced Nursing, 17, 52-63.

Department of Health & Human Services. (1991). State Operations Manual (HICFA-Publication No. 7). Washington, DC: U.S. Government Printing Office.

Duffy, J.R. (1992). The impact of nurse caring on patient outcomes. In D.A. Gaut (Ed.). The Presence of Caring in Nursing, (pp. 113-123). New York: NLN Press.

Farrell G. A. (1991). How accurately do nurses perceive patients' needs? A comparison of general and psychiatric settings. Journal of Advanced Nursing, 16, 1062-1070.

Gaut, D.A. (1991). Introductory remarks. In R.M. Neil & R. Watts (Eds.), Caring and nursing: Explorations in feminist perspectives (pp.5-7). New York: NLN Press.

Gustafson, N. (1984). Motivational and historical aspects of care and nursing. In M. Leininger (Ed.), Care: The essence of nursing and health (pp. 61-73). Thorofare, New Jersey: Slack.

Henry, O.M. (1975). Nurses behaviors perceived by patients as indicators of care. (Doctoral dissertation, Catholic University, Washington, D.C.) Dissertation Abstracts International, 36:(02652B). (University Microfilms #DA 8209803), 1982.

Joint Commission on the Accreditation of Healthcare Organizations. (1992). Accreditation Manual for Home Care (Vol. I-Standards). Oakbrook Terrace: IL, Author.

Larson, P. J. (1981) Oncology patients' and professional nurses' perceptions of important nurse-caring behaviors. (Doctoral Dissertation, University of California, San Francisco). (University Microfilm #81-16511).

Larson, P. J. (1984). Important nurse caring behaviors perceived by patients. Oncology Nursing Forum, 11(6), 46-50.

Larson, P. J. (1986). Cancer nurses' perceptions of caring. Cancer Nursing, 9(2), 86-91.

Larson, P. J. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviors. Heart & Lung, 16, 187-192.

Leininger, M. (1978). Transcultural nursing: Concepts, theories, and practices. New York: John Wesley & Sons.

Leininger, M. (1979). Foreward comments. In J. Watson (Ed.), Nursing: The philosophy and science of caring (p. xii-xiv). Boston: Little, Brown.

Leininger, M. (1988a). Caring: An essential human need. Detroit: Wayne State University Press.

Leininger M. (1988b). Care: The essence of nursing and health. In M. Leininger (Ed.). Care: The Essence of Nursing and Health. Detroit: Wayne State University Press.

Leininger, M. (Ed.). (1991). Culture, care, diversity, & universality: A theory of nursing. New York: NLN Press.

Mayer, D. K. (1986). Cancer patients' and families' perceptions of nurse caring behaviors. Topics in Clinical Nursing, 8(2), 63-69.

Mayer, D. K. (1987). Oncology nurses' versus cancer patients' perceptions of nurse caring behaviors: A replication study. Oncology Nursing Forum, 14(3), 48-52.

Mayerhoff, M. (1971). On caring. New York:Harper & Row.

Morse, J., Solberg, S., Neander, W., Botteroff, J., & Johnson, J. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science. 13(1), 1-14.

Nightingale, F. (1980). Notes on nursing: What it is and what it is not (Ed.). New York: Churchill & Livingstone.

Orem. D. (1980). Nursing concepts of practice (2nd ed.). New York: McGraw-Hill.

Orem, D. (1985). Nursing concepts of practice (3rd ed.). New York: McGraw-Hill.

Pelligrino, E. (1985). Caring, curing, coping: Nurse, physician, patient relationships. In A. Bishop & J.R. Scudder (Eds.), Health care ethics (pp. 8-30). Birmingham: University of Alabama Press.

Peplau, H.E. (1991). Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing. New York: Springer.

Smit, J., & Spoelstra, S. (1991). Perceptions of caring: Do patients and nurses agree? Caring, 10(10), 34-36.

Statistical Package for the Social Sciences (SPSS), (1991). Chicago, IL.

Stephenson, W. (1953). The study of behavioral Q technique and its methodology. Chicago: University of Chicago Press.

von Essen, L., & Sjoden, P. O. (1991). Patient and staff perceptions of caring: Review and replication. Journal of Advanced Nursing, 16, 1363-1374.

