Nurse caring behaviors as perceived by the emergency room nurse and the emergency room patient: A comparative study

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NURSE CARING BEHAVIORS AS PERCEIVED BY THE EMERGENCY
ROOM NURSE AND THE EMERGENCY ROOM PATIENT:
A COMPARATIVE STUDY

by

Carolyn T. Whipple

A Thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science
in
Nursing
Department of Nursing
University of Nevada, Las Vegas
December, 1995
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University of Nevada, Las Vegas
December, 1995
Abstract

The purpose of this study was to determine what emergency room nurses (n = 60) and emergency room patients (n = 60) perceived as caring behaviors, as measured by the Caring Behaviors Assessment (CBA) tool. The CBA assesses caring behaviors and follows the components of Watson's Theory of Caring (1988). As in previous study findings, the patients ranked technical skills, "Know what they're doing" and "Know how to give shots, IV's, etc." as most important. Unlike other studies the emergency room nurse ranked technical skills, "Know how to give shots, IV's, etc." as most important. The nurse ranked many of the helping and feeling cares significantly higher than the patient. Using t-tests, the responses of nurses and patients were compared. eleven out of the sixty-three items on the CBA had significant mean differences (p = .05). There were eleven areas of correlation, between the demographics and the CBA subscales, with a significance level set at p = .05. Cronbach's alpha reliability coefficient for the CBA tool was .96. It is important that nurses become aware of what patients perceive as caring behaviors and how these perceptions differ from their own. This awareness is one of the first steps to changing nurses' behavior, and hopefully better meet the needs of the patient.
TABLE OF CONTENTS

Abstract .......................................... iii
List of Tables ................................. vi
Acknowledgments ............................... viii
Chapter

I. Introduction ..................................... 1
   Problem Statement .................................. 2
   Purpose of the Study ................................ 3
   Significance of the Study ............................ 3

II. Review of the Literature and Conceptual Framework .......... 5
    Review of the Literature ........................... 5
    Conceptual Framework ................................ 20
    Research Questions ................................... 24
    Assumptions ......................................... 25
    Definitions of Terms .................................. 25

III. Methodology
    Research Design ..................................... 26
    Setting ............................................... 27
    Sampling ............................................. 28
    Human Subject Rights ................................ 29
    Data Collection ...................................... 30
    Instrument .......................................... 31
    Data Analysis ........................................ 33

IV. Results ......................................... 35

V. Discussion ...................................... 66
   Summary ............................................. 66
   Discussion and Conclusions .......................... 67
   Limitations ......................................... 85
   Recommendations .................................... 85

References ......................................... 90

Appendices
   A. Permission for Use of the Caring Behaviors Assessment tool .... 95
   B. Internal Review Board Consent:
      Dixie Regional Medical Center ........................ 98
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C.</td>
<td>Internal Review Board Consent:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LDS Hospital........................</td>
<td>100</td>
</tr>
<tr>
<td>D.</td>
<td>Human Subject Rights Committee Approval:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>University of Nevada, Las Vegas</td>
<td>102</td>
</tr>
<tr>
<td>E.</td>
<td>Consent Form: Patient .............</td>
<td>107</td>
</tr>
<tr>
<td>F.</td>
<td>Consent Form: Registered Nurse ....</td>
<td>110</td>
</tr>
<tr>
<td>G.</td>
<td>Patient Demographic Form ...........</td>
<td>113</td>
</tr>
<tr>
<td>H.</td>
<td>Registered Nurse Demographic Form</td>
<td>115</td>
</tr>
</tbody>
</table>
List of Tables

Table 1  Demographic data summarizing age for nurse and patient groups ............... 36
Table 2  Demographic data summarizing gender for nurse and patient groups ............... 38
Table 3  Demographic data summarizing race for both nurse and patient groups ............... 39
Table 4  Demographic data summarized for marital status of the nurse and patient groups .... 40
Table 5  Demographic data summary of patient insurance coverage and use of the emergency room ....................... 42
Table 6  Demographic data summarizing Nursing degree, experience in nursing and experience in the emergency room ............... 43
Table 7  Summary of significant correlation results of demographic data and carative factors subscales ....................... 45
Table 8  Significant mean differences of responses between urban and rural facilities ............... 48
Table 9  Mean scores for nurse and patient response to the Caring Behaviors Assessment tool ....................... 54
Table 10 Rankings of patients' perceived most important caring behaviors ....................... 56
Table 11 Rankings of nurses' perceived most important caring behaviors ....................... 57
Table 12 Ranking of patients' perceived least important caring behaviors ....................... 58
Table 13 Ranking of nurses' perceived least important caring behaviors ....................... 59
Table 14 Rankings of subscales by nurse and patient groups ....................... 60
Table 15 Significant mean differences of Caring Behaviors Assessment responses by nurse and patient groups ........... 62

Table 16 Cronbach's alpha for carative factors subscales ......................... 65
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Chapter I

Introduction

Nursing is caring; caring is the heart of nursing; and caring can be a powerful means for healing and promoting healthy life ways (Leininger, 1986). Caring has been described by many as the essence of nursing, that which delineates nursing from other fields of study. Yet in a survey of doctoral dissertations less than three percent focused on the caring phenomenon (Leininger, 1986).

Traditionally nurses have described their acts of administering to patients as care behaviors (Mangold, 1991). Mangold further indicates that many nurses have difficulty in defining caring behaviors. If it is so difficult for the nurse giving the care to define caring, what of the patient who is receiving that care? What does the patient perceive as caring and does it differ from the nurse's perception of caring? It is important that nurses be aware of what caring behaviors are and how caring is perceived by the patient. By being aware of these perceived caring behaviors the nurses can take the first step in changing their behavior to better meet the needs of the patients.
Problem Statement

Caring has been described as the very essence of nursing and the central, unifying focus for nursing practice. Nursing has traditionally been concerned with caring as a principle for nursing action. There are questions, however, about what behaviors indicate caring to others and how the effectiveness of caring can be measured (Cronin & Harrison, 1988).

Watson (1985) defines caring as the moral ideal of nursing where the end is protection, enhancement, and preservation of human dignity. Although numerous authors have analyzed caring as a concept, Watson more clearly shows how the components of the caring process operate (Cronin & Harrison, 1988).

The emergency room with its unique mixture of outpatient minor problems and acute life-threatening major problems offers a challenge to any nurse trying to meet the needs of the patient. It is, therefore, important to consider these factors in order to understand human care behaviors and to work toward achieving holistic care practices in nursing (Leininger, 1986). Analysis of the perceived caring behaviors of the emergency room nurse and how they differ from those of the emergency room patient will direct nursing care to achieve a more holistic nurse-patient interaction.
Purpose of the Study

The purpose of this study was to determine the perceived caring behaviors of the emergency room nurse as compared to the perceived caring behaviors of the emergency room patient. A comparative study using the Caring Behaviors Assessment (CBA) tool, which assesses caring behaviors and follows the components of Watson's Theory of Caring (1988) was implemented.

Significance of the Study

The literature indicates that what the nurse perceives as the most important caring behaviors are not necessarily what the patient perceives as the most important caring behaviors. One can wonder how the patient can feel cared for if the caring behaviors exhibited by the nurse are not perceived by the patient as true caring behaviors. Only by aligning both the nurses' and the patients' perceptions of caring behaviors can individual needs be met.

In the studies done comparing nurses' and patients' perceptions of what the most valued caring behaviors were, none have been found that evaluated the emergency room nurse and the emergency room patient. The emergency room setting presents challenges which are distinct from the general in-patient setting. The fast pace of an emergency room decreases even more the time allowed for implementing caring behaviors. The nurse would most
benefit the patient by exhibiting those behaviors which the patient will perceive as caring, particularly if there are significant constraints on the time available to exhibit those behaviors.

Nursing theory identifies basic principles that guide nursing education, practice, and research (Stithichoke-Rattan, 1989). By using Cronin and Harrison's (1988) Caring Behavior Assessment (CBA), which follows Watson's Theory of Care (1985), an additional benefit of this study was to further test Watson's theory in the clinical setting and refine the knowledge of caring for enhancement of nursing practice.
Chapter II

Review of the Literature and Conceptual Framework

Review of the Literature

Caring as an essential core component has been explored by a variety of nurse authors (Larson, 1981). Caring, the central focus of nursing, seems to be the very thing that differentiates nursing from other disciplines. Nurse theorists have spent the last twenty years in an attempt to develop a framework to provide guidance and direction for the field of nursing. In 1981 Patricia Larson was just one of those early theorists. In an attempt to identify the basic concepts of the caring concept of nursing, Larson developed a Q-sort tool called the CARE-Q. This tool was the first and dominant tool used throughout the literature in assessing caring behaviors. In the CARE-Q development, sixty-nine themes of caring were identified by the author from the current literature. To establish the tool's validity two review panels were used as well as psychometric consultants. Reliability of the tool was done by means of test-retest of cancer nurses (n = 12). To further address content validity, the tool was then
examined by a panel of four staff nurses and three patients. The final tool contains 50 items classified under the following six themes: anticipates, comforts, explains and facilitates, develops and sustains trusting relationships, monitors and follows through, and is accessible (Mayer, 1987).

Using the newly developed Care-Q, Larson (1981) conducted a study examining oncology patients and oncology nurses and their perceptions of caring behaviors. The purpose of Larson's study was to identify oncology patients' perceptions of caring behaviors and oncology nurses' perceptions of caring behaviors. Once those perceptions were identified, a comparison was done.

The patients (n = 57) ranked caring behaviors of a competent know-how nature as the most important with "knows how to give shots, IV's etc." and "how to manage the equipment" being the top items. The least important item ranked by the patient was, "asks patients what name they prefer to be called". The variables (hospital setting, age, gender, primary cancer site, and cancer treatment modality) were tested and no significant statistical differences were found (Larson, 1984).

The nurses (n = 57) ranked "listens to the patient" as the most important caring behavior while ranking "is professional in appearance" the least important. No significant effects from major variables (hospital
setting, age, sex, years in nursing, percentage of time spent with the patient, and type of patient cared for) were noted (Larson, 1986).

Larson's study (1981) demonstrated that nurses and patients differ in their perceptions of important caring behaviors, utilizing mean score comparisons. The nurse perceives comfort and trusting relationship behaviors as most important while in contrast the patient perceives clinical competence as the most important caring behavior.

Mayer (1987) replicated Larson's (1981) study again assessing oncology nurses (n = 28) and oncology patients (n = 54). Mayer stated no new validity or reliability studies for this replication. Mayer only cites the validity and reliability of the CARE-Q done by Larson (1981) in the original study. Utilizing the CARE-Q instrument, Mayer found that there was a significant correlation between the nurses' and the patients' perceptions of caring behaviors (p < .01). There were, however, differences between patients and nurses in specific behaviors and in what was considered the most or least important caring behaviors. The nurses ranked "listens to patient" as the most important while the patient ranked "knows how to give shots, IV's, etc." as the most important, concurring with Larson's study. Other variables were not addressed in the study.
Keane, Chastain, and Rudisill (1987), using the CARE-Q instrument, studied rehabilitation patients (n = 26) and rehabilitation nurses (n = 26). The purpose of the study was to identify areas of agreement or disagreement between the patients' and the nurses' perceptions of important nurse caring behaviors. Both the patients and the nurses identified "knows when to call the doctor" and "monitors and follows through" as the most important nurse caring behaviors. Keane et al. identified no other validity and reliability measurements beyond those supplied by Larson (1981).

The perceptions of nurse educators was researched by Komorita, Doehring and Hirschert (1991). Using the CARE-Q, 110 nurse faculty, managers, and clinical specialists were asked to indicate what they perceived as the most and the least important caring behaviors. Of the 110 nurses, 72 were educators and the remaining 38 nurses were either managers or clinical specialists. The study found that the responses were similar so all 110 nurse responses were grouped together. The nurses involved were master prepared practitioners and managers. Komorita et al. felt that a more homogeneous sample of nurses with advanced education (master prepared practitioners and managers) may provide different findings than previous studies (Larson, 1981 and Mayer, 1987). The results supported both previous studies
indicating that the nurse educators concurred with the oncology nurses and selected "listens to the patient" as the most important caring behavior. There were no significant differences in the variables studied (type of program or function group, age, years of experience or clinical areas). No further validity and reliability on the tool was done beyond Larson's (1981) original study.

Mangold (1991) conducted a comparison study using senior Bachelor of Science in Nursing students and professional nurses with one or more years of experience. The purpose of this study was to identify what senior nursing students perceive as effective care behaviors and to identify areas of agreement and disagreement between the students' responses and those of professional nurses with one or more years of experience. The CARE-Q was used to assess the respondent's perceptions. The validity and reliability used for this study was again from Larson's 1981 study. The students (n = 30) and the nurses (n = 30) only disagreed in their responses on 6 of the 50 behavioral items. The students and the nurses concurred that the most important caring behavior was "listens to the patient". The professional nurses felt that the least important caring behavior was "is professional in appearance", while the students felt that the least important behavior was "puts the patient
first no matter what". The only variable addressed in the study was that of age and Mangold indicated that no significant differences were found.

Rosenthal (1992) replicated Larson's 1981 study in a coronary care unit setting. The research question guiding this study was "What are patients' and nurses' perceptions of important nurse caring behaviors?". The CARE-Q instrument was used. Larson's validity and reliability values were accepted. The patients (n = 30) ranked "knows how to give shots, IV's, etc." as the most important nurse caring behavior and "checks out with the patient the best time to talk" as the least important nurse caring behavior. The nurses (n = 30) perceived "listens to the patient" as the most important care behavior and the least important care behavior as "ask the patient what name he/she prefers to be called". Rosenthal's findings support the findings of Larson (1981).

