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Perceptions of caring behaviors by elderly residents in extended care facilities

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**PERCEPTIONS OF CARING BEHAVIORS BY ELDERLY RESIDENTS
IN EXTENDED CARE FACILITIES**

by

Ludy Sta. Maria-Llasus

**Bachelor of Science in Nursing
West Visayas State University, Philippines
1991**

**A thesis submitted in partial fulfillment
of the requirements for the**

**Master of Science in Nursing
Department of Nursing
College of Health Sciences**

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Thesis Approval
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Master of Science in Nursing

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ABSTRACT

Perceptions of Caring Behaviors by Elderly Residents in Extended Care Facilities

By

Ludy Sta. Maria-Llasus

**Dr. Cheryl Bowles, Examination Committee Chair
Professor of Nursing
University of Nevada, Las Vegas**

The purpose of this descriptive study was to describe elderly residents' perceptions of which caring behaviors they want exhibited by the nursing staff in extended care facilities. Consequently, this study was able to identify which caring behaviors are important and least important to this population. Using Jean Watson's Theory of Transpersonal Caring as the framework, this study utilized Wolf's Caring Behaviors Inventory instrument to answer the study's research questions. Forty-eight participants wanted nursing staff to demonstrate behaviors under the professional knowledge and skill dimension of the CBI. The sample also identified five most important and least important nurse caring behaviors.

No significant difference was found between age, educational level and length of stay in the facility and perceptions of caring behaviors. This study's findings suggest gender difference in perceptions of caring behaviors.

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CHAPTER 1

INTRODUCTION

The concept of caring is central to the nursing profession. Caring is viewed as the moral ideal of nursing where there is the utmost concern for human dignity and preservation of humanity (Watson, 1985). Various nurse authors have defined caring in the context of the nursing profession and yet it continues to remain elusive and abstract. If caring is central to the nursing profession and promoting a caring environment is one of the goals of nursing care, a richer understanding of patient's perceptions of which caring behaviors are important to them is needed.

Background and Significance to Nursing

The growth of the older population will continue to rise with the government's projection that by 2030, 20% of the population will comprise 65 years and older, more than twice their number in 1998 (Profile of Older Americans, 1999). This aging of America has triggered issues on how it will affect health care delivery for this growing population. Increasing age can bring about disabilities among older adults, which tend to result from multiple medical diseases and can lead to many functional limitations (Mitchell and Kemp, 2000). As their functional limitation increases, these older adults are likely to need health care services provided by extended care facilities (ECFs) such as the long-term care unit or skilled nursing facilities. This presents a challenge to the nursing

profession as care in this setting is directly provided by nursing. Nursing care plays a significant role in fostering a richer meaning in the lives of these elderly who can no longer be self-reliant. When caring behaviors are used, patients may be more satisfied with their nursing care than if they perceived behaviors to be non-caring. Non-caring interactions with patients are not helpful in the healing process. In long-term care settings, neglect, fostered dependency, infantilization and depersonalization results from uncaring practices (Nay, 1998)

.

Problem Statement

Incongruence of how caring behaviors are perceived between patients and nurses has been documented in the literature. Behaviors which nurses perceives as caring is not necessarily perceived the same way by patients who are the recipients of care in the caring process. With study of elderly residents' perceptions of which caring behaviors they want exhibited more frequently by the nursing staff in extended care facilities, a greater understanding can be achieved and offers nurses knowledge of how to practice in a manner that communicates and promotes a caring environment.

Purpose

The purpose of this study was to describe elderly residents' perceptions of which caring behaviors they want exhibited by the nursing staff in extended care facilities. Consequently, this study also identified which caring behaviors are important and least important to the residents.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Introduction

The purpose of this study was to describe elderly residents' perceptions of which caring behaviors they want exhibited by the nursing staff in extended care facilities (ECFs). Consequently, this study identified which caring behaviors are important and least important to the residents. The review focuses on the theoretical and empirical literature on caring and caring behaviors within the context of the nursing discipline. The review begins with the theoretical literature on caring followed by the empirical research on caring behaviors. The review of the existing empirical studies includes both qualitative and quantitative studies in that order. Qualitative studies are followed by the quantitative studies. Furthermore, comparison of the type of instrument or tool used to measure caring behaviors in quantitative studies is presented.

Caring has been said to be the core of nursing, but what exactly is caring in nursing practice? A difficult concept to define even in the context of nurse-patient relationship, it has been viewed from different perspectives within the literature. The terms care and caring are used interchangeably and nurse researchers have their own view of the concept.

Theoretical Views on Caring

A philosophical analyses of caring in nursing was done by Griffin (1983), and it was stated that the concept of caring as applied to nursing has both an activities and an attitudes aspects with the latter being more complex, and caring involves cognitive, moral and emotional factors.

Gaut (1986) believes that caring is an ordered series of actions that begins with goal setting and ends with implementation. Further, Gaut believes that caring is manifested in nursing actions and these can be operationalized and investigated.

Morse, Bottorff, Neander and Solberg (1991) used content analysis to review the nursing literature pertaining to caring to explore the implications various conceptualizations of caring have for the nursing discipline. Morse et al (1991) identified twenty-five authors' definitions of caring and the main characteristics of each perspective and found five major conceptualizations: (a) caring as a human trait, (b) caring as a moral imperative, (c) caring as an affect, (d) caring as an interpersonal interaction, and (e) caring as an intervention. Morse et al concluded that caring as a concept was poorly developed and has not been clearly explicated and often lacks relevance to nursing practice.

To make explicit the meaning of care in nursing, a concept analysis of caring was also undertaken by Mc Cance, Mc Kenna and Boore (1997) and resulted in the identification of four critical attributes of caring which were: (a) serious attention, (b) concern, (c) providing for, and (d) getting to know the patient. Antecedents of caring identified were amount of time, respect for persons, and intention to care. While the authors had difficulty in ascertaining the effects of caring, the results of non-caring were

clearly demonstrated through their study's discussion of cases where patients described what they considered as not caring. McCance et al however, had difficulty identifying the empirical referents of caring referring to it as nebulous and recommend using qualitative methods to examine the experience of caring as opposed to operationalizing measurable empirical referents.

Crowden (1994) articulated that 'caring is a central core and element of nursing practice. Indeed it may well be the essence of nursing'. However, he viewed caring as a generic virtue common to all and not just unique to nursing.