Watson, J. (1979). Nursing: The philosophy & science of caring. Boston: Little Brown.

Watson, J. (1981). Nursing's scientific quest. Nursing Outlook, 29, 413-416.

Watson, J. (1985). Nursing: Human science and human caring. Norwalk: Appleton, Century, & Crofts.

Wilson, H. S. (1989). Research in Nursing (2nd ed.). Redwood City, CA: Addison-Wesley.

Wolf, Z. R. (1986). The caring concept and nurse identified caring behaviors. Topics in Clinical Nursing, 8(2), 84-96.

APPENDIX A

PARTICIPANT DATA SHEET

NURSE

1. **AGE:** _____

2. **SEX:** _____female _____male

3. **RACE:** _____Asian _____African-American

   _____Caucasian _____Hispanic _____Other

4. **PROFESSIONAL TITLE:** _____RN _____LPN

5. **HIGHEST NURSING EDUCATION STATUS ATTAINED:**

   _____LPN _____Diploma _____ADN _____BSN

   _____MSN _____Doctorate _____N.P.

6. **YEARS OF NURSING EXPERIENCE:** _____

7. **YEARS OF HOME HEALTH EXPERIENCE:** _____

8. **JOB CLASSIFICATION:**

   _____Staff Nurse

   _____Patient Care Coordinator (Team Leader)

   _____Manager/Administration

   _____Other, please list

9. **WORK STATUS:**

   _____Full-time _____Part-time _____Casual

PARTICIPANT DATA SHEET

PATIENT

1. AGE: _____

2. SEX: _____female _____male

3. RACE: _____Asian _____African-American
   _____Caucasian _____Hispanic _____Other

4. EDUCATIONAL LEVEL: _____

5. LIVING ARRANGEMENTS: ____Live alone ____Live with someone

6. WHAT IS YOUR MAIN HEALTH PROBLEM?_____

7. PAYOR SOURCE: (check all that apply)
   _____Medicare _____Medicaid _____Private Insurance
   _____Other

8. APPROXIMATE LENGTH OF TIME YOU HAVE BEEN RECEIVING HOME CARE:

   _____

CARING ASSESSMENT INSTRUMENT

In order to make you feel cared for, how important is it that the nurse does each of the following? Please circle one score for each question. A score of "7" means the behavior is most important. A score of "1" means the behavior is not important at all.

1. Frequently approaches the patient first, e.g., offering such things as pain medication, back rub, etc.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

2. Volunteers to do "little" things for the patient, e.g., brings a cup of coffee, paper, etc.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

3. Gives the patient's treatments and medications on time.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

4. Checks on the patient frequently.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

5. Gives a quick response to the patient's call.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

6. Encourages the patient to call if he/she has problems.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

7. Tells the patient of support systems available, such as self-help groups or patients with similar disease.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

8. Helps the patient not feel dumb by giving him/her adequate information.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

9. Tells the patient, in understandable language, what is important to know about his/her disease and treatment.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

10. Teaches the patient how to care for himself/herself whenever possible.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

11. Suggests questions for the patient to ask her/his doctor.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

12. Is honest with the patient about his medical condition.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

13. Provides basic comfort measures, such as appropriate lighting, control of noise, adequate blankets, etc.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

14. Provides the patient encouragement by identifying positive elements related to the patient's condition and treatment.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

15. Is patient even with "difficult" patients.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

16. Is cheerful.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

17. Sits down with the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

18. Touches the patient when he/she needs comforting.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

19. Listens to the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

20. Talks to the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

21. Involves the patient's family or significant others in their care.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

22. Realizes that the nights are frequently the most difficult time for the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

23. Anticipates the patient's and her/his family's shock over her/his diagnosis and plans opportunities for them, individually or as a group, to talk about it.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

24. Knows when the patient has "had enough" and acts accordingly, e.g., rearranges an examination, screens visitors, insures privacy.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

25. Is perceptive of the patient's needs and plans and acts accordingly, e.g., gives anti-nausea medication when patient is receiving medication which will probably induce nausea.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

26. Anticipates that the "first times" are the hardest and pays special attention to the patient during these times.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

27. When with a patient, concentrates only on that one patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

28. Continues to be interested in the patient even though a crisis or critical phase has passed.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