Scharf and Caley (1993) added an additional variable to their replication of Larson's study. Not only were the perceptions of nurses and patients assessed, but physicians were also included. All the participants were from a coronary care setting. Using the CARE-Q, 80 nurses, 50 patients, and 32 physicians were asked to rank the 50 items from most to least important nurse caring behaviors. All three groups failed to concur
on either the most or the least important caring behaviors. The nurse ranked "listens to patient" as the most important with the next most important behavior being "knows when to call the doctor". The physicians ranked "knows when to call the doctor" as the most important behavior and "listens to the patient" as the second most important caring behavior. The patient ranked "knows how to give shots, IV's, etc." as the most important nurse caring behavior and the second most important behavior selected was "listens to the patient". In summary, the responses appear to indicate that both the nurses and the physicians selected the same top five responses, but placed them in different order; while only one of the patients' top five rankings were the same as either the nurses or the physicians. Again Larson's 1981 study was referenced for the validity and reliability of the CARE-Q.

In 1993, Gooding, Sloan, and Gagnon replicated Larson's 1981 study. The purpose of the study was to examine the phenomenon of care/caring as perceived by oncology patients and nurses. The study addressed the research questions: 1) How do oncology patients and nurses rank caring behaviors in order of importance? 2) What is the relationship between these rankings of caring behaviors? 3) Are there differences between
subscales scores of these caring behaviors for oncology patients and nurses? (Gooding et al., 1993).

The CARE-Q instrument was used to collect the data. The validity and reliability of Larson's original 1981 study was cited for this study. In addition to Larson's reliability test-retest, Gooding et al. (1993) conducted a small test-retest of their own using nine undergraduate nursing students. A perfect correlation was found between the first and the second testing.

The oncology patients (n = 42) ranked "knows how to give shots, IV's, etc." as the most important caring behavior and ranked "asks the patient what he/she prefers to be called" as the least important caring behavior. The oncology nurses (n = 46) ranked "listens to the patient" as the most important caring behavior and "is professional in appearance" as the least important. Results again supported prior studies using Larson's tool.

In Sweden, von Essen and Sjoden (1991a) used Larson's (1981) CARE-Q to compare the perceptions of caring behaviors by a group of medical-surgical, cancer and orthopedic nurses (n = 46) and patients (n = 42). The only modification done to the CARE-Q was to translate it into Swedish. Reliability and validity were taken from Larson's original 1981 study. The results of the study were compared to both Larson (1981) and Mayer (1987)
and found to be in support of both studies. The nurses' perceptions differed from the patients in that the patient viewed the instrumental behaviors as most important while the nursing staff viewed the expressive behaviors as most important.

von Essen and Sjoden (1991b) later replicated their prior study but modified the CARE-Q substantially. von Essen and Sjoden felt that the forced responses elicited with the CARE-Q caused a quasi-normal distribution. The modifications resulted in a free response format allowing the participants to choose any number of most important responses. Using a systematic replication and methodological extension of the previous study, von Essen and Sjoden used only medical-surgical patients (n = 86) and nurses (n = 73). No additional reliability or validity was done on the modified tool. Patients perceived the most important caring behaviors to be "giving honest and clear information" and "shows competent clinical expertise" while the nurses indicated "listens to the patient" and talks to the patient" as the most important.

von Essen and Sjoden (1993) further compared the perceived caring behaviors of the psychiatric staff (n = 63) and the psychiatric patient (n = 61). Both groups concurred that the most important caring behavior was "listens to the patient". Of the ten most important
caring behaviors selected by the individual groups, four behaviors were common to both groups. Of the ten least important items, seven were common to both groups. No further reliability or validity was done beyond that reported in Larson's (1981) original study.

In each of the studies using the Q-sort method frustration of the participants, with the Q-sort, was expressed. The participants found the Q-sort method time consuming, and the instructions difficult to understand. The choices caused forced answers and resulted in delays in completing the tool (Larson, 1984, 1986, 1987; Keane, et al., 1987; Mayer, 1987; Mangold, 1991; von Essen & Sjoden, 1991a, 1991b, 1993; and Scharf & Caley, 1993). Due to the negative aspects of the Q-sort method of collecting data, other methods were being explored by other researchers. Trustworthiness of the data collection method was not addressed in the study.

Using a phenomenological approach, Reiman (1986) analyzed ten patients' descriptions of non-caring behaviors and attitudes of nurses. Three themes were identified by the researchers that characterized the basic structure of a non-caring interaction. The first theme identified the nurse as being physically present but emotionally distant. The second theme identified the nurse's actions as belittling and inhumane, resulting
in a devaluing of the patient as a unique individual. The third theme indicated that patients had resulting feelings of frustration, depression, anger, and anxiety from the other two themes.

Thirteen critical care patients were assessed as part of a phenomenological study by Burfitt, Greiner, Miers, Kinney, and Branyon (1993). The objectives of this study were to have patients describe their perceptions of caring as exhibited by the professional nurses in a critical care unit. The patients did not separate the caring behaviors observed from the feeling those behaviors elicited, thus resulting in three caring concepts being identified by a five member research team as vigilance, mutuality, and healing. The study indicated very clearly that patients were quite aware of the nurse and their actions.

Wolf, Riviello, Giardino, Osborn, and Ambrose (1994) elicited responses from nurses (n = 278) and patients (n = 263) who had been hospitalized and cared for by a nurse in secondary or tertiary health care settings to identify dimensions of nurse caring. The researchers used a revised Caring Behaviors Inventory (CBI) instrument, in which five dimensions were identified, those dimensions were: 1) respectful differences to others; 2) assurance of human presence; 3) positive connectiveness; 4) professional knowledge and skill;
and 5) attentiveness to the other's experience. Content validity of the CBI was established by a panel of four nurse experts. Reliability was established by a test-retest using a nurse sample and resulted in an Cronbach's alpha coefficient of .83.

In 1988 Cronin and Harrison developed the Caring Behaviors Assessment (CBA). The CBA identifies 61 nursing behaviors ordered in seven subscales that are congruent with Watson's carative factors (1985). The use of a five-point Likert-type scale which indicates the degree to which behavior communicates caring behaviors replaces the forced choice of the CARE-Q. Validity of the tool was established by a panel of four experts familiar with Watson's (1988) model. Reliability was determined only by calculating Cronbach's alpha for each subscale and are as follows:

<table>
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<tr>
<th>Subscale-Caring Behaviors</th>
<th>Cronbach's alpha</th>
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<tr>
<td>Humanism/faith-hope/sensitivity</td>
<td>0.84</td>
</tr>
<tr>
<td>Helping/trust</td>
<td>0.76</td>
</tr>
<tr>
<td>Expression of positive/negative feelings</td>
<td>0.67</td>
</tr>
<tr>
<td>Teaching/learning</td>
<td>0.90</td>
</tr>
<tr>
<td>Supportive/protective/corrective environment</td>
<td>0.79</td>
</tr>
<tr>
<td>Human needs assistance</td>
<td>0.89</td>
</tr>
<tr>
<td>Existential/phenomenological/spiritual forces</td>
<td>0.66</td>
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(Cronin & Harrison, 1988)
Cronin and Harrison (1988) studied twenty-two coronary care patients' perceptions of nurse caring behaviors. The results revealed that the nursing actions focused on the physical care and monitoring of patients were perceived by the patient as the most important. No significant differences were found on the basis of the variables of sex, age, educational level, or length of Coronary Care Unit stay.

Parsons, Kee, and Gray (1993) replicated the Cronin and Harrison (1988) study using surgical patients (n = 19). It was Parsons et al.'s intent to identify perioperative nurse caring behaviors perceived as caring by outpatient surgical patients and to determine if any of the behaviors were perceived as more important than others. The results were compared to those of Cronin and Harrison.

The two most important caring behaviors identified by the study were, "Know what they are doing" and "Be kind and considerate". The least important behaviors were identified as "Understand when I need to be alone" and "Visit me if I move to another hospital unit". Six of the twelve most important caring behaviors selected by the surgical patients were similar to the most important caring behaviors selected by the coronary care patients in the study by Cronin and Harrison (1988).
No significant difference was found in relationship to age, sex, educational, or income levels.

Parsons, Kee, and Gray (1993) modified the CBA tool after the participants were interviewed and asked to identify, in their own words, nursing behaviors that they perceived as caring. Eight items were eliminated from the CBA, and not used in the results, because it was felt that those items applied only to the patient whose hospital stay extended beyond 24 hours. No further validity or reliability of the modified CBA tool was addressed.

Huggins, Gandy, and Kohut (1993) attempted to replicate and extend the findings of the Cronin and Harrison (1988) study in the emergency room. Huggins et al. examined the different triage levels of the patients in the emergency room to determine if levels of triage categories had any effect on their perceptions of nurse caring behaviors. A modified Caring Behaviors Assessment tool was used. The tool was modified for administration on the telephone and for use with the emergency room patient. The seventh subscale, Existential/phenomenological/spiritual forces, was eliminated and some of the questions shortened in the remaining subscales. Huggins et al. conducted a pilot test among 20 participants in an attempt to gauge the success. Cronbach's alpha was done on all the remaining
six subscales and found to be consistent with the Cronin and Harrison study (1988) and the pilot study.

Huggins et al.'s study supported Cronin and Harrison's (1988) study indicating that the most important behaviors perceived by the patients were human needs and assistance. It was also found that despite the triage category of the emergency room patient, the technical nursing behaviors were the items seen as most important to experience care.

In critically looking at the studies conducted it was apparent that the studies using Larson's 1981 Q-sort method were basing the reliability of the tool on the original study (n = 12). No further reliability coefficients were calculated by the subsequent studies (Larson, 1984, 1986, 1987; Keane, Chastain & Rudisill, 1987; Mayer, 1987; Komorita, Doehring & Hirchert, 1991; Mangold, 1991; Scharf & Caley, 1993; Gooding, Sloan & Gagnon, 1993; von Essen & Sjoden, 1991a, 1991b, 1993; and Rosenthal, 1992)

Parsons, Kee, and Gray, (1993) based the reliability of the CBA used in their study on the original reliability coefficients done by Cronin and Harrison (1988). Huggins, Gandy, and Kohut (1993) conducted reliability testing of the adapted tool by use of test-retest and Cronbach's alpha. All of the studies that used the CBA conducted reliability testing on the
carative factors subscales only. No reliability coefficients were done on the entire tool. Given this data, it is impossible to ascertain whether the CBA as a whole is a reliable tool.

In summary, numerous studies have shown that the nurse and the patient do not concur on their perceptions of what caring behaviors are most important (Larson, 1981, 1984, 1986, 1987; Keane, Chastain & Rudisill, 1987; Mayer, 1987; Komorita, Doehring & Hirchert, 1991; Mangold, 1991; Scharf & Caley, 1993; Gooding, Sloan & Gagnon, 1993; von Essen & Sjoden, 1991a, 1991b, 1993; Rosenthal, 1992; Cronin & Harrison, 1988; Parsons, Kee & Gray, 1993; and Huggins, Gandy & Kohut, 1993). No studies could be found that compared the perceptions of the emergency room patient with the emergency room nurse. The purpose of this study was to compare the emergency room patients' and nurses' perceptions of caring behavior.

Conceptual Framework

Several definitions of caring are cited in the literature. Jean Watson's Theory of Caring (Watson, 1979, 1988) appears to be one of the dominant theories when studying aspects of caring in the field of nursing. Watson's theory, with her ten carative factors emphasizing nursing practice, has particular promise in linking theory to practice (Sithichoke-Rattan, 1989).
Watson's theory began as an attempt to solve some conceptual and empirical problems about nursing, what comprises nursing, and how various components of nursing relate to and direct education, practice, and research (Watson, 1988, p. x). Caring is presented as a moral ideal of nursing with concern for preservation of humanity, dignity and the fullness of self (Watson, 1988). If caring is really the "essence of nursing" then it must be demonstrated and not simply proclaimed. If caring is the "central, dominant, and unifying feature of nursing", then it must be relevant to practice and to the patient and not merely an internalized feeling on the part of the nurse (Morse, Bottorff, Neander & Solberg, 1991). Interventions related to the human care process require an intention, a will, a relationship, and an action. Watson feels that the interventions in her theory relate to the human care process with full participation of the nurse/person with the patient/person (1988). The process affirms the subjectivity of persons and leads to change for the welfare of others, but also allows the nurse to benefit and grow. Watson refers to the combinations of interventions as carative factors. Bennett, Porter and Sloan (1989) outline Watson's ten carative factors as the following:
1. FORMATION OF A HUMANISTIC-ALTRUISTIC SYSTEM OF VALUES. Humanistic and altruistic values learned early in life but can be greatly influenced by nursing educators. This factor describes satisfaction through giving and extension of the sense of self.

2. INSTILLATION OF FAITH-HOPE. This factor describes the nurse's role in promoting wellness by helping the client adopt health-seeking behaviors.

3. CULTIVATION OF SENSITIVITY TO ONE'S SELF AND OTHERS. Recognition of feelings leads to self-actualization through self-acceptance for the nurse and the client.

4. DEVELOPMENT OF A HELPING-TRUST RELATIONSHIP. A helping-trust relationship promotes and accepts the expression of positive and negative feeling. It involves congruence, empathy, nonpossessive warmth, and effective communication.

5. PROMOTION AND ACCEPTANCE OF THE EXPRESSION OF POSITIVE AND NEGATIVE FEELINGS. The sharing of feelings is a risk-taking experience for both the nurse and the client. The nurse must be prepared for negative feelings. The nurse must understand that intellectual and emotional understanding of a situation are different.
6. SYSTEMATIC USE OF THE SCIENTIFIC PROBLEM-SOLVING METHOD FOR DECISION MAKING. Use of the nursing process brings a scientific problem-solving approach to nursing care, dispelling the traditional image of nurses as the "doctor's handmaiden".