Fealy (1995) attempted to characterize professional caring by exploring the moral dimension of caring. According to this author, the moral dimension of professional caring entails professional actions which demand the universal ethic of respect for others and specific professionally derived moral imperative that results from the carer's membership in a professional community and a professional code of practice. Caring in this context is based on a formal basis rather than everyday relationships. Fealy (1995) further suggested that 'caring is not simply a series of actions but rather is a way of acting which is both contextually dependent and value bound' (1995, p. 1136).

Radsma (1994) cited factors that contribute to the difficulty of explicating the significance, meaning and function of care and why caring remains undefined and intangible in nursing. The factors identified were language, history, feminism and carework, intent and context of care, nonsupportive environment, valuing care, health care economics and policy and the care for the caregiver. Radsma cited that an explicit and implicit understanding of what professional caring entails in nursing was needed.

McCance, McKenna and Boore (1999) reviewed and contrasted four nursing theories of caring: Leininger's Theory of Culture Care, Watson's Theory of Human Care, Roach's Conceptualization of Nursing and Boykin and Schoenhofer's Theory of Nursing as Caring. As cited in the article, the four theorists' definition of caring are as follows: For Leininger, 'caring refers to actions and activities directed toward assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway; or to face death'. For Watson, 'caring is a value and an attitude that has to become a will, an intention or a commitment, that manifests itself in concrete acts'. 'Caring is a human mode of being', according to Roach, Boykin & Schoenhofer and they define caring as the intentional and authentic presence of the nurse with another who is recognized as a person living caring and growing in caring (McCance et al.,1999). Overall, McCance et al. concluded that the four theories were grounded in humanism and the notion that caring in nursing is based on a human science perspective. It was also found that the descriptions of nursing and caring within the theories reflected a dual component of attitudes/values and activities.

Watson's Theory of Human Care (1985) was developed from humanistic philosophy and science and views caring as the moral ideal of nursing whereby the end is protecting, enhancement and preservation of human dignity. Watson described ten carative factors essential for professional nursing. These carative factors were: (a) formation of a humanistic-altruistic system of values, (b) instillation of faith-hope, (c) cultivation of sensitivity to one's self and to others, (d) development of a helping-trust relationship, (e) promotion and acceptance of the expression of positive and negative

feelings, (f) systematic use of the scientific problem-solving method for decision making, (g) promotion of interpersonal teaching-learning, (h) provision for a supportive, protective, and or corrective mental, physical, sociocultural, and spiritual environment, (i) assistance with the gratification of human needs and (j) allowance for existential-phenomenological forces. This model of care also focuses on caring behaviors as both instrumental and expressive activities. Watson believes that these carative factors serve as a foundation for nursing care (Watson, 1985).

Studies on Caring and Caring Behaviors

Studies reported in the literature have asked individuals both nurses and patients to identify specific actions or attributes of nurses that indicate care. Most studies were done in acute care settings with a variety of patient populations but few studies were focused on the geriatric population residing in the long-term care setting. Studies done have used both qualitative and quantitative approaches to explicate and identify what constitutes caring behaviors from both the patient and nurses' perspectives.

Caring Studies Using the Qualitative Approach

Linda Brown (1986) using the qualitative approach, examined the experience of care from the patient's perspective. Fifty participants with ages ranging from 22 to 65 years old were interviewed and eight care themes emerged after patients were asked to describe an experience in which they felt cared for by a nurse during their hospital stay in the medical surgical unit. The main themes identified included recognition of individual qualities and needs, reassuring presence, provision of information, demonstration of professional knowledge and skill, assistance with pain, amount of time

spent, promotion of autonomy and surveillance. Further analysis of these themes led to the identification and description of two patterns of patient needs and nurse responses that made up the experience of care. The first pattern identified was the combined themes of demonstration of professional knowledge, skill, surveillance and reassuring presence which emphasized the ability of the nurse to recognize an immediate threat and the competency to carry out the required action. The second pattern included the themes of recognition of individual qualities and needs, promotion of autonomy, and time spent, which focuses on interactions that promoted empowerment for patients to participate in their care. Brown also identified a four part process of care consisting of patient perception of a need or wish that the patient cannot satisfy, recognition and acknowledgment by the nurse of the patient need, action taken to satisfy the need and the way in which nursing action is performed. Brown indicated that, fundamental to the life experience of care was the patient's confidence in the ability of the nurse to provide the necessary physical care and treatment. By demonstrating competency in meeting patient's treatment needs, the manner in which it is carried out then becomes important. This study supported the theoretical description of care as presented by Watson as including both instrumental and expressive activities that enhance the unique identity of the individual.

Riemen (1986) utilized the phenomenological approach to study the patient's description of non-caring in a clinical setting. Analysis of ten patients descriptions of nurse patient interactions, revealed that noncaring was perceived by patients as being in a hurry and efficient but no human element, just doing a job, being rough and belittling patients, not responding to patient requests, and treating patients as objects and not as a

human being. These non-caring interactions resulted in patients feeling helpless, vulnerable, frightened, humiliated, depressed, out of control of the situation and convinced that the nurse did not care about them as a whole person. This study emphasized that caring required the nurse to be truly present in the nurse-patient interaction while being efficient without the human element on the part of the nurse was described as non-caring.

Aventuro (1991) interviewed 12 older adults, 63-98 years old in a private long-term care institution. Symbolic interactionism where meaning is derived from the social interaction one has with another was utilized to identify and describe the meaning of care for these geriatric residents. The elderly participants viewed care as an all-pervasive force in their lives, which was interwoven with their basic existence. Findings of this study indicated that there were few identified caring interactions between the elderly residents and the nursing staff. Meaningful contact between registered nurses and the residents was rare. The participants talked about care at an affective level that extends beyond physical care. Nurses being truly present with them was given importance by the participants. The participants described care as consisting of two aspects that has to go together, the physical or instrumental and the emotional or affective aspects. For them, no satisfaction can be derived from their physical care even if it is adequate if the person taking care of them did not care about them. Overall findings of this study indicated that the care needs of these elderly nursing home residents were not adequately met, and their perception that their needs for being “cared for” were not met if they were not “cared about”.