29. Offers reasonable alternatives to the patient, such as choice of appointment times, bath times, etc.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

30. Helps the patient establish realistic goals.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

31. Checks out with the patient the best time to talk with the patient about changes in his/her condition.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

32. Checks his/her perceptions of the patient with the patient before initiating any action, e.g., if she/he (the nurse) has the feeling that the patient is upset with the treatment plan, discusses this with the patient before talking about it to the doctor.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

33. Helps the patient clarify his thinking in regard to his/her disease and treatments.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

34. Realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

35. Encourages the patient to ask her/him any questions he/she might have.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

36. Puts the patient first, no matter what else happens.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

37. Is pleasant and friendly to the patient's family and significant others.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

38. Allows the patient to express his feelings about his/her disease and treatment fully, and treats the information confidentially.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

39. Asks the patient what name he/she prefers to be called.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

40. Has a consistent approach with the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

41. Gets to know the patient as an individual person.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

42. Introduces himself/herself and tells the patient what she/he does.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

43. Is professional in appearance--wears appropriate identifiable clothing and identification.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

44. Makes sure that professional appointment scheduling e.g., x-ray, special procedures, etc. are realistic to the patient's condition and situation.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

45. Is well organized.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

46. Knows how to give shots, I.V.'s, etc. and how to manage the equipment like I.V.'s, suction machines, etc.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

47. Is calm.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

48. Gives good physical care to the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

49. Makes sure others know how to care for the patient.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

50. Knows when to call the doctor.

7	6	5	4	3	2	1
Most Important			Neither Important Nor Unimportant			Not Important

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

You are being invited to participate in a research study currently being conducted by Sally Welsh, RN, a masters student at Georgia Southern University. Your decision to participate is voluntary and will in no way affect the care that you receive. You may also change your mind to participate at anytime.

The study, titled Home Care Nurses' and Home Care Patients': Differences in Perception of Nurse Caring Behaviors, is being conducted to: (1) identify the most important nurse caring behaviors as perceived by home care patients and home care nurses, and (2) to determine if patients and nurses differ in their perceptions of the most important nurse caring behaviors.

Participants will include patients and nurses who are currently affiliated with one local home health agency. To be eligible for participation, patients must have received a minimum of four nursing visits and nurses must have been employed by the agency for at least six months. This study will include 50-60 nurses and patients.

Your participation in the study will involve filling out a participant information sheet and completing the 50 item Caring Assessment Inventory (CARE-Q). It will take approximately 30 minutes to complete these forms. Participants will be given instructions from either the researcher or a trained data collector regarding the scoring guidelines for the CARE-Q instrument. If you prefer, a data collector will read the questions out to you and you will then score each individual question. The study does not involve any treatments and there are no risks to you as a participant. There are no costs associated with study participation.

You may find the tool to be long and some questions difficult to rate. There will be no direct benefits to you as a result of participation in this study. You may experience a sense of satisfaction in expressing your opinions regarding this subject. The results of this study may have some positive future benefits for home care patients and nurses.

The results of this study will be analyzed by the researcher and a formal summary report will be written. The results of

_____
Participant's
Initials

this study may also be published in professional journals. Each participant will be assigned a code number for identification purposes. No participant's name will be mentioned in any report or publication.

If you have questions regarding your participation in this study, you may contact Sally Welsh, RN at 350-6110, Mondays through Fridays, 9:00 a.m. to 5:00 p.m. or after hours at 927-2861, or you may send correspondence to her at 7135 Hodgson Memorial Drive, Suite 10, Savannah, Georgia 31406, or contact Dr. Jim McMillan, Chairman of the Georgia Southern University Institutional Review Board at 912-681-2000.

You will be given a copy of your consent form. Your signature below indicates that you agree to participate in this study.

_____ _____

Participant's Signature Date

_____ _____

Investigator's Signature Date

You can obtain a copy of the study results by marking the space below and filling in your complete address.

Would you like a copy of the study results?

_____ Yes _____ No

If yes, please list your address.

_____

_____

_____

THANK YOU.