7. PROMOTION OF INTERPERSONAL TEACHING-LEARNING. This concept separates caring from curing. It allows the patient to be informed and thus shifts responsibility for wellness to the client.

8. PROVISION FOR A SUPPORTIVE, PROTECTIVE, OR CORRECTIVE MENTAL, PHYSICAL, SOCIOCULTURAL, AND SPIRITUAL ENVIRONMENT. Nursing must recognize that the client's environment includes external and internal variables.

9. ASSISTANCE WITH THE GRATIFICATION OF HUMAN NEED. The nurse recognizes the biological, psychophysical, psychosocial, and interpersonal needs of oneself and one's client. Clients must attain the lower order of needs before attaining those higher in the needs hierarchy.

10. ALLOWANCE FOR EXISTENTIAL-PHENOMENOLOGICAL FORCES. Phenomenology describes data of the immediate situation that help people understand the phenomena in question.
These carative factors combine humanistic values with a scientific knowledge base to guide nursing action. The review of literature reveals the dominance and influence of Watson's Caring Theory (1988) as the basis for the majority of instruments used to denote caring behaviors. The Caring Behaviors Assessment tool, selected for use in this study, is one instrument which is congruent with Watson's Caring Theory (1988).

**Research Questions**

The research questions for this study were:

1. What do emergency room nurses perceive as caring behaviors as measured by the Caring Behaviors Assessment tool (CBA)?

2. What do emergency room patients perceive as caring behaviors as measured by the CBA?

3. Do emergency room nurses perceive caring behaviors differently than emergency room patients?

4. Are the demographic factors of age, sex, race, marital status, use of the emergency room, facility, or insurance coverage correlated to perceived caring behaviors in the patient?

5. Are the demographic factors of age, sex, race, marital status, facility, years of experience as a nurse, years of experience as an emergency room nurse, and level of education correlated to perceived caring behaviors in the nurse?
Assumptions

The following assumptions are basic to this study:

1. Caring can be described in terms of behaviors within the realm of nursing.

2. Nurses and patients can identify nurse behaviors which denote care.

3. Respondents will answer the questionnaire truthfully.

Definitions of Terms

1. Caring - the process by which the nurse becomes responsive to another person as a unique individual, perceives the other's feelings, and sets that person apart from the ordinary (Watson, 1988).

2. Nurse caring behaviors - those things that a nurse says or does that communicate caring to the patient (Cronin & Harrison, 1988).
Chapter III

Methodology

Research Design

The purpose of this study was to identify perceived caring behaviors of the emergency room nurse as compared to the emergency room patient. The research design selected was an exploratory design with a correlation survey.

Woods and Mitchell (1988) state, "Exploratory studies provide a means for investigators to contribute to understanding about relationships between phenomena-to discover relevant connections or differences" (p. 150). Woods and Mitchell continue to state that a correlation survey, an exploratory study, is a research design that relates multiple variables within the collected data. This design allows a researcher to better identify any correlation between groups and variables of interest.

Being aware of the experiences that incorporate critique of the current health care system, and analysis of the present and future health needs of the population, serves as the basis for transforming the health care system (Tanner, 1990). Nurses must become aware of what conveys caring to patients before interventions can be
designed (Cronin & Harrison, 1988). Obtaining information from the patient group, will provide the nurse knowledge needed to plan care which will meet the needs of the patient.

When a tool based on a nursing theory is used, as is the case in this study, it would only be logical to select a research design that generates theory development. Chinn and Kramer (1995) indicate, research that generates theory is designed to discover and describe relationships between things that are observed or inferred from events without imposing preconceived notions of what phenomena mean. An exploratory study design is a theory generating design and very applicable for this study. Through the use of the Caring Behaviors Assessment tool this study has aided in the testing of Watson's Nursing Theory (1985).

Setting

The settings of this study included two hospital emergency rooms in a southwestern state. One emergency room was located in a rural hospital in the southern portion of the state and the second located in an urban hospital in the northern section of the state. Both facility emergency rooms, provide services to approximately 22,000 to 26,000 patients on a yearly basis.
Nurse and patient participants represented both urban and rural facilities with 30 patients and 30 nurses from each facility.

**Sampling**

The sampling consisted of adult emergency room patients \((n = 60)\) and Registered Nurses \((n = 60)\) presently working as direct care givers in an emergency room. All participants were invited to participate in the study on a voluntary basis. The selection of the patient participants were done by using convenience sampling. This was accomplished by assessing every patient that presented to the emergency room on selected days. Every eligible patient was given the opportunity to participate. Patients meeting the inclusive criteria were asked to participate either during a waiting period prior to or waiting for results of tests ie. x-rays, lab results or just prior to discharge from the emergency room.

The following inclusion criteria were used for the patient participants: (1) an individual 18 years of age or older being treated in the emergency room; (2) patients who did not present to the emergency room for treatment of a mental disorder or for a trauma severe enough to inhibit communication and; (3) all eligible patient participants were able to speak, write, and understand English.
The following inclusion criteria were used to select the nurse participants: (1) currently employed Registered Nurses in the emergency room of the selected hospitals. This study compared emergency room nurses as a group to emergency room patients as a group. No attempt was made to directly match nurse to patient for any comparisons. The nurse group responses on the tool were compared to the patient group responses.

**Human Subject Rights**

Prior to participation in this study, all individuals were informed of the purpose and procedure of the study. All participants were made aware that this study contained no known risks. Each subject was given the opportunity to ask questions or clarify any misunderstandings concerning participation prior to doing so. It was made clear to the participants that participation was voluntary and that they would not suffer any negative consequences for not participating. Subjects were also advised that they were free to withdraw from the study at any time. Care in the emergency room was the same regardless of participation.

Confidentiality of the participants was maintained at all times throughout the study. Written consent forms were obtained from all participants. Approval for the study was obtained from the Human Subject Rights Committee at the University of Nevada, Las Vegas and
both of the facilities used in the study prior to data collection. The completed data sheet and consent forms were kept in a locked file cabinet to which only the investigator had access.

Data Collection

Once the investigator validated that subjects met the inclusion criteria, those subjects were approached by the investigator and the study was explained. Individuals interested in participating were asked to sign the consent form, then the demographic data sheet and the CBA tool were left for them to complete. The patients were given the research materials by the investigator at a time when they were either waiting for tests, the results of tests or waiting to be discharged from the emergency room. The study took approximately 15 minutes for the participants to complete. All patient participants returned the completed material to the investigator prior to leaving the emergency room.

Working through the nurse managers of the two hospitals, the research materials were introduced during a staff meeting at the work places of the Registered Nurses. This approach was used in an attempt to contact a concentrated number of emergency room nurses at one time. Nurses not contacted in the staff meeting were given an opportunity to participate while on duty in the emergency room. All participants had the choice
to participate or not, as outlined by the Human Subject Rights Protocol. The study materials consisted of an explanation of the study and consent form, a demographic data sheet, and the Caring Behaviors Assessment tool.

Instrument

The Caring Behaviors Assessment (CBA) was developed by Cronin and Harrison in 1988, to "assess the relative contribution of identified nursing behaviors to the patient's sense of feeling cared for and cared about" (S. Cronin & B. Harrison, personal communication, March 6, 1992). Patient perceptions of nurse caring behaviors are measured by the CBA (Cronin & Harrison, 1988).

The CBA was chosen for this study because of its simplicity and ease of administration. The CBA was an established tool which had proven to be reliable by Cronin and Harrison (1988). The CBA takes a relatively short period of time to complete and was assessable to the researcher.

The Caring Behaviors Assessment is comprised of 63 nursing behaviors ordered in seven subscales that are congruent with Watson's ten carative factors. The reliability of the CBA was determined by Cronin and Harrison (1988) in their original study. In an internal consistency reliability determination, Cronbach's alpha, was calculated using sample responses for each of the
seven subscales. Reliability coefficients ranged from 0.66 to 0.90 (Cronin & Harrison, p. 377).

Face and content validity were established by the use of four content specialists familiar with Watson's conceptual model. The behavior's congruency was determined by each expert and placed in the appropriate subscale. If the interrater reliability was less than 0.75 the behaviors were recategorized into a more appropriate subscale (S. Cronin & B. Harrison, personal communication, March 6, 1992).

The Caring Behaviors Assessment tool's 63 behaviors are in seven subscales. Those subscales are representative of Watson's ten carative factors and correspond in the following manner:

<table>
<thead>
<tr>
<th>Subscale-Caring Behaviors</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanism/Faith-hope/Sensitivity</td>
<td>1-16</td>
</tr>
<tr>
<td>Helping/Trust</td>
<td>17-27</td>
</tr>
<tr>
<td>Expression of positive/negative feelings</td>
<td>28-31</td>
</tr>
<tr>
<td>Teaching/Learning</td>
<td>32-39</td>
</tr>
<tr>
<td>Supportive/Protective/Corrective environment</td>
<td>40-51</td>
</tr>
<tr>
<td>Human needs assistance</td>
<td>52-60</td>
</tr>
<tr>
<td>Existential/phenomenological/spiritual forces</td>
<td>61-63</td>
</tr>
</tbody>
</table>

(S. Cronin & B. Harrison, personal communication, March 6, 1992)

A five-point Likert-type scale is used in the Caring Behavior Assessment. Each subject is asked to indicate
to what degree each behavior communicates caring to them. The five on the scale indicates much importance and the one on the scale indicates little importance. The wording of the tool is at a sixth grade level, which the reading specialist determined to be the most readable as well as understandable by the lay person (Cronin & Harrison, p. 377).

Data Analysis

The responses from the Caring Behavior Assessment tool were converted to a numeric scale. The nurse subjects were analyzed as a group and compared to the patient subjects as a group. No attempt was made to directly match individual nurses to individual patients for any comparisons. Means were calculated on the total sample of the nurses (n = 60) and the patients (n = 60) regardless of the facility where data were collected. The scores were then ranked according to the means to determine what each group perceived as important. The mean scores and rankings of the mean scores were then compared.

A t-test was completed to assess the magnitude and the significance of the difference between nurses' and patients' perceptions of caring. The t-test was selected because of its ability to assess differences between groups, specifically evaluating the difference between two means (Jackson, 1988, p. 358). Similarities between
the nurse and patient subject groups included mean score comparisons by item (Caring Behaviors Assessment) and subscales. A significant level of .05 was utilized.

The statistical analysis addressed demographics of each group using a correlation design. The demographic variables; age, sex, race, use of emergency room, facility, and insurance coverage were correlated to the CBA responses of the patients. The demographic variables; age, sex, race, facility, education level, experience as a nurse, and experience as an emergency room nurse were correlated to the CBA responses of the nurses.

The reliability of the CBA tool as well as the seven CBA subscales was assessed by calculating Cronbach's alpha coefficients.
Chapter IV

Results

This chapter consists of the statistical results of the data collected using the Caring Behaviors Assessment tool (CBA) and the demographics. Included in this chapter are the responses from both the nurses and the patients and the comparisons of the groups. A report of the correlation of the demographic data and the CBA is also presented.

The nurse population (n = 60) ranged in age from 18 to 59 years. Five percent (n = 3) of the nurse respondents ranged in age from 18 to 29, 50% (n = 30) ranged in age from 30 to 39, 38.3% (n = 23) ranged in age from 40 to 49 and 4% (n = 4) ranged in the age from 50 to 59. The mean age range for the nurse respondents was 30 to 39 years (see Table 1).

The patient population (n = 60) age range mean was 18 to 29 years of age. Thirty-five percent (n = 21) of the patient population ranged in age from 18 to 29, 11.7% (n = 7) ranged in age from 30 to 39, 15% (n = 9) ranged in age from 40 to 49, 13.3% (n = 8) ranged in age from 50 to 59, 11.7% (n = 7) ranged in age from
Table 1

Demographic data summarizing age for nurse and patient groups

<table>
<thead>
<tr>
<th>Years</th>
<th>Patient (n = 60)</th>
<th>Nurse (n = 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>18-29</td>
<td>21</td>
<td>35</td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>40-49</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>50-59</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>60-69</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>70-79</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>80+</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
60 to 69, 8.3% (n = 5) ranged in age from 70 to 79 and 5% (n = 3) ranged in age of 80 and above (see Table 1).

Of the nurse respondents (n = 60), 83.3% (n = 50) were female while 16.7% (n = 10) were male. Of the patient respondents (n = 60), 56.7% (n = 34) were males and 43.3% (n = 26) were female (see Table 2).

The nurse population demonstrated that 98.3% (n = 50) were Caucasian with the remaining 1.7% (n = 1) classifying themselves as other. The patient population (n = 60) demonstrated that 88.3% (n = 53) were Caucasian, 3.3% (n = 2) were Hispanic, 6.7% (n = 4) were Native American and 1.7% (n = 1) were Asian (see Table 3).

Of the nurse respondents, 5% (n = 3) were single, 80% (n = 48) were married, 13.3% (n = 8) were divorced, and 1.7% (n = 1) were widowed. None of the nurse respondents indicated separated as a choice (see Table 4).

Of the patient respondents, 33.3% (n = 20) were single, 51.7% (n = 31) were married, 10% (n = 6) were divorced and 5% (n = 3) were widowed. None of the patients were separated (see Table 4).