Hutchinson and Bahr (1991) utilized the grounded theory method to explore and describe the types and meanings of caring behaviors engaged in by elderly nursing home residents with each other, towards the staff, visitors and the investigator. Twenty nursing home residents, 62 years and older were interviewed and observed. Four major properties of caring emerged. They were protecting, supporting, confirming and transcending. Protecting was a means of preserving the safety of or shielding another from injury through verbalizing concerns. Supporting was assessing an individual in meeting her or his need by reinforcing a “normal” self-image in another. Confirming was a way to validate the personhood of another in a manner that demonstrated care, respect, empathy or compassion. Transcending was seeking divine intervention through prayer for the benefit of others. In this study caring emerged as a major way in which residents maintained their personal identity, sense of value and continuation of personhood. This study was conducted in a religiously affiliated long-term healthcare environment limiting its generalizability.

Poole and Rowat (1994) utilized a descriptive multiple case study design to examine the community based elderly person’s perception of caring behaviors of a home care nurse within the context of home health care nursing. Five participants, consisting of three women and a married couple were interviewed over a 3-5 month period. Poole and Rowat found that for these participants, it was not what the nurse did but how it was done that was most important. The meaning of caring was perceived in terms of nurses’ attributes such as being cheerful, respectful, understanding and patient over physical caring behaviors. It was further suggested that nursing interventions may be ineffective if the caring attributes of the nurses are absent. A gender difference as to

how caring behaviors are perceived was also noted in the study where the male participant valued physical care over affective behaviors. A limitation of this study was the sample size $n=5$.

Santo-Novak (1997) also utilized a qualitative descriptive approach to identify twenty-eight older adults' role expectations of nursing. The older adults in this study expected the nurse to be knowledgeable, caring and attentive by demonstrating professional competence when recognizing patient's needs as well as being concerned for the individual in the responsive delivery of services. The finding of this study although not using Watson's framework, clearly supports the theoretical description of care as both instrumental and expressive activities.

Nay (1998) cited the findings of her earlier 1993 study where she interviewed 19 residents and 17 nurses from five Australian nursing homes, on their perception of caring. Nurses who are cheerful, interested and enjoys their work, anticipates and respond to resident's individual needs, were perceived as caring and reduces resident's embarrassment and feelings of being burdensome. Caring in this study was also associated with the nurse's knowledge and skills to competently perform their role. Nurse's description of caring nurses was found to be consistent with that of the residents.

Caring Studies Using Quantitative Approach

Larson (1984) conducted early research examining nurse caring behaviors utilizing the quantitative approach with oncology patients and nurses. Fifty seven adult patients with cancer, from three acute care hospitals in two western states, were asked to rank by importance their perceptions of nurse caring behaviors using the Caring

Assessment Instrument (CARE- Q) based upon the Q methodology technique. This technique had the individual sort cards to identify the most important nurse caring behaviors. The Care-Q consists of 50 behavioral items ordered in six subscales of caring, uses a forced choice format that allows for the ranking of items by priority. The six subscales included are: (a) accessible, explains and facilitates, (b) comforts, (c) anticipates, (d) develops a trusting relationship, (e) monitors and (f) follows through. The individual CARE-Q items are sorted by the subject into seven different packets ranging from most important to not important. Subjects are instructed to sort out only one item as most important, four items as fairly important, ten items as somewhat important, 20 items as neither important nor unimportant, and one item as not important. The specified intent of the importance is to measure by ranked importance the differences and similarities of perceptions that nurse and patients have of the 50 identified nurse caring behaviors.

The ten most important nurse caring behaviors identified by the patients were: (1) knows how to give shots and IV etc., (2) how to manage the equipment, (3) knows when to call the doctor, (4) responds quickly to patients call, (5) gives good physical care to patient, (6) gives the patients treatments and medications on time, (7) puts patients first no matter what else happens, (8) listens to the patient, (9) talks to the patients, (10) checks on the patient frequently and is well organized (Larson, 1984). The patients in the study reported 'being accessible' and 'monitoring and following through' as the most important nurse caring behaviors. The top ranking of competency skills precedes the patients' needs to be listened to by the nurse. Listening and talking, psychosocial skills highly valued by nurses, appeared to become important to these

patients only after their basic “getting better” needs were met (Larson, 1984).

Limitations of the study were that the CARE-Q provided only a forced choice distribution and the lack of reliability and validity testing.

A follow up study Larson (1987) compared cancer patients and professional nurses’ perceptions of important nurse caring behaviors. A convenience sample of 57 nurses and 57 patients provided data using the CARE-Q instrument. A significant difference between the nurses and patients ranking of the most important caring behaviors was noted. Nurses perceived comforting and trusting behaviors as being most important in making patients feel cared for. On the other hand, cancer patients ranked behaviors of nurses that demonstrated being accessible, monitoring and following through as most caring.

Mayer (1986) replicated Larson’s study using a different group of cancer patients and oncology nurses. This study supported Larson’s finding that patients valued the instrumental, technical caring skills, while nurses rank the expressive behaviors higher. The difference in perception was attributed to patients not being receptive to the expressive caring behaviors until basic physical needs have been met through instrumental activities. This finding was also similar with Brown (1986).

Keane, Chastain and Rudisill (1987) conducted a similar study using a different sample population of rehabilitation patients. They sought to identify areas of agreement and disagreement between patient and nurse perceptions of important nurse caring behaviors; examine congruence between these perceptions and use a systematic approach to obtain baseline data on specific needs of rehabilitation patients. Twenty-six nurses and 26 rehabilitation patients participated using the Caring Assessment Report

Evaluation Q-Sort (CARE-Q). Patients and nurses were in agreement by ranking 'knows when to call the doctor' as the most important nurse caring behavior. Patients in this study (Keane et al) identified monitoring, following through and accessibility as important caring behaviors. The result was in agreement with findings of Larson (1984,1987), and Mayer (1986) that patients perceive competent nursing skill as being more important nurse caring behavior than the nurses' affective behavior.

Rosenthal (1992) examined the relationship of patient perceived and nurse perceived caring behaviors in the coronary care unit. Coronary care patients (30) and coronary care nurses (30) in three not-for-profit hospitals in a large metropolitan western city used Larson's Care-Q to rank their perceived most important nurse caring behaviors. The patients perceived instrumental care as the most important nurse caring behaviors while the nurses perceived expressive care as the most important. The results supported Larson's finding that nurses and patients differed in identifying which behaviors demonstrate caring. The results of this study supported the findings of Larson (1984,1987), Keane et al (1987) and Mayer (1986) and revealed there is an incongruence between the perceptions of caring behaviors of patients and those of nurses. Findings also agreed with the previous research which found that patients tend to place more importance on the technical or instrumental aspects of care than the non-technical (expressive).