University of California, San Francisco...A Health Sciences Campus

July 23, 1992

Sally Welsh
811 Dyches Drive
Savannah, GA 31406

Dear Ms. Welsh:

Thank you for your interest in my work on caring. I am enclosing the information on: 1) the description of the derivation of the CARE-Q I items and scales; and 2) the evolved CARE/SAT. As noted the satisfaction paper should be treated as privileged communication.

To use the CARE/SAT all questionnaires must be xeroxed from the enclosed copy. This is to ensure that the visual analog line remains a constant 100mm line (apparently xeroxing from copies causes the line to be enlarged in length). To gain the patients' response use a metric ruler, and measure at the mid-point of the "X". If the patient makes two "X's" toss a coin to select one. If the patient marks an "X" beyond the line consider it 100; if below, it is then ranked as 0. The CARE-Q in its present form does not generate a total score.

You are welcome to use either instrument. If you decide to use one or both please let me know and provide me with an abstract of the study's findings upon completion. I would also appreciate your acknowledgement of my authorship of the instrument.

If I can be of further assistance, please let me know.

Sincerely,

Patricia J. Larson

Patricia J. Larson, RN, DNSc
Assistant Professor
and Interim Chair, Oncology Program

PL/ad

Enclosures

811 Dyches Drive
Savannah, GA 31406
November 30, 1992

Jean Watson
University of Colorado
Health Sciences Center
E. Janasko - C288
4200 East Ninth Avenue
Denver, CO 80262

Dear Dr. Watson:

I had written to you previously, stating that I was anticipating doing my thesis utilizing your theory of caring as my theoretical framework. I just submitted a draft of my first two chapters to my thesis committee for review. In my thesis, I quoted your seven basic assumptions and ten carative factors for the science of caring in nursing. One of my professors recommended that I write to you and obtain written permission to quote these sections in my thesis. Therefore, I would like to request your written permission to quote these two sections in my thesis.

Your assistance would be greatly appreciated. I have enclosed a stamped, self-addressed envelope for your convenience.

Sincerely,

Sally

Sally Welsh

December 11, 1992

Dear Sally:

You have my permission to quote the material you describe in complete form with reference cited. Good wishes.

Very sincerely,

Jean Watson per V Tormey

M. Jean Watson
Dictated and signed in Dr. Watson's absence with her approval/vt

[redacted] Memorial Medical Center, Inc.

Memorandum

DATE:

TO: Kavah Ehsanipoor, M.D. Chairman, Institutional Review Board

FROM: Clinical Research Department

SUBJ: Expedited Review

STUDY: HOME CARE NURSES AND HOME CARE PATIENTS: DIFFERENCES IN PERCEPTIONS OF NURSE CARING BEHAVIORS

ISSUE: The purpose of this study is to (a) identify the most important nurse caring behaviors as identified by both home care nurses and home care patients & b) to see if there is a significant difference between the home care nurses and home care patients perceptions of the most important nurse caring behaviors.

Sara K. "Sally" Welsh, R.N.
PRINCIPAL INVESTIGATOR RESEARCH COORDINATOR

APPROVED ✓ DISAPPROVED DATE 3/8/93

CHAIRMAN, INSTITUTIONAL REVIEW BOARD

Please place on agenda for next IRB meeting.

[redacted] An affiliate of Provident Health Services, Inc.

INSTITUTIONAL REVIEW BOARD

GEORGIA SOUTHERN UNIVERSITY

To be submitted to the Institutional Review Board for the protection of Human Subjects in Research prior to the initiation of any investigation involving human subjects. A copy of the research proposal and approval form must be attached.

APPROVAL FORM

Date: 2/10/93

Research Title: Home Care Nurses & Home Care Patients: Differences in Perceptions of Nurse Caring Behaviors - A Replication Study

Principal Investigator: Sara K. "Sally" Welsh Title: R.N.

Department: Nursing

Campus Address: Fair Rd. Phone: 681 - 0017

Signature: Sara K. Sally Welsh Principal Investigator

Sara E. Conn, MSN (if student research, major professor)

Martha A. Coleman Department Head

Determination of Institutional Review Board:

Human Subjects: At Risk ✓ Not At Risk

Action: ✓ Approved ____ Not Approved ____ Reapproved

____ Returned for Revisions

Signed: John Mullen Chair, Institutional Review Board Date: 4-6-93