With respect to insurance coverage, 65% (n = 39) of the patient population had private insurance, 18.3% (n = 11) had Medicare, 5% (n = 3) had Medicaid and 11.7% (n = 7) carried none. Many of the patients on Medicare
Table 2
Demographic data summarizing gender for nurse and patient groups

<table>
<thead>
<tr>
<th>Sex</th>
<th>n</th>
<th>%</th>
<th>Sex</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>34</td>
<td>56.7</td>
<td>Male</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>43.3</td>
<td>Female</td>
<td>50</td>
<td>83.3</td>
</tr>
</tbody>
</table>
Table 3

Demographic data summarizing race for both nurse and patient groups

<table>
<thead>
<tr>
<th>Race</th>
<th>Patient</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>53</td>
<td>88.3</td>
</tr>
<tr>
<td>African-American</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Native American</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 4

Demographic data summarized for marital status of nurse and patient groups

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Patient n</th>
<th>Patient %</th>
<th>Nurse n</th>
<th>Nurse %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>20</td>
<td>33.3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Married</td>
<td>31</td>
<td>51.7</td>
<td>48</td>
<td>80</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1.7</td>
</tr>
</tbody>
</table>
also had supplemental private insurance but for this study they were classified as Medicare (see Table 5).

When asked about how often the patient respondents used the emergency room, 1.7% (n = 1) used the emergency room weekly, 1.7% (n = 1) used the emergency room on a monthly basis, 5% (n = 3) used the emergency room 6 to 11 times per year, 5% (n = 3) used the emergency room 3 to 6 times yearly, 10% (n = 6) twice a year, 15% (n = 9) used the emergency room yearly, 3.3% (n = 2) used it every other year, 33.3% (n = 20) use the emergency room less than every other year, and 25% (n = 15) were first time users (see Table 5).

The nurse respondents were the only group asked to indicate educational levels. Thirty-three point three percent (n = 20) of the nurses had an Associate Degree of Nursing, 6.7% (n = 4) had a diploma in nursing, 55% (n = 33) had a Bachelor of Science in Nursing and 5% (n = 3) had a Masters Degree in Nursing (see Table 6).

The nurse respondents were asked the length of their experience in nursing. Of the nurse respondents 3.3% (n = 2) had up to one year of experience in nursing, 8.3% (n = 5) had 2 to 5 years experience, 18.3% (n = 11) had 6 to 10 years of experience, 26.7% (n = 16) had 11 to 15 years of experience, 30% (n = 18) had 16 to 20 years of experience, and 13.3% (n = 10) had 21 years or more experience in nursing. The mean
Table 5
Demographic data summary of patient insurance coverage and use of the emergency room (n = 60)

<table>
<thead>
<tr>
<th>Insurance</th>
<th>n</th>
<th>%</th>
<th>Use</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>private</td>
<td>39</td>
<td>65</td>
<td>weekly</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Medicare</td>
<td>11</td>
<td>18.3</td>
<td>monthly</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Medicaid</td>
<td>3</td>
<td>5</td>
<td>6-11 x yr</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>none</td>
<td>7</td>
<td>11.7</td>
<td>3-6 x yr</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 x yr</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 x yr</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>bi-yearly</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt; bi-yearly</td>
<td>20</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>first time</td>
<td>15</td>
<td>25</td>
</tr>
</tbody>
</table>
Table 6
Demographic data summarizing nursing degree, experience
in nursing and experience in the emergency room (n = 60)

<table>
<thead>
<tr>
<th>Degree</th>
<th>n</th>
<th>%</th>
<th>Exp.</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADN*</td>
<td>20</td>
<td>33.3</td>
<td>0-1</td>
<td>2</td>
<td>3.3</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Diploma</td>
<td>4</td>
<td>6.7</td>
<td>2-5</td>
<td>5</td>
<td>8.3</td>
<td>14</td>
<td>23.3</td>
</tr>
<tr>
<td>BSN**</td>
<td>33</td>
<td>55</td>
<td>6-10</td>
<td>11</td>
<td>18.3</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>MSN***</td>
<td>3</td>
<td>5</td>
<td>11-15</td>
<td>16</td>
<td>26.7</td>
<td>16</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>16-20</td>
<td>18</td>
<td>30</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21+</td>
<td>8</td>
<td>13.3</td>
<td>1</td>
<td>1.7</td>
</tr>
</tbody>
</table>

ADN = Associate Degree in Nursing
BSN = Bachelor of Science in Nursing
MSN = Master of Science in Nursing
range was 11 to 15 years of nursing experience (see Table 6).

When asked about years of experience working in the emergency room, the nurse respondents indicated that 8.3% ($n = 5$) had up to one year of experience, 23.3% ($n = 14$) had 2 to 5 years of experience, 30% ($n = 18$) had 6 to 10 years of experience, 26.7% ($n = 16$) had 11 to 15 years of experience, 10% ($n = 6$) had 16 to 20 years of experience, and 1.7% ($n = 1$) had 21 plus years of experience working in the emergency room. The mean range for years of experience working in the emergency room was 6 to 10 years (see Table 6).

A correlation analysis was done to determine if any correlation existed between the demographic data and the responses of the respondents to the CBA. Correlation coefficients were done on each of the sixty-three items of the CBA and the carative factors subscales in relationship to the demographic data (see Table 7).

The correlation between the carative factors subscale and the demographic data revealed eleven correlations with $p = .05$. There were an additional two correlations just larger than the significance level .05. Subscale one, "Humanism/Faith-Hope/Sensitivity", revealed two areas of correlation. Gender had a $p$ value of .015 and Experience in Nursing a $p$ value of .004.
Table 7

Summary of significant correlation results of demographic data and carative factors subscales

<table>
<thead>
<tr>
<th>Subscale 1</th>
<th>Age</th>
<th>Gender</th>
<th>Facility</th>
<th>Nursing Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscale 2</td>
<td>0.024</td>
<td>0.043</td>
<td>0.064</td>
<td>0.026</td>
</tr>
<tr>
<td>Subscale 3</td>
<td>0.010</td>
<td>-</td>
<td>-</td>
<td>0.007</td>
</tr>
<tr>
<td>Subscale 4</td>
<td>0.029</td>
<td>-</td>
<td>-</td>
<td>0.058</td>
</tr>
<tr>
<td>Subscale 5</td>
<td>-</td>
<td>-</td>
<td>0.032</td>
<td>0.048</td>
</tr>
<tr>
<td>Subscale 6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Subscale 7</td>
<td>0.017</td>
<td>-</td>
<td>-</td>
<td>0.059</td>
</tr>
</tbody>
</table>

p = 0.05
Both of these values are much more significant with values far less than the chosen .05 level.

Subscale two, "Helping/Trust", indicated three areas of correlation. Age had a $p = .024$, Gender a $p = .043$ and Nursing experience a $p = .026$.

Subscale three, "Expression of positive/negative feelings" indicated two areas of high correlation. Age had a $p = .010$ and Nursing experience a $p = .007$. No other areas were noted to be close to the chosen significance level of $p = .05$.

Subscale four, "Teaching/Learning" indicated one correlation within the chosen significance of $p = .05$ and one area just slightly larger than the significance level. Age had a $p = .029$ and Nursing experience had a $p$ value of .058.

Two of the demographic variables correlated with the CBA in the fifth subscale, "Supportive/Protective/Corrective environment". Facility had a $p$ value of .032 and Nursing experience had a $p$ value of .048. No other areas were close to the significance level.

There were no correlations of a significant level between the demographic data and the CBA in subscale six, "Human needs assistance". Subscale seven "Existential/phenomenological/spiritual forces", had one area of correlation and one slightly higher than
the significant level. Age had a p value of .017, and Nursing experience had a p value of .059.

To determine if any significant differences were found between the responses to the CBA given by the nurses working in the rural facility (n = 30) and those working in the urban facilities (n = 30), t-tests were done comparing the mean scores. The t-test results indicated sixteen items with significant differences at the .05 level (see Table 8).

Those items with significant mean differences have been placed in their carative factors subscales for reporting purposes. Item 6, "Encourage me to believe in myself", had a two tailed significance of .005 with the mean difference of .633. Item 12, "Be sensitive to my feelings and moods" had a significance of .015 with a mean difference of .566. Item 13, "Be kind and considerate" had a two-tailed significance of .015 with a mean difference of .333. The above three items are included in the first subscale "Humanism/Faith-Hope/Sensitivity".

Item 25, "Visit me if I move to another hospital unit", had a two-tailed significance of .003 with a mean difference of .633. Item 26, "Touch me when I need it for comfort", had a significance level of .043 with a mean difference of .400. Item 19, "Come into my room just to check on me", had a significance level of
Table 8

Significant mean differences of responses between urban and rural facilities

<table>
<thead>
<tr>
<th>Subscale 1</th>
<th>Rural</th>
<th>Urban</th>
<th>MD*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage me to believe in myself</td>
<td>3.53</td>
<td>2.90</td>
<td>.633</td>
<td>.005</td>
</tr>
<tr>
<td>Be sensitive to my feeling and moods</td>
<td>4.10</td>
<td>3.53</td>
<td>.566</td>
<td>.015</td>
</tr>
<tr>
<td>Be kind and considerate</td>
<td>4.66</td>
<td>4.33</td>
<td>.333</td>
<td>.015</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale 2</th>
<th>Rural</th>
<th>Urban</th>
<th>MD*</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Come into my room just to check on me</td>
<td>4.26</td>
<td>3.93</td>
<td>.333</td>
<td>.057</td>
</tr>
<tr>
<td>Visit me if I move to another hospital unit</td>
<td>2.30</td>
<td>1.66</td>
<td>.633</td>
<td>.003</td>
</tr>
<tr>
<td>Touch me when I need it for comfort</td>
<td>3.46</td>
<td>3.26</td>
<td>.400</td>
<td>.043</td>
</tr>
</tbody>
</table>

(table continued)
Table 8

<table>
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<tr>
<th>Subscale 3</th>
<th>Rural</th>
<th>Urban</th>
<th>MD*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't give up on me when I'm difficult to get along with</td>
<td>3.80</td>
<td>3.36</td>
<td>.433</td>
<td>.015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale 5</th>
<th>Rural</th>
<th>Urban</th>
<th>MD*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand when I need to be alone</td>
<td>3.60</td>
<td>3.10</td>
<td>.500</td>
<td>.026</td>
</tr>
<tr>
<td>Check with me before leaving the room</td>
<td>4.06</td>
<td>3.53</td>
<td>.533</td>
<td>.007</td>
</tr>
<tr>
<td>Consider my spiritual needs</td>
<td>3.76</td>
<td>2.90</td>
<td>.866</td>
<td>.000</td>
</tr>
<tr>
<td>Are gentle with me</td>
<td>4.16</td>
<td>3.70</td>
<td>.466</td>
<td>.012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale 6</th>
<th>Rural</th>
<th>Urban</th>
<th>MD*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help me with my care until I'm able</td>
<td>3.93</td>
<td>3.53</td>
<td>.400</td>
<td>.039</td>
</tr>
<tr>
<td>Keep my family informed</td>
<td>4.20</td>
<td>3.80</td>
<td>.400</td>
<td>.046</td>
</tr>
<tr>
<td>Let my family visit as much as possible</td>
<td>3.90</td>
<td>3.36</td>
<td>.533</td>
<td>.021</td>
</tr>
</tbody>
</table>

*(table continued)*
Table 8

<table>
<thead>
<tr>
<th>Subscale 7</th>
<th>Rural M</th>
<th>Rural M</th>
<th>MD*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seem to know how I feel</td>
<td>3.90</td>
<td>3.30</td>
<td>.600</td>
<td>.001</td>
</tr>
<tr>
<td>Help me see that my past experiences important</td>
<td>3.40</td>
<td>2.80</td>
<td>.633</td>
<td>.005</td>
</tr>
<tr>
<td>Help me feel good about myself</td>
<td>3.76</td>
<td>3.13</td>
<td>.633</td>
<td>.006</td>
</tr>
</tbody>
</table>

* MD = mean difference

P = .05
\[ p = 0.057, \] which is just above the chosen significant value. The second subscale of "Helping/Trust" includes the above three items.

The third carative factors subscale, "Expression of positive/negative feelings", includes the following item. Item 31, "Don't give up on me when I'm difficult to get along with", had a significance of .015 with a mean difference of .433.

The next four items are included in the fifth subscale "Supportive/Protective/Corrective environment". Item 41, "Understand when I need to be alone", had a two-tailed significance of .026 with a mean difference of .500. Item 48, "Check with me before leaving the room to be sure I have everything I need within reach", had a two-tailed significance of .007 with a mean difference of .533. Item 49, "Consider my spiritual needs", had a significance of .000 with a mean difference of .866. Item 50, "Are gentle with me", had a significance of .012 with a mean difference of .466.

Item 52, "Help me with my care until I'm able to do it for myself", had a two-tailed significance of .039 with a mean difference of .400. Item 56, "Keep my family informed of my progress", had a significance of .046 with a mean difference of .400. Item 57, "Let my family visit as much as possible", had a two-tailed significance
of .021 with a mean difference of .533. Subscale 6, "Human needs assistance", included these items.

Item 61, "Seem to know how I feel", had a significance of .001 with a mean difference of .600. Item 62, "Help me see that my past experiences are important", had a significance of .005 with a mean difference of .633. Item 63, "Help me feel good about myself", had a significance of .006 with a mean difference of .633. These three items represent all the items contained in the seventh subscale, "Existential/phenomenological/spiritual forces".

The significance of the mean differences were identified when t-tests were conducted on the responses of the patients seen in the rural facility (n = 30) and the patients seen in the urban facility (n = 30). The only item with a two-tailed significance of .05 was item 38, "Help me plan ways to meet these goals", with a significance of .028 and a mean difference of .666. Item 38 is included in the fourth carative factors subscale, "Teaching/Learning".