Smith and Sullivan (1997) studied caring behaviors as perceived by professional nurses and nursing home patients. The CARE-Q instrument by Larson was used to identify these behaviors. The study was conducted on a nursing home care unit at a Veterans' Affairs Medical Center. Fourteen patients and 15 registered nurses

participated in the study. The patients' ranked five instrumental and five expressive behaviors as the most important caring behaviors. Caring behaviors such as, puts the patient first, no matter what else happens and knows how to give shots, IV manage equipment were the top two behaviors patient identified as the most important nurse caring behaviors. Nurses perceived listening to the patient as the most important caring behavior. Nurses selected seven expressive and three instrumental behaviors.

Expressive behaviors are concerned with establishing trust, acceptance of feelings, faith, and genuineness. Instrumental, task-oriented activities include physical action, as well as cognitive-oriented interventions. Treatments, procedures, stress relief, teaching, and problem solving fall in this category. In this study, nurse and patients agreed on 6 of the 10 most important behaviors, choosing three instrumental and three expressive behaviors. It demonstrated a basic agreement in perception of caring priorities between patients and nurses. Smith and Sullivan (1997) concluded that nurses approach caring as the demonstration of a few instrumental behaviors performed in the context of accessibility and comforting, while patients seem to value both clinically competent behaviors and expressive behaviors having to do with comforting and trust. Patients also indicated a desire for honesty combined with informed dialogue about their conditions and treatments. Patients also valued cheerfulness more than the nurses. A limitation of this study is the small sample size and that most of the patients were elderly men while the nurses were all women. Another limitation was the unique setting of the Veterans' Affairs Medical Center which differs from other nursing homes in that residents are mostly men. The sample also was not representative of all patients, many of whom were unable to participate in the study due to their impairments. Three patient

sample dropped out of the study because they found the Q Sort as complicated or stressful.

In addition to the Care-Q another instrument has been used to measure caring behaviors. The Caring Behaviors Assessment (CBA) was developed by Cronin and Harrison (1988). The CBA lists 61 nurse caring behaviors that are congruent with the carative factors in Jean Watson's Theory of Human Care. It considers the multiple aspects of nursing care including physical, psychological, social and spiritual considerations. It is based on a five point Likert scale indicating the degree to which each behavior listed communicates caring to the participant. Cronin and Harrison (1988) conducted a study on the importance of nurse caring behaviors as perceived by patients after myocardial infarction. Twenty-two participants ranging from 35-83 years old, the majority of whom were retirees were included in the sample. Using the CBA, behaviors rated as most important in this study were the following: know what they are doing, making me feel someone is there if I need them, know how to give shots, IV's etc., know how to handle equipment (e.g. monitors), know when it is necessary to call the doctor, do what they said they will do, answer my questions clearly, be kind and considerate and teach me about my illness. The identified behaviors focused more on the monitoring of the patient condition and the demonstration of professional competence. These findings, although using a different measurement tool, are very similar to Larson (1984), Brown (1986), Mayer (1986), Rosenthal (1992), Keane et al (1987), and Smith and Sullivan (1997). Furthermore, no differences were found in the perceptions of caring behaviors based on patient's age, gender, educational level or length of stay. Limitations of the CBA were its length and variability in the number of

items per subscale. However, no significant differences in responses were found when the tool was read aloud to participants who could not complete it independently making the tool valuable for use in a variety of patient populations. Cronin and Harrison urged that further research be undertaken on the nurse caring behaviors identified in their study to substantiate the caring process, to refine Watson's theoretical model and determine the effect that caring behaviors have on patients' outcomes.

Huggins, Gandy and Kohut (1993) studied which behaviors performed by emergency department nurses were perceived by patients as important indicators of caring. Two hundred and eighty-eight ambulatory patients, treated in the emergency department of two private urban hospitals, were interviewed within 30 days of discharge. The subjects were categorized into emergent, urgent and non-urgent based on the nature of the visit to the emergency department. Caring behaviors most frequently identified by patients from the three triage categories were items from human needs/assistance subscale. This subscale is composed of behaviors that reflects the technical competency of the nurse or caregiver. The humanism/faith-hope/sensitivity subscale reflects the importance placed on nurse competency in treating patients.

Parsons, Kee and Gray (1993) assessed surgical patients' perception of nurse caring behaviors. Utilizing the CBA as a measuring tool, 19 subjects who had undergone outpatient surgery comprised the sample. The twelve most important nurse caring behaviors for this population were grouped into four categories. The first category had the two highest scoring items: nurses know what they are doing and that they are kind and considerate. The second category next three highest scoring were the nurses treat the patient as an individual, that reassurance is provided, and that the

patient's condition is closely checked. The third category consisted of three items: (a) nurses make the patient feel that someone is there if the patient needs someone, (b) that they would do what they say they will do, and (c) that they answer the patient's questions clearly. The fourth group of items were that the nurses give the patient their full attention when they are with the patient, that they are gentle with the patient, that they are cheerful, and that they know how to handle equipment. These twelve single CBA items identified behaviors that portray the nurses' expertise in the context of humanistic and interactive skills. In this study, the patients felt that the nurses' attention to their physical and emotional well being was of great importance. The result was similar to Cronin and Harrison's study as well as previously mentioned studies. A limitation of this study was the sample size of 19.

Munn (1995) identified nurse caregiver behaviors that were perceived as important indicators of caring by elderly persons residing in Extended Care Facilities (ECF). A sample of 107 residents ranging from 66-95 years old from two urban and one rural ECF participated in the study. The CBA was used as the measurement tool. The subscale of assistance was important to this population. The assistance subscale deals with caring behaviors such as knowing how to manipulate equipment etc. This population valued caregiver competence. The lowest subscale was teaching and learning.

Mullins (1996) studied nurse caring behaviors desired by patients with acquired immunodeficiency syndrome (AIDS). Forty-six adults participated ranging from 18-55 years old. Using the CBA as a measuring tool, the most important nurse caring behaviors identified was treat me as an individual, know what they are doing, knows

how to give shots were ranked second and third. Instrumental and expressive behaviors were identified as most important indicating this population's desire for competent and humanistic care. Themes derived by the author from the data included acceptance, respect, treatment of the person as an individual, and non-judgmental attitudes of the nurse toward the person with AIDS/HIV.