To determine what were perceived as important caring behaviors, a mean was calculated for each response to the CBA tool for each of the two groups of respondents, the emergency room nurses (n = 60) and emergency room patients (n = 60). The possible responses of the CBA were 1 = least important, 2 = not very important,
3 = somewhat important, 4 = important and 5 = most important. Table 9 presents the calculated mean value for each response of the CBA for each of the two groups.

For the nurse respondents, the mean range was 1.98 to 4.58 with the accumulative mean score of 3.79 (standard deviation, .739). The mean range for the patient respondents was 2.26 to 4.85 with an accumulative mean score of 3.84 (standard deviation, .928).

According to the calculated mean value for each of the items the ten highest responses and the ten lowest or least important responses were determined for each group. Those responses were then compared. Tables 10 and 11 present the top ten responses of each group. Tables 12 and 13 present the ten least important responses of each group.

The carative factor subscales were then ranked by calculating the means for each of the subscales. Table 14 presents the ranking of the carative factors subscales according to the mean of each subscale. Both groups ranked the subscales in an identical order.

A t-test was done to test if there were any significant differences in the mean scores, of the individual items of the CBA, by comparing the nurse group and the patient group responses. There were 12 items on the CBA tool that showed a significance level of .05.
Table 9

Mean scores for nurse and patient response to the Caring Behaviors Assessment tool*

<table>
<thead>
<tr>
<th>Item</th>
<th>Nurse</th>
<th>Patient</th>
<th>Item</th>
<th>Nurse</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.33</td>
<td>4.40</td>
<td>20</td>
<td>2.63</td>
<td>2.38</td>
</tr>
<tr>
<td>2</td>
<td>4.08</td>
<td>4.05</td>
<td>21</td>
<td>3.25</td>
<td>2.95</td>
</tr>
<tr>
<td>3</td>
<td>4.48</td>
<td>4.85</td>
<td>22</td>
<td>3.78</td>
<td>3.63</td>
</tr>
<tr>
<td>4</td>
<td>4.21</td>
<td>4.03</td>
<td>23</td>
<td>3.90</td>
<td>4.05</td>
</tr>
<tr>
<td>5</td>
<td>4.25</td>
<td>4.13</td>
<td>24</td>
<td>4.21</td>
<td>4.15</td>
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<tr>
<td>6</td>
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<td>3.33</td>
<td>25</td>
<td>1.98</td>
<td>2.26</td>
</tr>
<tr>
<td>7</td>
<td>3.41</td>
<td>3.73</td>
<td>26</td>
<td>3.46</td>
<td>2.91</td>
</tr>
<tr>
<td>8</td>
<td>3.45</td>
<td>3.40</td>
<td>27</td>
<td>4.28</td>
<td>4.30</td>
</tr>
<tr>
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<td>3.91</td>
<td>3.73</td>
<td>28</td>
<td>3.46</td>
<td>3.26</td>
</tr>
<tr>
<td>10</td>
<td>3.56</td>
<td>3.65</td>
<td>29</td>
<td>3.70</td>
<td>3.65</td>
</tr>
<tr>
<td>11</td>
<td>3.95</td>
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<td>30</td>
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</tr>
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<td>3.81</td>
<td>31</td>
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<tr>
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<tr>
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<td>3.85</td>
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<td>4.31</td>
<td>4.50</td>
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<tr>
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<td>36</td>
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<td>4.00</td>
</tr>
<tr>
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<td>4.13</td>
<td>3.83</td>
<td>37</td>
<td>3.35</td>
<td>3.53</td>
</tr>
<tr>
<td>19</td>
<td>4.10</td>
<td>3.81</td>
<td>38</td>
<td>3.21</td>
<td>3.40</td>
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</tbody>
</table>

(table continues)
Table 9

<table>
<thead>
<tr>
<th>Item</th>
<th>Nurse</th>
<th>Patient</th>
<th>Item</th>
<th>Nurse</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>3.26</td>
<td>3.53</td>
<td>52</td>
<td>3.73</td>
<td>4.00</td>
</tr>
<tr>
<td>40</td>
<td>3.16</td>
<td>3.80</td>
<td>53</td>
<td>4.58</td>
<td>4.70</td>
</tr>
<tr>
<td>41</td>
<td>3.35</td>
<td>3.70</td>
<td>54</td>
<td>4.46</td>
<td>4.70</td>
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<tr>
<td>42</td>
<td>3.76</td>
<td>3.81</td>
<td>55</td>
<td>4.26</td>
<td>4.55</td>
</tr>
<tr>
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<td>3.26</td>
<td>3.33</td>
<td>56</td>
<td>4.00</td>
<td>4.20</td>
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<td>44</td>
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<td>57</td>
<td>3.63</td>
<td>4.01</td>
</tr>
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<td>4.33</td>
<td>4.31</td>
<td>58</td>
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<td>4.41</td>
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<td>3.75</td>
<td>4.15</td>
<td>59</td>
<td>3.95</td>
<td>4.03</td>
</tr>
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<td>60</td>
<td>4.45</td>
<td>4.70</td>
</tr>
<tr>
<td>48</td>
<td>3.80</td>
<td>3.93</td>
<td>61</td>
<td>3.60</td>
<td>3.70</td>
</tr>
<tr>
<td>49</td>
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<td>62</td>
<td>3.11</td>
<td>3.05</td>
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<tr>
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<td>3.93</td>
<td>4.01</td>
<td>63</td>
<td>3.45</td>
<td>3.36</td>
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<tr>
<td>51</td>
<td>3.91</td>
<td>4.00</td>
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</tbody>
</table>

*Range 1 = most important  2 = important
   3 = somewhat important  4 = least important
   5 = not very important
Table 10

Ranking of patients' perceived most important caring behaviors

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>*3</td>
<td>Know what they're doing</td>
<td>4.85</td>
<td>.577</td>
</tr>
<tr>
<td>*53</td>
<td>Know how to give shots, IV's, etc.</td>
<td>4.70</td>
<td>.591</td>
</tr>
<tr>
<td>*54</td>
<td>Know how to handle equipment</td>
<td>4.70</td>
<td>.561</td>
</tr>
<tr>
<td>*60</td>
<td>Know when it's necessary to call the doctor</td>
<td>4.70</td>
<td>.462</td>
</tr>
<tr>
<td>55</td>
<td>Give my treatments and medications on time</td>
<td>4.55</td>
<td>.622</td>
</tr>
<tr>
<td>*33</td>
<td>Answer my questions clearly</td>
<td>4.50</td>
<td>.597</td>
</tr>
<tr>
<td>58</td>
<td>Check my condition very closely</td>
<td>4.41</td>
<td>.645</td>
</tr>
<tr>
<td>*1</td>
<td>Treat me as an individual</td>
<td>4.40</td>
<td>.616</td>
</tr>
<tr>
<td>*45</td>
<td>Give my pain medication when I need it</td>
<td>4.31</td>
<td>.676</td>
</tr>
<tr>
<td>*13</td>
<td>Be kind and considerate</td>
<td>4.31</td>
<td>.725</td>
</tr>
</tbody>
</table>

* Denotes item that was ranked in top ten positions by both groups.
<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>*53</td>
<td>Know how to give shots, IV's, etc.</td>
<td>4.58</td>
<td>.561</td>
</tr>
<tr>
<td>16</td>
<td>Treat me with respect</td>
<td>4.55</td>
<td>.534</td>
</tr>
<tr>
<td>*13</td>
<td>Be kind and considerate</td>
<td>4.50</td>
<td>.537</td>
</tr>
<tr>
<td>*3</td>
<td>Know what they're doing</td>
<td>4.48</td>
<td>.701</td>
</tr>
<tr>
<td>*54</td>
<td>Know how to handle equipment</td>
<td>4.46</td>
<td>.650</td>
</tr>
<tr>
<td>*60</td>
<td>Know when it's necessary to call the doctor</td>
<td>4.45</td>
<td>.622</td>
</tr>
<tr>
<td>17</td>
<td>Really listen to me when I talk</td>
<td>4.36</td>
<td>.802</td>
</tr>
<tr>
<td>*45</td>
<td>Give my pain medication when I need it</td>
<td>4.33</td>
<td>.629</td>
</tr>
<tr>
<td>*1</td>
<td>Treat me as an individual</td>
<td>4.33</td>
<td>.542</td>
</tr>
<tr>
<td>*33</td>
<td>Answer my questions clearly</td>
<td>4.31</td>
<td>.624</td>
</tr>
</tbody>
</table>

* Denotes item that was ranked in the top ten by both groups.
**Table 12**

*Ranking of patients' perceived least important caring behaviors*

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25</strong></td>
<td>Visit me if I move to another hospital unit</td>
<td>2.26</td>
<td>1.191</td>
</tr>
<tr>
<td><strong>20</strong></td>
<td>Talk to me about my life outside the hospital</td>
<td>2.38</td>
<td>0.958</td>
</tr>
<tr>
<td>26</td>
<td>Touch me when I need it for comfort</td>
<td>2.91</td>
<td>1.169</td>
</tr>
<tr>
<td><em>21</em></td>
<td>Ask me what I like to be called</td>
<td>2.95</td>
<td>1.111</td>
</tr>
<tr>
<td><em>62</em></td>
<td>Help me to see that my past experiences are important</td>
<td>3.05</td>
<td>1.281</td>
</tr>
<tr>
<td><em>30</em></td>
<td>Help me understand my feelings</td>
<td>3.15</td>
<td>1.132</td>
</tr>
<tr>
<td>49</td>
<td>Consider my spiritual needs</td>
<td>3.20</td>
<td>1.436</td>
</tr>
<tr>
<td>28</td>
<td>Encourage me to talk about how I feel</td>
<td>3.26</td>
<td>1.103</td>
</tr>
<tr>
<td><em>6</em></td>
<td>Encourage me to believe in myself</td>
<td>3.33</td>
<td>1.203</td>
</tr>
<tr>
<td><em>43</em></td>
<td>Leave my room neat after working with me</td>
<td>3.33</td>
<td>1.115</td>
</tr>
</tbody>
</table>

* Denotes item ranked as least important by both groups.
** Denotes item ranked in the same position by both groups.
### Table 13

Ranking of nurses' perceived least important caring behaviors

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>**25</td>
<td>Visit me if I move to another hospital unit</td>
<td>1.98</td>
<td>.854</td>
</tr>
<tr>
<td>**20</td>
<td>Talk to me about my life outside the hospital</td>
<td>2.68</td>
<td>.823</td>
</tr>
<tr>
<td>*62</td>
<td>Help me see that my past experiences are important</td>
<td>3.11</td>
<td>.885</td>
</tr>
<tr>
<td>40</td>
<td>Tell me what to expect during the day</td>
<td>3.16</td>
<td>.940</td>
</tr>
<tr>
<td>*30</td>
<td>Help me understand my feelings</td>
<td>3.18</td>
<td>.873</td>
</tr>
<tr>
<td>38</td>
<td>Help me plan ways to meet these goals</td>
<td>3.21</td>
<td>.739</td>
</tr>
<tr>
<td>*6</td>
<td>Encourage me to believe in myself</td>
<td>3.21</td>
<td>.885</td>
</tr>
<tr>
<td>*21</td>
<td>Ask me what I like to be called</td>
<td>3.25</td>
<td>.728</td>
</tr>
<tr>
<td>*43</td>
<td>Leave my room neat after working with me</td>
<td>3.26</td>
<td>.778</td>
</tr>
<tr>
<td>37</td>
<td>Help me set realistic goals for my health</td>
<td>3.35</td>
<td>.732</td>
</tr>
<tr>
<td>41</td>
<td>Understand when I need to be alone</td>
<td>3.35</td>
<td>.880</td>
</tr>
</tbody>
</table>

*Denotes item ranked least important by both groups.*

**Denotes item ranked in the same position by both groups.*
Table 14

Rankings of subscales by nurse and patient groups

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Nurse</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human needs assistance</td>
<td>4.19</td>
<td>4.41</td>
</tr>
<tr>
<td>Humanism/Faith-hope/Sensitivity</td>
<td>3.99</td>
<td>3.97</td>
</tr>
<tr>
<td>Supportive/Protective/Corrective enviroment</td>
<td>3.70</td>
<td>3.86</td>
</tr>
<tr>
<td>Teaching/Learning</td>
<td>3.69</td>
<td>3.84</td>
</tr>
<tr>
<td>Helping/Trust</td>
<td>3.64</td>
<td>3.51</td>
</tr>
<tr>
<td>Expression of positive/negative feelings</td>
<td>3.48</td>
<td>3.44</td>
</tr>
<tr>
<td>Existential/phenomenological/spiritual forces</td>
<td>3.37</td>
<td>3.37</td>
</tr>
</tbody>
</table>
The twelve items with significant difference have been placed in their carative factors subscales for reporting (see Table 15). The first subscale, "Humanism/Faith-hope/Sensitivity", contained five items with a significant level of .05. Item 3, "Know what they're doing", had a significance level of .001 with a mean difference of .400. Item 7, "Point out positive things about me and my condition", had a two-tailed significance of .022 with a mean difference of .466. Item 9, "Understand me", had a significance of .059 with a mean difference of .433. Item 13, "Be kind and considerate", had a significance level of .038 with a mean difference of .333. Item 16, "Treat me with respect", had a significance level of .020 with a mean difference of .400.

There were three items in the second subscale, "Helping/Trust", that had two-tailed significance levels of .05. Item 18, "Accept my feeling without judging them", had a significance of .032 with a mean difference of .433. Item 19, "Come into my room just to check on me", had a significance of .032 with a mean difference of .433. Item 25, "Visit me if I move to another hospital unit", had a significance level of .006 with a mean difference of .733.

The fourth subscale, "Teaching/Learning", contained two items with a significant level. Item 36, with a
Table 15

Significant mean differences of Caring Behaviors Assessment responses by nurse and patient groups

<table>
<thead>
<tr>
<th>Subscale 1</th>
<th>Nurse M</th>
<th>Patient M</th>
<th>MD*</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know what they're doing</td>
<td>4.56</td>
<td>4.96</td>
<td>.400</td>
<td>.001</td>
</tr>
<tr>
<td>Point out positive things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>about me and my condition</td>
<td>3.43</td>
<td>3.90</td>
<td>.466</td>
<td>.022</td>
</tr>
<tr>
<td>Understand me</td>
<td>4.03</td>
<td>3.60</td>
<td>.433</td>
<td>.059</td>
</tr>
<tr>
<td>Be kind and considerate</td>
<td>4.66</td>
<td>4.33</td>
<td>.333</td>
<td>.038</td>
</tr>
<tr>
<td>Treat me with respect</td>
<td>4.63</td>
<td>4.23</td>
<td>.400</td>
<td>.020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale 2</th>
<th>Nurse M</th>
<th>Patient M</th>
<th>MD*</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accept my feeling without</td>
<td>4.26</td>
<td>3.83</td>
<td>.433</td>
<td>.032</td>
</tr>
<tr>
<td>judging them</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Come into my room just to</td>
<td>4.26</td>
<td>3.83</td>
<td>.433</td>
<td>.032</td>
</tr>
<tr>
<td>check on me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touch me when I need it</td>
<td>3.66</td>
<td>2.93</td>
<td>.733</td>
<td>.006</td>
</tr>
<tr>
<td>for comfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(table continued)
Table 15

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Patient</th>
<th>MD*</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subscale 4

- Ask me what I want to know about my health/illness: 3.56, 4.03, .466, .026
- Help me plan ways to meet these goals: 3.23, 3.73, .500, .025

Subscale 5

- Encourage me to do for things for myself: 3.80, 4.30, .466, .010

Subscale 7

- Help me see that my past experiences are important: 3.43, 2.83, .600, .028

p = .05
significance of .026 and a mean difference of .466 and item 38 had a significance of .025 with a mean difference of .50.

The fifth subscale, "Supportive/Protective/Corrective environment", had one item; item 46, with a significance of .010 and a mean difference of .466. The seventh subscale, "Existential/phenomenological/spiritual forces", also had only one item with a significance level of .05. Item 62 had a level of .028 with a mean difference of .60.

A reliability analysis was done on the CBA tool and Cronbach's alpha was calculated for the tool as a whole and each of the seven subscale. The Cronbach's alpha coefficient for the CBA tool was .96. The Cronbach's alpha coefficients for the subscales ranged from .78 to .88. The Cronbach's alpha reliability coefficients for the seven subscales are presented in Table 16.
<table>
<thead>
<tr>
<th>Subscales</th>
<th>alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanism/Faith-hope/Sensitivity</td>
<td>.86</td>
</tr>
<tr>
<td>Helping/Trust</td>
<td>.83</td>
</tr>
<tr>
<td>Expression of positive/negative feelings</td>
<td>.80</td>
</tr>
<tr>
<td>Teaching/Learning</td>
<td>.79</td>
</tr>
<tr>
<td>Supportive/Protective/Corrective enviroment</td>
<td>.88</td>
</tr>
<tr>
<td>Human needs assistance</td>
<td>.82</td>
</tr>
<tr>
<td>Eistential/phenomenological/spiritual forces</td>
<td>.78</td>
</tr>
</tbody>
</table>
Summary

The purpose of the study was to determine what emergency room nurses perceive as caring behaviors of the nurse as compared to what the emergency room patient perceives as caring behaviors of the nurse. The study also examined if those perceptions were influenced by certain demographic variables.

The settings for this study were two hospital emergency rooms from a rural and an urban area of a southwestern state. The subjects included 30 patients and 30 nurses from each facility.

By use of convenience sampling, patients presenting to the emergency rooms were asked to participate in the study. Patients who were less than 18 years of age, unable to read, speak or understand English, presented to the emergency room for treatment of a mental disorder or treatment of severe trauma were not included. All the registered nurses on staff of the participating facilities' emergency rooms were asked to participate.

Data analysis consisted of ascertaining the mean of the responses from the two groups, nurses and
patients. To compare the means of each group t-tests were done to determine any significant differences in the groups' responses. Correlation studies were done to determine if any significant correlation existed between the responses to the questionnaire (CBA) and the demographic variables.

**Discussion and Conclusions**

The first research question asked, "What do emergency room nurses perceive as caring behaviors as measured by the Caring Behaviors Assessment tool?"

Technical behaviors were ranked high by the nurses in the emergency room interspersed with helping, trusting caring behaviors. The nurses' top responses were "Know how to give shots, IV's, etc."; "Treat me with respect"; "Be kind and considerate", and "Know what they're doing". This supports the findings of the study done by Keane, Chastain, and Rudisill (1987) in which both the rehabilitation nurses and patients concurred that the most important caring behaviors were "knows when to call the Doctor" and "monitors and follows through". The nurses indicated that the least important caring behaviors were "Visit me if I move to another hospital unit" and "Talk to me about my life outside the hospital".

Many different factors may have influenced the ranking of technical caring behaviors by the nurse in the emergency room. The emergency room nurse responses
tended to indicate the nature of their job setting. Unlike the units of an inpatient setting, the staff in the emergency rooms studied treat 50 to 150 patients in a 24 hour period. To expect the same amount of care in a hour stay in the emergency room that an inpatient receives in 24 to 48 hours or more, would be unrealistic due to the time restraints placed on the nurse. Many of the helping and supportive cares are adapted to the pace of the unit and the entire emergency room environment, which is significantly different from an inpatient unit. The nurse prioritizes the care which is given to fit the situation. The purpose of an emergency room is to facilitate quick and efficient medical care and expedite the patient's discharge from the emergency room or facilitate admission to the hospital. Emergency room nurses have learned that prioritizing caring behaviors does not indicate that those behaviors which are less important should be ignored, only adapted to the situation. With limited time available, the most important cares take priority (technical skills) and the others follow, as time permits. This prioritizing by the nurse may have contributed to the way in which these nurses ranked the caring behaviors.

The nurses' rankings also reflect the trusting and helping aspects of nursing care. These behaviors may
indicate their background experience and their nursing education. The physical care (technical skills) of the patient and behaviors which convey caring have generally been separated by the educational system. The physical aspects of care (technical behaviors) have been emphasized as inherently basic to all nurses and not taught as an indicator of caring. In terms of caring, nursing educational systems place emphasis on the trusting, helping aspects of care. This emphasis may account for the importance placed on the trusting, helping caring behaviors by the nurse. Several comments from the nurse respondents such as "knowing how to start IVs and handle equipment is what we do, not how we care about the patient", may indicate that physical cares are not perceived as something that conveys caring. This may account for the way in which the nurses ranked the caring behaviors.

In reviewing the literature no study was identified which used the Caring Behaviors Assessment questionnaire with nurses. Thus, the results of this study can only be compared to other studies using different tools, means, and involving nurse populations. However the results of this research are similar to other studies which found that nurses rank helping and trusting behaviors as important caring behaviors (Larson, 1981, 1984, 1986, 1987; Mayer, 1987; Komorita, Doehring &

In ranking "Visit me if I move to another hospital unit", and "Talk to me about my life outside the hospital", as least important caring behaviors may be a result of the situation of treating patients in the emergency room. The majority of the patients cared for in the emergency room are discharged and not admitted to the hospital, making this statement, "Visit me if I move to another hospital unit", non-applicable to the situation. Nurses may view, "Talk to me about my life outside the hospital" as less important and time consuming, unless it pertains to the patient's care. The importance of these statement may change with the situation of the patient.

The second research question asked, "What do emergency room patients perceive as caring behaviors as measured by the CBA?" The patients selected technically based competence caring behaviors such as, "Know what they're doing" and "Know how to give shots, IV's, etc." as the top two responses. This demonstrates similar findings in which patients rank technical behaviors as most important caring behaviors (Larson, 1981, 1984, 1986, 1987; Mayer, 1987; Keane, Chastain

For the patients in the emergency room, numerous factors may have influenced their importance ranking of the caring behaviors. When patients present to the emergency room, they consider their visit as a short temporary means to an end; medical treatment. It is usually not their intention to remain in the emergency room for a long period of time. They want their medical problem handled quickly and efficiently. Perhaps these perceptions could lead the emergency room patients to rank technical aspects of caring higher in this situation.

Patients ranked "Visit me if I move to another hospital unit", and "Talk to me about my life outside the hospital", as the least important caring behaviors. With the patient viewing a visit to the emergency room as something brief, and they are not going to be admitted to the hospital, having the nurse visit them if they're admitted, may be seen as non-applicable or least important. The briefness of the visit to the emergency room may have also influenced the patient to rank talking
about their life outside the hospital as least important for the situation.

The third research question asks, "Do emergency room nurses perceive caring behaviors differently than emergency room patients?" In determining what each of the groups, nurses and patients, perceive as caring behaviors the means for each of the CBA items were calculated and ranked from highest to lowest then those means were compared. Those comparisons indicated that eight out of the ten highest ranked behaviors were the same in both groups but in somewhat different rank order. The nurse respondents tended to rank the helping trusting behaviors higher than the patient respondents. The two behaviors not included in the patients' top ten caring behaviors, but indicated by the nurse group as most important were, "Treat me with respect" and "Really listen to me when I talk".

The patient and the nurse groups agreed on the two least important caring behaviors, "Visit me if I move to another hospital unit" and "Talk to me about my life outside the hospital". Of the eight remaining least important caring behaviors four were selected by both groups but placed in different rank order.

In analyzing the results of the t-test to determine what responses had significant differences, the test revealed that eleven items on the CBA had a significant
level = .05 and one item a significant level just above .05 at .059. These twelve items fell in five of the seven carative factors subscales. When comparing the means of the two groups responses it was noted that never were the means at opposite ends of the scale.

In speculating why the differences in means of the caring behavior items occurred between the patients and nurses, one needs to look at the items separately. Five of the twelve items contained in the first subscale, "Humanism/Faith-hope/Sensitivity" were significantly different. Item 3, "Know what they're doing" indicated the nurse group's mean was significantly lower than the patient group. The nurses may have discounted the idea that knowing what you are doing is not a real caring behavior and placed less importance on this item. It is has been shown through research (Larson, 1981, 1984, 1986, 1987; Mayer, 1987; Keane, Chastain & Rudisill, 1987; Komorita, Doehring & Hirchert, 1991; Mangold, 1991; Scharf & Caley, 1993; Gooding, Sloan & Gagnon, 1993; von Essen & Sjoden, 1991a, 1991b; Rosenthal, 1992; Cronin & Harrison, 1988; Huggins, Gandy & Kohut, 1993; and Parsons, Kee & Gray, 1993) that patient populations place a higher importance on nurses knowing what they are doing than the nurse. A significantly higher mean was indicated by the patients for item 7, "Points out positive things about my condition". Several comments
from the nurse respondents concerning this item were "it depends on the circumstances of the patient" and "there are times when this is more appropriate", could indicate that the nurse adjusts the care to fit the situation accounting for the lower mean of this item by the nurse respondents. Item 9, "Understand me", item 13, "Be kind and considerate", and item 16 "Treat me with respect", had significantly higher means indicated by the nurses. These perceptions may be in direct relationship to what was taught to nurses at the basic level of their training. Feeling, trusting, helping aspects have all been reiterated to the nurse over and over as what caring behaviors are. This continual reinforcement may account for the higher means of these items by the nurse.

Three of the twelve items were contained in the second subscale "Helping/Trusting. Item 18, "Accept my feelings without judging them", item 19, "Come into my room just to check on me", and item 26, "Touch me if I need it for comfort", indicated a significantly higher mean in the nurse group. Again, with the nurse denoting trusting, helping aspects of care significantly more important than the patient, helps to reinforce the idea that the nurses' basic training concerning caring behaviors are evident. Comments from patients indicated that they knew the nurses were busy and that it was not
necessary for the nurse to "Come into my room just to check on me".

Both items 36, "Ask me what I want to know about my illness", and item 38, "Help me plan ways to meet these goals", had a significantly higher mean by the patient group than the nurse group. These items are both contained in subscale 4, "Teaching/Leaning. The difference may have resulted from the fact that many emergency room nurses delegate these tasks to other health professions ie. home health, social services. The nurse may view this as less important while the patient only perceives that the activity is accomplished.

In analyzing the difference in the responses of the groups for item 46, "Encourage me to do for myself" contained in the fifth subscale "Supportive/Protective/Corrective environment", it was found that the patient assigned this item a significantly higher mean than the nurse. Gaut (1986) describes caring in terms of doings or activities required of the nurse to be performed for the patient. Many nurses considered themselves helping, caring individuals and to give up doing for the patient would be difficult. If the nurse does not do the care for the patient, the nurse may not perceive that the patient feels cared for or about by the nurse. Again, these perceptions reflect the basic nursing education of the nurse. One has to look at the age of the nurse
group and remember when his/her basic education in nursing took place. The majority of the nurses ranged in age from 29 to 49. What was the philosophy of caring 20 to 25 years ago? In reviewing nursing texts from that time, autonomy of the patient in relationship to their care was not addressed. Brunner, Emerson, Ferguson and Suddarth (1970) indicated that for caring to be conveyed by the nurse, the nurse must be aware of the emotions of the situation and be supportive, protective and sensitive to the patient's needs anticipating and personally meeting those needs. The nurse was trained to do the care for the patient. It is only recently that allowing the patient to do for themselves has been advocated. This conflict with training may have influenced the lower mean of this item by the nurse.