Marini (1997) studied the perception of older adults residing in institutional settings of nurse caring behaviors using the CBA. This was the second study in this literature review using the quantitative approach with the institutionalized older adults as participants. Twenty-one residents, a mix of long term care and residential assisted living residents identified the highest indicator of nurse caring as the nurses' technical competency in meeting physical needs. This indicator is part of the human needs/assistance subscale. The subscale humanism/faith-hope/ sensitivity ranked second in importance. Being treated with respect and care that enhanced individualism was important for this population. Limitations of the study were the small sample size and the length of the instrument. The older adults with impairments had to take frequent breaks in answering the questionnaire. This was the first study in the literature review that used the CBA on the older adults in an institutional setting. The CBA has been widely used in the acute care setting.

An additional instrument used to measure caring behaviors is Wolf's (1986) Caring Behaviors Inventory (CBI). This instrument was also found to be congruent with Watson's Theory of Transpersonal Caring. Wolf, Giardino, Osborne, and Ambrose (1994) conducted a study of dimensions of nurse caring. A revised CBI, 42 item from the original 75-item instrument was used. A convenience sample of 541 subjects; 278

nurses and 263 patients in an acute care setting participated in this study. The revised CBI included 42 items, using a four point Likert scale to elicit the degree of response. Test/retest reliability was established on a nurse sample ($r=.96, p=.000$; $\rho=.88, p=.000$). The alpha coefficient was .83. Internal consistency reliability resulted in an alpha coefficient of .96 in a combined sample of nurses and patients. Content validity was established by a panel of four nurse experts and construct validity was addressed with an unpaired *t test* result of $t = 3.01$; $df = 539$; $p = .003$ indicating the patients and nurses were different. Exploratory factor analysis and varimax rotation resulted in the five dimensions of the CBI: (a) respectful deference to the other, (b) assurance of human presence, (c) positive connectedness, (d) professional knowledge and skill and (e) attentiveness to the other's experience.

Wolf, Colahan, Costello, Warwick, Ambrose & Giardino (1998) used the CBI in a correlational study on nurse caring and patient satisfaction. A sample size of 335 medical-surgical patients reported a strong, positive correlation between the two variables ($r = 0.78, p < .001, R^2 = 61.46\%$). In this study, the CBI was scaled to a six point Likert scale to increase the variability of responses and directions on the tool was revised. The subscale 'Respectful deference to other' was ranked highest. No further study on caring behaviors utilizing the Caring Behavior Inventory as a measurement tool was found.

Comparison of Caring Measurement Tools

The three tools used to measure nurse caring behaviors quantitatively are Care Q (Larson, 1984), CBA (Cronin & Harrison, 1988) and the CBI (Wolf, 1986). The Care Q

aims to determine patients' perceptions of important nurse caring behaviors and consists of 50 behavioral items under six identified subscales of caring as being accessible, explains and facilitates, comforts, anticipates, trusting relationship, monitors and follows through. The Care Q uses the Q methodology and involves a forced choice format where the participant selects items from each of the most important to least important categories. Mean time of administration was 26 minutes (Beck, 1999). In comparing several tools that define nurse caring behaviors utilizing 26 nurse administrators Andrews, Daniels and Hall (1996) found that the Care Q was time consuming for the participants to complete and they had difficulty understanding the directions of the tool. It was determined that elderly residents in ECFs may have difficulty completing this tool and therefore, it was not considered for this study. In addition, reliability and validity of the tool has not been established.

The Caring Behavior Assessment (CBA) by Cronin and Harrison (1988) is based on Watson's (1985) carative factors. It consists of 61 nurse caring behaviors grouped into seven subscales identified as (1) humanism/faith-hope/sensitivity, (2) helping/trust, (3) expression of positive/negative feelings, (4) teaching/learning supportive/protective/corrective environment, (5) human needs assistance and (6) existential/phenomenological. The CBA is a five point Likert scale which indicates the degree to which each behavior listed communicates caring to the participants. The CBA was written at the sixth grade level of education. Four content experts familiar with Watson's conceptual model established face and content validity. The internal consistency reliability coefficient ranged from 0.66 to 0.90 for the individual caring behavior. The length of the tool and variability in the number of items per subscale was

pointed out by the author as one of the limitation of the tool. Marini (1997) in her study of institutionalized older adults perceptions of caring behaviors cited that subjects found the tool lengthy and frequent breaks during the tool's administration had to be undertaken.

Wolf's (1986) CBI was developed based on caring behaviors derived from the literature. It consists of 42 items ranked on a 6 point Likert scale. Wolf (1986) conceptualized caring as an interpersonal intervention and views caring as an intimate exchange between the nurse and patient that enhances the growth of both parties. The five dimensions of the CBI: (a) respectful deference to the other, (b) assurance of human presence, (c) positive connectedness, (d) professional knowledge and skill and (e) attentiveness to the other's experience were found to be congruent with Watson's (1985) theory of transpersonal care. Mean time of administration as identified by Beck (1999) was 6 minutes. Andrews et al (1996) found the CBI was the most user friendly in terms of the consistency in its language as well as the instructions to the participant are brief and easy to understand.

In comparison of the three tools reviewed, the CBI appears most appropriate for use with elderly residents in ECFs due to its fewer number of items and briefer instructions to the participants when compared with the Care Q or the CBA. Marini (1997) also recommended the use of this tool in assessing perceptions of caring behaviors by older adults.

Summary

Empirical studies reviewed indicated that nurses and patients differ in their perception of nurse caring behaviors. Studies revealed that patients' value instrumental/technical activities over expressive activities, while the reverse is true for nurses. It cannot be denied however, that the studies reviewed support that caring has both instrumental and expressive dimensions. The context in which the nurse-patient interaction occurs may also impact the way caring is perceived. There is a need to focus on which nurse caring behaviors patients' want, being the recipient of care in the caring interaction. Furthermore, studies on caring behaviors from the perspective of older adults' living in extended care facilities are limited. For nursing to deliver a competent and humanistic care, knowledge and information of which caring behaviors elderly residents in extended care facilities want from the nursing staff is needed. A greater understanding of these behaviors can enhance and improve nursing care provided to patients in these facilities, promote a caring environment and obviate ill effects of non caring practices such as neglect, depersonalization, fostered dependency and infantilization (Nay, 1998).