The last item which had a significant difference was item 62, "Help me see that my past experiences are important", which is contained in the sixth subscale "Existential/phenomenological/spiritual forces. A higher mean was indicated by the nurses than the patients. One reason for the difference may be that nurses see the importance of the patient's past experiences and their contribution to the total care of the patient. By being aware of the patient's past experiences the nurse can better plan with the patient
their discharge from the emergency room. The past experience may be as simple as the patient being aware that amoxicillin caused a rash or their chronic bronchitis doesn't respond well to erythromycin. The nurse, through training and experience has found that past experiences can play an important part in the care of the patient. A large portion of this study's patient population (35%) ranged in age from 18 to 29 and 88% used the emergency room less than every other year. The young inexperienced patients with fewer past experiences may not comprehend the value of past experiences, accounting for the differences between the nurses and patients' response concerning this caring behavior.

In comparing the means of the carative factors subscales ranking by each group, it was noted that both the patient and the nurse groups placed the subscales in identical order of importance. In evaluating the identical rankings of the subscales by the two groups one must remember that even though there were several items with significant difference noted by the t-test, never were the responses at opposite ends of the scale. This finding tends to support the theory that the nurse and patient groups perceive caring behaviors of the nurse as relatively the same despite the individual item differences.
The possibility of a type I error may be significant with the number of t-test done \( n = 63 \) in calculating the significant differences in the two groups, patients and nurses. With an alpha of .05 the researcher accepts the risk of type I errors in approximately 5 of every 100 samples (Woods, 1988). With this study eleven significant differences were identified. With an error rate of approximately 5% it is questioned how many significant differences were related to type I error as opposed to significant differences in the responses. The significant differences are further questioned when the carative factor subscales were ranked in identical order by the two groups. Further testing is needed to determine any significant differences between the subscale means.

Research question four addresses the demographic variables of age, gender, race, marital status, use of the emergency room, facility treated, and insurance coverage and if they effected the perceived caring behaviors of the patient. The demographic data was correlated with the responses of the CBA items as separated into carative factors subscales. There were three demographic variables which correlated with the subscales. Significant correlations between subscales 2, "Helping/Trusting", subscale 3, "Expression of positive/negative feelings", subscale 4, "Teaching/
Learning" and subscale 7, "Existential/phenomenological/spiritual forces" and the age of the respondent. These findings are supported by conceptual changes which occur in the process of normal growth and development of the adult (Jarvis, 1992). An eighteen year old would probably place different importance on items on the CBA, than an eighty year old. Experience in life may influence what you see as important in terms of care.

Significant correlations between subscale 1, "Humanism/Faith-hope/Sensitivity", and subscale 2, "Helping/Trust" were found with the gender of the respondents. Both subscales deal with sensitivity and helping. Caring has long been synonymous with the female gender (Watson, 1990). Fifty-six percent of the patient respondents were male. The correlation of gender with these subscales may be due to the male/female roles that are directed by society concerning caring behaviors.

Correlations were found between subscale 5, "Supportive/ Protective/Corrective environment", and the facility of the respondents. This subscale deals with the external and internal variables (Watson, 1988). Even though each of facilities used care for close to the same numbers of patients, there are enough differences in those numbers and the types of patients seen, to possibly change the climate in the individual facilities resulting in the differences seen between
the facilities. The rural facility sees more patients with non-urgent complaints, due to the lack of clinics available in the area, causing their patient population to have higher percentages of non-urgent patients than the urban facility. The literature has indicated that patients with non-urgent complaints have a tendency to place a higher priority on helping and supportive caring behaviors (Huggins, Gandy & Kohut, 1993).

Research question five asks if the demographic variables of age, gender, race, marital status, facility employed, years of experience as a nurse, years of experience as an emergency room nurse, and level of nursing education correlated to perceived caring behaviors in the nurse? There were four demographic variables which correlated with the carative factors subscales. Significant correlations between subscales 2, "Helping/Trusting", subscale 3, "Expression of positive/negative feelings", subscale 4, "Teaching/Learning" and subscale 7, "Existential/phenomenological/spiritual forces" and the age of the respondent were found. These findings again are supported by conceptual changes which occur in the process of normal growth and development of the adult (Jarvis, 1992). Experience in life may influence what you see as important in terms of care. These changes may contribute to the correlation of the age variable and these subscales.
Significant correlation between subscale 1, "Humanism/Faith-hope/Sensitivity" and subscale 2, "Helping/Trust" were found with the gender of the respondents. Both subscales deal with sensitivity and helping. Caring has long been synonymous with the female gender (Watson, 1990). Eighty-three percent of the nurse respondents were female. The correlation of gender with these subscales may be due to the male/female roles that are directed by society concerning caring behaviors.

Correlations were found between subscale 5, "Supportive/Protective/Corrective environment", and the facility of the respondents. This subscale deals with the recognition of external and internal variables in the patient's environment (Watson, 1988). While each of facilities in which data was collected care for similar numbers of patients, there may be enough differences in the number and the type of patients seen, to change the environment of the individual facilities resulting in the differences between the facilities.

Correlations between nursing experience appeared in all the subscales except subscale 6, "Human needs assistance". This correlation is not a surprise. Nursing experience has been defined as the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances of differences to theory (Benner, 1984, p. 36). Nursing
experience facilitates the nurse's ability to put the needs of the patient into perspective. Unlike novice counterparts, experienced nurses possess the experience to know which caring behaviors take priority over another to insure that patients have the best and most efficient care while in the emergency room. The experienced nurse has gained information beyond what was taught in school. The experienced nurse has taken the context of the classroom and tempered it with the reality of the practical situation. He/she knows first hand, through experience in the actual clinical setting, what needs to be done and what is important, and does not have to rely on what a book or an instructor has told them to do in that situation. The reason subscale 6, "Human needs assistance" did not correlate with nursing experience, may be that this area is basic to all nurses despite their degree of experience.

The alpha coefficient reliability of the Caring Behaviors Assessment tool in this study was .96 indicating a high reliability of the tool. The alpha coefficients for the seven carative factors subscales ranged from .78 to .88 indicating a high reliability of the tool's seven subscales. These findings concerning the seven subscales further support Cronin and Harrison's 1988 initial study of the tool. As to why the reliability coefficients were higher for the seven
subscales than in Cronin and Harrison's (1988) original study, one answer may be a result of the difference in the populations of the two studies. In reviewing the literature, it was found that the CBA tool has never been used with nurses. Reliability estimates are population-dependent measures, meaning that the use of the same instrument with vastly different populations will result in different reliability estimates (Woods, 1988).

A final question, though not one of the stated research questions was indirectly asked, "Did this study aid in the testing of Watson's Theory of Caring (1985)?" The data collection tool (CBA) was developed by Cronin and Harrison (1988) based on Watson's Theory of Caring. The seven CBA subscales are congruent with the ten carative factors in Watson's Theory of Caring (1985). Sixty-one of the 63 items on the CBA tool were rated above "3", on the Likert scale by the nurse respondent group and 59 of the 63 items were rated above "3" on the scale by the patient respondent group. No mean was below "3" in either the patient's or nurse's rating of the carative factors subscales. Those items above "3" indicate that the groups perceived the majority of the items and all the subscales "somewhat important", "important", and "most important". This would indicate that the participants of this study considered the items
on the CBA to be indicators of caring and therefore support Watson's Theory of Caring (1985) in the clinical setting.

It was discovered through t-test comparisons that 16 items on the CBA indicated significant differences between the rural and urban nurses' responses. There was one item on the CBA that indicated a significant difference in the responses of the rural and urban patients. These results were unexpected; however, because this testing was not directly related to the research questions of this study, the results will not be addressed at this time. These results warrant further study as to their value.

In summarizing the data, it was found that the CBA proved to be a reliable tool. The nurse and patient respondent groups had significant differences on 11 items (19%) of the CBA. Eighty-one percent of the items were rated similarly by the two groups. The patient and nurse groups concurred on eight (80%) of the 10 items ranked most important and six (60%) of the least important caring behavior items. There was a correlation between four of the demographic variables; age, gender, facility and nursing experience and the CBA subscales. Both emergency room patients and nurses placed importance on technical skills. In summary the emergency room nurses
and patients in this study perceived caring behaviors more similarly than dissimilar.

Limitations

There were several limitations identified with the Caring Behaviors Assessment tool. The CBA has never been used to assess perceived caring behaviors of the nurse. The tool was found to be difficult for the nurses to read because the language was written for the patient. Several nurse participants stated that it was difficult to follow because of this language and they had to continually stop during the tool to ask, "This is the patient talking about the nurse?". With the language written for the patient it may have prompted misconceptions by the nurse about what the statements were asking besides being difficult to follow.

Another limitation of the CBA tool is the unequal distribution of the items contained in each subscale (3 to 16 items). This may have inadvertently skewed the results. If the number of items contained in each subscale group were equal the results might be different.

Recommendations

A number of recommendations surfaced after review of this study. It is important to know what patients perceive as caring behaviors, but equally important is the need to know what nurses perceive as caring behaviors. The CBA needs to have more extensive testing
with the nurse population in conjunction with the patient population. It may also be an advantage to change the wording in the CBA, for the nurse population, so that it is less awkward to read.

Huggins, Gandy and Kohut (1993) adapted the CBA for the emergency room setting and to be administered over the telephone. The researchers eliminated parts of the CBA indicating that they felt those were non-applicable in the emergency room setting. It is the recommendation of this study that the CBA not be altered this drastically, in an effort to have a tool which is more universal and allows for study results to be compared one to another despite the health care arena in which the tool is administered. If there are areas of the CBA which are not applicable to the population being studied, it would be more prudent to provide the respondents with the option of "not applicable" on the questionnaire. Thus, one can actually see what those respondents deem not applicable rather than the researcher having to speculate because the tool was altered.

It is strongly recommended that future comparison studies using the Caring Behaviors Assessment tool conduct comparisons of the subscales, calculating significant differences, in addition to comparisons of CBA items. This recommendation is due to the high
probability of type I errors associated with the item comparison \((n = 63)\) of this tool. The possibility of a type I error may be significant with the number of \(t\)-test done \((n = 63)\) in calculating the significant differences in two groups. With an alpha of .05 the researcher accepts the risk of type I errors in approximately 5 of every 100 samples (Woods, 1988). By conducting comparisons on the subscales the researcher will be able to make better determinations as to the validity of the significant differences obtained in the item analysis. If testing is not done on the subscales there is a high probability that the researcher may determine that there is a significant difference in the groups being compared when in actuality there is none.

An important recommendation is that the research results be communicated to the general nurse population. The patient's perception of the most important nurse caring behaviors has been documented for several years, but nurses do not appear to have significantly incorporated this knowledge into their practice. The greatest reason that no change has occurred may be that nurses are not aware of what patients perceive as caring behaviors. Nurses continue to use their valuable, limited time on activities they believe convey caring, but the activities are falling short of this goal, because the nurses lack this needed information. The educational
system is not adequately teaching graduates what is important to the patient. Educators continue to teach nursing students to spend more time listening, talking and comforting and less time focusing on the technological interactions (Hughes, 1995). The educational system needs to use the available research, thus further providing new nurses the advantage of being able to adapt care to meet the expectations of the patient.

The findings of Keane, Chastain, and Rudisill (1987) in which both the rehabilitation nurses and patients concurred that the most important caring behaviors were "knows when to call the Doctor" and "monitors and follows through", and the findings of von Essen and Sjoden (1993) revealing that the psychiatric nurses and the patients agreed that the most important caring behavior was "listens to the patient", added to the similar findings of this study may indicate that nurses practicing in specialty areas concur with their patients on important caring behaviors. Further study needs to be done to determine if nurses in specialty areas agree with the patients on important caring behaviors. This also raises the question whether nurses know that they need to adapt the method by which they display caring depending on the area they work.

Because the CBA was administered in the emergency room setting, while the patients were being seen, many
patients were excluded from participating due to lack of time or discomfort of the patient. It is believed that many of the patient respondents were also of a low acuity level, young and male, which may have influenced the results of this study. These findings raise questions as to whether a broader patient group with more equal distribution of age, gender and acuity level (severity of illness or injury) might change the results. It is recommended that larger more diverse groups need to be used for further studies.

Even though the racial distribution of this study is heavily Caucasian, it was a good representation of the racial make up of the state in which the study was conducted. It is a recommendation of this study to use the CBA in geographical areas that have a more diverse racial mix. The question was raised, would a more diverse racially mixed sampling change the results?
References


Larson, P. J. (1981). Oncology patients' and professional nurses' perceptions of important nurse caring behaviors. *University Microfilms International. (University Microfilms No. 8116511).*


Appendix A:

Permission for Use of the Caring Behaviors Assessment Tool
November 4, 1994

Carolyn T. Whipple
2278 Pintura Drive
St. George VT 84770

Dear Carolyn:

Thank you for your interest in the Caring Behaviors Assessment. Enclosed is a copy of the tool and additional information regarding its development. Please feel free to use the CBA. In return, we ask that you acknowledge its authorship (reference to the Heart and Lung article is sufficient) and, upon completion of your work, please send us a copy of your abstract. We would also appreciate the results of any further reliability and validity testing of the CBA.

We have also enclosed the signed permission form required by your university. However, we have deleted the portion that gives permission to include the tool in the manuscript that will go to University Microfilms, Inc. We prefer that researchers contact us directly to obtain copies of the CBA. That way, we can maintain records regarding its use.

If you have not already seen it, you may want to look at an article by Huggins, Gandy, & Kohut ("Emergency department patients' perceptions of nurse caring behaviors" Heart & Lung, 1993, 22(4), 356-364), who used the CBA in an emergency setting.