CHAPTER 3

CONCEPTUAL FRAMEWORK

Jean Watson's theory of Transpersonal Caring provides the theoretical framework for this study. Watson believes that nursing is a human science of persons and human health-illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human transactions (Watson, 1999). According to Watson, the process of nursing is human care and views it as the moral ideal of nursing. For Watson, human care and caring consists of transpersonal human-to-human attempts to protect, enhance, and preserve humanity by helping a person find meaning in illness, suffering, pain, and existence; to help another gain self-knowledge, control and self-healing wherein a sense of inner harmony is restored regardless of the external circumstances. The nurse is a coparticipant in a process in which the ideal of nursing is intersubjectivity (Watson, 1999, p.54). Human caring involves values, a will and a commitment to care, knowledge, caring actions and consequences. Transpersonal human caring and caring transactions are those scientific, professional, ethical yet esthetic, creative and personalized giving-receiving behaviors and responses between nurse and patient that allow for contact between the subjective world of the experiencing persons through physical, mental, or spiritual routes or some combination thereof (Watson, 1999, p.58)

According to Watson, caring takes place during a single caring moment where experience and perception are taking place between the nurse and the individual. This is

the moment where both the nurse and the individual decides on how to be in the relationship. It begins with the nurse, influenced by the caring consciousness and her will and intention to care, enters the life space of the individual and senses his or her condition and responds to it. This moment is based on mutual and complementary exchange of subjective feelings between the nurse and the individual allowing an intersubjective flow to occur.

For Watson, the goals for the theory ideals are associated with mental-spiritual growth for self and others, finding meaning in one's own existence and experiences, discovering inner power and control, and potentiating instances of transcendence and self-healing. The individual patient is considered as the agent of change with the nurse being a coparticipant in that change through the human care process. The interventions in this theory are related to the human care process with full participation of the nurse/person with the patient/person. According to Watson, "Human care requires knowledge of human behavior and human responses to actual or potential health problems; knowledge and understanding of the individual needs; knowledge of how to respond to others' needs; knowledge of our strengths and limitation; knowledge of who the other person is, his or her strengths and limitations, the meaning of the situation for him or her; and knowledge of how to comfort, offer compassion and empathy. Human care also requires enabling actions, that is, actions that allow another to solve problems, grow, and transcend the here and now, actions that are related to general and specific knowledge of caring and human responses" (Watson, 1999, p.74). The intervention is referred to as "carative factors" occurs in that caring occasion, where the nurse is being

with individual patient. The ten carative factors are Watson's bases for nursing practice (Watson, 1985). The ten carative factors are summarized as follows:

1. **Formation of a humanistic-altruistic system of values.** This is the first and most basic factor for the science of caring. It is the commitment to and satisfaction of receiving through giving. Humanistic-altruistic values are learned early in life and continues as one grow and mature. It is the ability to appreciate diversity and individuality of others.
2. **Instillation of faith-hope.** This factor promotes holistic professional care and produce positive health by giving regard to the patient's belief. This allows the patient to accept information from the nurse and engage in attitude change and health seeking behaviors.
3. **Cultivation of sensitivity to one's self and to others.** Sensitivity to one's self and others leads to self-acceptance and psychological growth and allows the nurse to develop self and fully utilize self with others.
4. **Development of a helping-trust relationship.** This factor involves the quality of the nurse's interpersonal communication. It involves congruence, empathy, nonpossessive warmth, and effective communication. It consists of all the cognitive, affective, and behavioral responses used to convey a message to another person and facilitate health-seeking behaviors.
5. **Promotion and acceptance of the expression of positive and negative feelings.** This allows, promotes, and accepts expression of positive and negative feelings in self and others. This improves one's level of awareness and internal control over one's

behavior and actions. A focus on one's feelings and the "non-rational" emotional aspect of an event is necessary for nurses engaged in the human caring process.

- 6. Systematic use of the scientific problem-solving method for discussion making. The nursing process, a systematic problem solving approach is the nurse's valuable tool in the care of a person, family, group, or even a community. It is similar to the research process in that it is systematic and organized.**
- 7. Promotion of interpersonal teaching learning. This includes the teaching and learning process and the consideration of all processes that facilitates learning. This factor includes scanning, formulating, appraising, developing a willingness to problem solve, planning, implementing and evaluating.**
- 8. Provision for a supportive, protective, or corrective mental, physical, sociocultural, and spiritual environment. These are the routine functions and activities of the nurses that promote or restore health, prevent illness, or care for the sick. This includes comfort, privacy, safety and clean aesthetic surroundings.**
- 9. Assistance with gratification of human needs. The ordering of needs most relevant to nursing as the science of nursing are biophysical, psychophysical, psychosocial and intrapersonal-interpersonal needs. The nurse must respond to the patient as an individual and in doing so assists with the gratification of the patient's needs. Equal attention must be given to all the needs for when one is affected all others are affected, directly or indirectly.**
- 10. Allowance for existential-phenomenological forces. This factor acknowledges the foundation of the separateness and identity of each person. This helps the nurse to**

understand and comprehend the meaning of life or of the illness situation for the patient.

According to Watson (1999), all of these carative factors become actualized in the moment-to-moment human care process where the nurse is being with the patient. Human care requires the nurse to possess specific intentions, a will, values, and a commitment to an ideal intersubjective human-to-human care transaction that is directed toward the preservation of personhood and humanity of both nurse and patient (Watson, 1999, p.75).

For this study, the extended care facility is where the caring occasion occurs and where nursing care is manifested through instrumental and affective behaviors that convey caring to the elderly resident. Nursing care plays a significant role in fostering a richer meaning in the lives of the elderly residents. The caring occasion allows the nurse or the nurse's aide to enter the life space of the elderly resident, allowing a mutual intersubjective relationship to occur. When the ten carative factors guides this caring occasion, it transcends that occasion and brings about preservation of human dignity and the personhood which are important to the elderly resident.

Assumptions

The following assumptions underlie this study:

1. Caring is the moral imperative of nursing (Watson, 1999).
2. Caring is an important aspect of nursing intervention and the nurse-patient relationship.
3. Care can be identified and described by residents in ECFs in terms of behaviors.