We will be most interested in your findings. If we can answer any questions or be of any further assistance, please feel free to contact us.

Sincerely,

LANSING SCHOOL OF NURSING

Sherill Nones Cronin, PhD, RN, C
Associate Professor

Barbara Harrison, MSN, RN, C
Chair, BSN Program
Permission to Use Copyrighted Material

I, Sherill Nones Cronin

holder of copyright on material entitled Caring Behaviors Assessment

______________________________

authored by Sherill Nones Cronin & Barbara Harrison

and originally published in Heart & Lung [1988, 17, 374-80]

______________________________

hereby give permission for the author to use the above described material in total or in part for inclusion in a master's thesis/doctoral dissertation at the University of Nevada, Las Vegas.

______________________________ 11/4/94

Signature Date

Sherill Nones Cronin  

Name (typed) Title

Associate Professor

Bellarmine College - Lansing School of Nursing

Representing

The Graduate College
University of Nevada, Las Vegas
4505 Maryland Parkway
Box 451017
Las Vegas, NV 89154-1017
Appendix B:

Internal Review Board Consent: Dixie Regional Medical Center
January 13, 1995

Carolyn Whipple, R.N.
St. George, Utah 84770

RE: NURSE CARING BEHAVIORS AS PERCEIVED BY THE EMERGENCY ROOM NURSE AND THE EMERGENCY ROOM PATIENT.

Dear Carolyn:

The IRB Committee of Dixie Regional Medical Center has considered your proposed study of Nurse Caring Behavior as Perceived by the Emergency Room Patient. We have approved conducting this study.

Sincerely,

Craig L. Booth, M.D.
Co-Chairman IRB Committee

CLB/lr

MS/lr
Appendix C:

Internal Review Board Consent: LDS Hospital
DATE: July 28, 1995

TO: Carolyn T. Whipple, R.N.

Your request to do a research project entitled: IRB# 571, Nurse Caring Behaviors as Perceived by the Emergency Room Nurse and the Emergency Room Patient: A Comparative Study has been discussed by the Research and Human Rights Committee and the following decision made:

1. Approval Given EXPEDITED REVIEW
2. Approval Refused
3. The Committee has authorized the Chair or Vice-Chair to approve the project upon receipt of changes in protocol and/or the consent document as follows: (AN APPROVAL LETTER WILL BE SENT TO YOU UPON RECEIPT OF THESE CHANGES).
4. Study Tabled pending appearance of the investigator at the next meeting.
5. Study Tabled pending the following information being furnished to the Committee for review at the next meeting:

If you have any questions regarding this decision, please contact A. Jennifer Fischbach, M.D., who was the Committee member who reviewed this project for the Committee.

If a paper results from your study, it should be approved by the Research and Human Rights Committee before it is submitted for publication. Whether or not a paper is written, we would like a copy of your findings for our files.

It is your responsibility to notify DHHS and/or the FDA and the Chairperson of the Research Committee of any occurrence or emergency which seriously increases the risk to or affects the welfare of subjects.

The FDA requires that research projects be reviewed yearly, or more often at the discretion of the Research Committee. You will receive notification from the Research Committee when it is time for review of this study. It is your responsibility to respond to this notification or approval for this study will be discontinued.

A. Jennifer Fischbach, M.D., Chair
Research and Human Rights Committee
LDS Hospital
Appendix D:
Human Subject Rights Committee Approval:
University of Nevada, Las Vegas
DATE: July 11, 1995

TO: Carolyn T. Whipple (NUR)
M/S: 3018

FROM: Dr. Frederick W. Preston
Chairman, Social Behavioral Committee of the
Institutional Review Board

RE: Status of Human Subject Protocol entitled:
"Nurse Caring Behaviors as Perceived by the Emergency
Room and the Emergency Room Patient: A Comparative
Study"

OSP # 501s0695-013

This memorandum is official notification that the protocol for
the project referenced above has been approved by the Biomedical
Subcommittee of the Institutional Review Board. This approval is
approved for a period of one year from the date of this
notification, and work on the project may proceed. At the end of
the year, you must notify this office if the project will be
continued.

Should the use of human subjects described in this protocol
continue beyond a year from the date of this notification, it
will be necessary to request an extension.

If you have any questions or require any assistance, please give
us a call.

cc: Dr. Carolyn Sabo (NUR-3018)
OSP File

Office of Sponsored Programs
4505 Maryland Parkway • Box 451037 • Las Vegas, Nevada 89154-1037
(702) 895-1357 • FAX (702) 895-4242
UNIVERSITY OF NEVADA, LAS VEGAS

PROTOCOL FORM

FOR RESEARCH INVOLVING HUMAN SUBJECTS

INVESTIGATORS: List person principally responsible for the investigation on line a). If principal investigator is a student, list faculty advisor on line b).

<table>
<thead>
<tr>
<th>Investigator</th>
<th>Department</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Carolyn T. Whipple RN</td>
<td>Nursing</td>
<td>(702) 895-3360</td>
</tr>
<tr>
<td>b) Carolyn Sabo RN EdD</td>
<td>Nursing</td>
<td>(702) 895-3360</td>
</tr>
<tr>
<td>c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td></td>
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</tbody>
</table>

UNLV status of Principal Investigator (circle): Faculty/Post-doctoral/Graduate/Undergraduate/Other

TITLE OF PROJECT: Nurse Caring Behaviors as Perceived by the Emergency Room and the Emergency Room Patient: A Comparative Study

NAME AND ADDRESS of sponsoring agency or foundation (if other than UNLV)

CONTRACT OR GRANT NUMBER (if known)

DURATION OF STUDY (Protocols must be renewed annually): Start 6-1-95; End 6-1-96

TYPE OF SUBMISSION: ___ New, Renewal (attach progress report), ___ Continuation, ___ Modification, Previous Log = (if any)

LOCATION(S) OR FACILITIES where study will take place: Dixie Regional Medical Center, 544 S. 500 E., St. George, Utah

Principal Investigator's Signature

Department Chair or Unit Head's Signature

Faculty Advisor's Signature (if warranted)
SUBJECTS: (Please estimate numbers)

- [ ] Patients as experimental subjects
- [ ] Patients
- [ ] Minors (under 18)
- [ ] I N I X students
- [ ] Pregnant women or fetuses
- [ ] Mentally disabled

105

- [ ] Prisoners, incarcerated subjects
- [ ] Normal adult volunteers
- [ ] Persons whose first language is not English
- [ ] Other (please specify)

60

120 TOTAL ANTICIPATED SUBJECTS

PROCEDURES: (ATTACH relevant materials, such as questionnaires, interview schedules, written test instruments, etc.)

- [ ] Survey, questionnaire(s)
- [ ] Interview: phone/in-person
- [ ] Medical or other personal records
- [ ] Filming, taping, recording
- [ ] Observation
- [ ] Participant observation
- [ ] Anthropological fieldwork
- [ ] Psychological intervention
- [ ] Complete disclosure of purpose
- [ ] Consent of subjects
- [ ] Costs to subject/third parties

Brief Explanation of Procedures:

Investigational Drug*

Approved Drug, New Use*

Investigational Device (attach relevant info)

Placebo

Ionizing Radiation (attach CURRENT approval)

Surgery

In vitro fertilization

Venipuncture

Other body fluids, excreta

Abortus, placenta, excess tissue

Other (please specify)
Title of Project: Nurse Caring Behaviors as Perceived by the Emergency Room Nurse and the Emergency Room Patient: A Comparative Study

Investigator: Carolyn T. Whipple

After reviewing this proposal, the members of the Review Committee have indicated below their approval/disapproval of this proposal.

Signature of Committee Members

Sue Watt
Maie A. Szmatlaw

Audit

Approve
Disapprove

The above named project is hereby approved/disapproved (circle one)

Date: 5/6/95

Committee Chairman's Signature
Appendix E:

Consent Form: Patient
CONSENT TO PARTICIPATE IN A RESEARCH STUDY
UNIVERSITY OF NEVADA, LAS VEGAS
DEPARTMENT OF NURSING

TITLE OF STUDY: Nurse Caring Behaviors as Perceived by
The Emergency Room Nurse and The Emergency Room
Patient: A Comparative Study

Carolyn T. Whipple R.N. B.S.N.
Graduate Student

PURPOSE OF THE STUDY

You are being asked to participate in a research study. The purpose of this study is to determine what you as an emergency room patient perceive as caring behaviors of the emergency room nurse and compare those responses to those of the emergency room nurses' perception of caring behaviors.

PARTICIPANTS

Because you are or have been a patient in the emergency room, you are being asked to participate in a study. Although participating in this study will not be of immediate benefit to you, the information you contribute may benefit future patients by making nurses more aware of what nurse behaviors, patients identify as caring and helpful while in the emergency room.

PROCEDURES

If you choose to participate in this study, you will be asked to complete a demographic questionnaire and the Caring Behaviors Assessment tool (CBA). This will take about 15 minutes to complete.

RISKS

No risks have been identified for those persons participating in this study. There is no cost for participating. No treatment or service has been altered for participating in this study.

CONFIDENTIALITY

Your participation in this project is completely voluntary and you may decide to participate or to withdraw at any time from the study, even after you have initially begun. No names will be used, and the questionnaire will be kept in a locked file cabinet. Only the investigator or designated assistants will have access to the questionnaires.
QUESTIONS

If you have further questions, please ask. If you have any questions later, contact Carolyn T. Whipple RN or Dr. Carolyn Sabo RN PhD at:
(702) 895-3360, Department of Nursing, 4505 S. Maryland Parkway, Las Vegas, NV 89154.

You will be given a signed and dated copy of this form to keep.

********

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE DECIDED TO VOLUNTEER AS A PARTICIPANT IN THE STUDY DESCRIBED ABOVE AND THAT YOU HAVE READ THE INFORMATION PROVIDED ABOVE.

Signature of Participant       Date

Signature of Investigator      Date
Appendix F:

Consent Form: Registered Nurse
UNIVERSITY OF NEVADA, LAS VEGAS  
DEPARTMENT OF NURSING  

TITLE OF STUDY: Nurse Caring Behaviors as Perceived by  
The Emergency Room Nurse and The Emergency Room  
Patient: A Comparative Study  

Carolyn T. Whipple R.N. B.S.N.  
Graduate Student  

PURPOSE OF THE STUDY  

You are being asked to participate in a research study.  
The purpose of this study is to determine the perceived  
caring behaviors of the emergency room nurse as compared  
to the perceived caring behaviors of the emergency room  
patient.  

PARTICIPANTS  

Because you are a registered nurse presently employed  
in the emergency room, you are being asked to participate  
in a study. Although participating in this study will not  
be of immediate benefit to you, the information you  
contribute may benefit future patients and nurses by making  
nurses more aware of what nurse behaviors, patients identify  
as caring and helpful while in the emergency room.  

PROCEDURES  

If you choose to participate in this study, you will  
be asked to complete a demographic questionnaire and the  
Caring Behaviors Assessment tool (CBA). This will take  
about 15 minutes to complete.  

RISKS  

No risks have been identified for those persons  
participating in this study. There is no cost for  
participating. There are no repercussions for participating  
or not participating in this study.  

CONFIDENTIALITY  

Your participation in this project is completely  
voluntary and you may decide to participate or to withdraw  
at any time. No names will be used, and the questionnaire  
will be kept in a locked file cabinet. Only the investigator  
or designated assistants will have access to the  
questionnaires.
QUESTIONS

If you have further questions, please ask. If you have any questions later, contact Carolyn T. Whipple RN or Dr. Carolyn Sabo RN PhD at:
(702) 895-3360, Department of Nursing, 4505 S. Maryland Parkway, Las Vegas, NV 89154.

You will be given a signed and dated copy of this form to keep.

******

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE DECIDED TO VOLUNTEER AS A PARTICIPANT IN THE STUDY DESCRIBED ABOVE AND THAT YOU HAVE READ THE INFORMATION PROVIDED ABOVE.

_________________________      ________________
Signature of Participant      Date

_________________________
Signature of Investigator

_________________________
Date
Appendix G:

Patient Demographic Form
PATIENT DEMOGRAPHICS

Directions: Please mark the blanks below, one in each category, that applies to you.

AGE:

___ 18-29
___ 30-39
___ 40-49
___ 50-59
___ 60-69
___ 70-79
___ 80-89
___ 90+

EMERGENCY ROOM USE:

___ Weekly
___ Monthly
___ 6-11 x yearly
___ 3-6 x yearly
___ 2 x yearly
___ 1 x year
___ Every other year
___ Less than every other year
___ First time

SEX:

___ Male
___ Female

FACILITY:

___ LDSH
___ Dixie Regional

RACE:

___ Caucasian
___ African-American
___ Hispanic
___ Native American
___ Asian
___ Other

MARITAL STATUS:

___ Single
___ Married
___ Separated
___ Divorced
___ Widowed

INSURANCE COVERAGE:

___ Private
___ Medicare
___ Medicaid
___ None
Appendix H:

Registered Nurse Demographic Form
NURSE DEMOGRAPHICS

Directions: Please mark the blanks below, one in each category, that apply to you.

AGE:
- 18-29
- 30-39
- 40-49
- 50-59
- 60+

NURSING DEGREE HELD:
- ADN
- Diploma
- BSN
- MSN

SEX:
- Male
- Female

EXPERIENCE IN NURSING:
- 0-1 years
- 2-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21+ years

RACE:
- Caucasian
- African-American
- Hispanic
- Native American
- Asian
- Other

EXPERIENCE IN EMERGENCY ROOM:
- 0-1 years
- 2-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21+ years

MARITAL STATUS:
- Single
- Married
- Separated
- Divorced
- Widowed

FACILITY EMPLOYED:
- LDSH
- Dixie Regional