4. Residents of the extended care facilities (ECFs) are able to identify which caring behaviors are perceived as most important.
5. Participants will answer the questionnaire truthfully.
6. Caring can be measured (Gaut, 1986, Cronin and Harrison, 1988).

Research Questions

The following are the research questions to be answered by this study:

1. Which caring behaviors elderly residents want exhibited by the nursing staff in extended care facilities?
2. Which caring behaviors are perceived as most important and least important?
3. Do demographic variables of age, gender, ethnicity, level of education and length of stay in this facilities influence these perceptions?

Definition of Terms

For the purpose of this study the following terms will be defined:

Nurse caring behavior – Jean Watson’s concept of intersubjective or transpersonal care will be utilized to define this concept. Transpersonal human care and caring are those scientific, professional, ethical, yet esthetic, creative and personalized giving-receiving behaviors and responses between the nurse and the patient. Transpersonal care allows for contact between the subjective world of the experiencing persons (through physical, mental, or spiritual routes or some combination thereof). There is an interconnectedness between the one cared for and the one caring (Watson, 1988, p.58).

Operationally, it is defined as the nurse caring behaviors included in the Caring Behaviors Inventory (CBI) by Wolf (1986).

Caregiver- Webster's 1994 conceptually defines caregiver as a person who takes care of someone requiring close attention. Operationally, caregiver is defined as registered nurses, licensed practical nurses and certified nursing assistants. All three are the direct caregivers in the extended care facilities.

Extended Care Facilities (ECF) – conceptually defined as a skilled nursing facility that provides skilled nursing or rehabilitative services (<http://www.medicare.gov>). Operationally, it is defined as long-term care facilities licensed as skilled nursing facilities. It excludes rehabilitation units.

Resident – conceptually will be an individual who is cognitively aware, has resided in the ECF for three months or longer, who is 65 years and older and is unable to live in the community due to some impairment. Resident is operationally defined as an individual 65 years and older living in ECFs for at least three months who is cognitively intact, no severe hearing or speech impairment, no diagnosis of dementia as indicated by no presence of triggers in sections B, C and I of the Minimum Data Set (MDS) and does not require a guardian in making decision for themselves. The Minimum Data Set (MDS) is a uniform set of elements extracted from the Resident Assessment Instrument (RAI) which is a standardized tool for assessing the functional capacity of residents of long-term care facilities. Section B of MDS addresses cognitive patterns, section C addresses communication/hearing patterns and section I addresses disease diagnosis.

CHAPTER 4

METHODOLOGY

Introduction

This chapter presents the study methodology. It describes the research design, population and sample, the instrument (CBI), human subject rights, explanation of the procedure of data collection and the data analyses.

Research Design

A non-experimental descriptive design was used for this study. Descriptive research aims at describing phenomenon rather than explaining them (Polit & Hungler, p.144, 1991). It provides an accurate portrayal or account of characteristics of a particular individual, event, or group in real-life situation for the purpose of discovering new meanings describing what exists, determining the frequency with which something occurs and categorizing information (Burns & Grove, p. 779, 1997). A richer understanding about the concept of caring is now developing and a follow up study of Marini's 1999 pilot study will contribute to this growing body of knowledge.

Nurse caring behaviors from the perspective of the older adults living in extended care facilities was the phenomenon of interest of this study. Incongruence of how caring is perceived by nurses as opposed to patients was well documented in this

study's literature review. Nurse caring behavior was the concept studied within the conceptual framework of Watson's Theory of Transpersonal Care (1985). The ten carative factors within the conceptual framework further guided the research design by the use of five correlated nurse caring dimensions of the Caring Behavior Inventory (CBI). The research variable nurse caring behavior was measured through the analysis of the Caring Behavior Inventory (CBI) scores which is congruent with Watson's Theory of Transpersonal Caring. This instrument was used based on the recommendation from Marini's (1999) pilot study.

Population and Sample

This study was conducted at six suburban for profit skilled nursing facilities in the southwest area of the United States. The target population were the older adults living in extended care facilities. The accessible population were the older adults living in the long-term care unit of six suburban skilled nursing facilities in the southwest area of the United States who participated in this study. The facilities were a combination of private and corporate owned, for profit type of facilities. Bed capacities of these facilities ranges from 98 to 1030. Data collection was done in these facilities.

Non-probability sampling by convenience method was used. A list of residents who met the study's criteria was requested from the facility's director of nursing with the assistance of the facility's Minimum Data Set (MDS) coordinator. The Minimum Data Set (MDS) is a uniform set of elements extracted from the Resident Assessment Instrument (RAI) which is a standardized tool for assessing the functional capacity of residents of long-term care facilities. Completion and transmission of this data to

designate state agencies is a requirement for long-term care facilities who participate in the Medicare and Medicaid programs. This reporting was mandated by the Omnibus Budget Reconciliation Act of 1987 and was funded by the Health Care Financing Administration (HCFA). The Minimum Data Set was utilized to ensure that the study's sampling criteria was met. Residents who were cognitively intact, no severe hearing or speech impairment and no disease diagnosis of dementia, who were 65 years and older and has been in the facility for at least three months was included. Section B of the MDS addresses cognitive patterns, section C addresses communication/hearing patterns and section I addresses disease diagnoses. Older adults with the diagnosis of Alzheimer's disease, multi-infarct dementia, senile dementia, psychosis and confusion were excluded from this study. This diagnosis was indicated in section I of the MDS.

Sampling power analysis was done utilizing Borenstein & Cohen's (1990) Statistical Power Analysis software and a sample of 193 residents was needed to achieve a power of .80. However, only 48 subjects were obtained who met the criteria for participation in the study. Many of the residents in the available ECFs had cognitive limitations that prevented their participation.

Instrument Description

Nurse caring behaviors were measured by the Caring Behavior Inventory (CBI) by Wolf (1986, 1994 & 1998). The CBI is a 42 item questionnaire with a six-point Likert type scale. It elicits responses of 1= never, 2 = almost never, 3 = occasionally, 4 = usually, 5 = almost always, and 6 = always. The CBI has five dimensions or subscales of nurse caring which is congruent with Watson's Theory of Transpersonal

Care. The subscales include (a) respectful deference to others, (b) assurance of human presence, (c) positive connectedness, (d) professional knowledge and skill, and (e) attentiveness to the other's experience. 'Respectful deference to others,' has twelve items that describes a courteous regard for the other. 'Assurance of human presence', includes twelve items that reflected an investment in the other's needs and security. 'Positive connectedness' includes nine items that portrays an optimistic and constant readiness on the part of the nurse to help. 'Professional knowledge and skill' includes five items that indicates nurse caring as proficient, informed and skillful. 'Attentive to other's experience' has four items that incorporates an appreciation of and engrossment in the other's perspective and experience (Wolf et al., 1994).

The CBI was developed by Wolf based on caring behaviors from the literature. The CBI consists of 42 items ranked on a 6 point Likert scale with '6' as always and '1' as never. The CBI was used in this study to measure nurse caring behaviors. The level of measurement that was obtained from this tool can be classified as interval data. In the 1994 study done by Wolf, Giardino, Osborne & Ambrose the CBI's internal consistency reliability was established at .96 in the combined nurse and patient sample. A panel of four nurse experts established content validity. Construct validity of the contrasted nurse and patient group using an unpaired *t* test revealed differences between the two groups

($t=3.01$; $df = 539$; $p = .003$). The CBI's overall internal consistency reliability was established at .98 for Wolf's et al 1998 study. Literacy of the CBI was established at grade 5.9 using the Fleschers Kincaid Grade Level and Flesch Reading Ease was 60.7. The CBI also includes a patient profile section for demographic data.

The use of this tool for the current study was based upon the recommendation of Marini's (1999) pilot study. She cited the difficulty of some older adults in completing the 61 item Caring Behavior Assessment (CBA) by Cronin and Harrison (1988). The length and time of administration of the CBI were considered appropriate for older adult's use in comparison with other tools used to define perceptions of nurse caring behaviors. The average amount of time the subjects completed the CBI for the current study ranged from 10 to 30 minutes. The CBI has never been used in the older adults in extended care facilities. It was used in acute care settings only. The instructions and wording of CBI was modified with the permission of the tool's author to fit this study's population and setting. To assure the appropriateness of the CBI for the current study, a pilot study was conducted with five older residents in extended care facilities. No problems were encountered in the ability of the pilot sample to complete the CBI. Internal consistency Chronbach alpha was performed to determine reliability for this study's sample.

Human Subject Rights

The administrator and the director of nursing at the extended care facilities were contacted for their approval to conduct research within their facility. A list of residents that met the study's criteria was requested from the facility's director of nursing. Each resident on the list was approached by the researcher and invited to participate in the study. Informed consent was obtained from the participants who agreed to participate. Each participant was informed of the purpose of the study, procedure, potential benefits and potential complications of participating. Each participant was given the opportunity

to ask questions or clarify any misunderstandings before consenting to participate in the study. They were informed that there were no consequences or repercussions if they chose not to participate, and that they could withdraw from participation at any time. Written consents was obtained from each participant. Confidentiality was maintained by not using the resident or the facility's name on the questionnaire or demographic profile section. Questionnaires were coded for each facility with only the researcher knowing the code. Anonymity was maintained by not using the resident's or the facility's name in the documentation of the results. Approval to conduct the study was obtained from the Human Subjects Rights Committee at the University of Nevada, Las Vegas and from participating extended care facilities.

Data Collection Methods

Potential subjects were identified by the facility's director of nursing with the assistance of the MDS coordinator utilizing the study's inclusion criteria. Each resident on the list provided was approached by the researcher to extend an invitation to participate and to explain the study and its purpose. The residents who were interested in participating were asked to sign an informed consent prior to data collection. The residents who agreed to participate completed the CBI and demographic patient profile. For most of the participants, the investigator read the question aloud to the resident and marked the responses they indicated for each item in the CBI.

Confidentiality was maintained by separating the demographic data and CBI response sheets from the signed consent form. Each questionnaire was coded according to facility. The researcher was the only person with access to the completed

questionnaires. The questionnaires were kept in a locked cabinet with only the researcher possessing the key. The data collected will be stored for three years and will then be destroyed.

Statistical Analyses

Research Questions

The following research questions provided direction for the analysis of this study's data.

1. Which caring behaviors do elderly residents want exhibited by the nursing staff in extended care facilities?

Individual item responses to the CBI were summed to calculate the total Caring Behaviors Inventory (CBI) score. Mean scores (M) and standard deviations (SD) were calculated for each of the 42 item on the CBI. Total mean scores were also calculated for items within each of the five dimensions of the CBI. The dimension with the highest mean score was identified as the caring behaviors elderly residents want exhibited by the nursing staff in ECFs.

2. Which nurse caring behaviors are perceived as most important and least important by the elderly residents?

The mean scores (M) and standard deviations (SD) were examined for each of the 42 items on the CBI. The top five items with the highest mean scores were identified as the most important caring behaviors and the five items with the lowest mean score were identified as the least important caring behaviors as perceived by the elderly residents in this sample.

3. Do sample demographic variables of age, gender, ethnicity, level of education and length of stay in this facilities influence these perceptions of caring behaviors?

Frequency distributions of the demographic variables of the sample were run using the Statistical Package for the Social Sciences (SPSS) to organize the data for examination. The Pearson's product-moment correlation was utilized to determine if age was related to perceptions of caring behaviors. The Independent T test was utilized to determine if there was a difference between gender and perceptions of caring behaviors. A significance of .05 was established.

With the small sample size of this study it was not feasible to analyze the data as originally anticipated. Therefore, categories of level of education and length of stay were collapsed into two independent categories to allow an independent t test to be performed. Educational level was collapsed into (1) high school or less and (2) some college or more. Length of stay in the facility was collapsed into: (1) less than a year and (2) more than a year. Collapsing the variables allowed analysis to be performed to determine the difference in perceptions of caring behaviors between those who had a high school diploma or less and those with some college education or more. The difference between the means of those who have stayed in the facility for less than a year and those who have stayed in the facility for more than a year regarding perceptions of caring behaviors were also analyzed. A significance level of .05 was established.

The data regarding ethnicity were significantly skewed. Eighty five percent of the sample were Caucasians, therefore no statistical comparisons were made for ethnicity.

CHAPTER 5

DATA ANALYSIS

Introduction

This chapter summarizes the results of the study and its findings. Statistical analyses used in answering the study's three research questions are presented. The Statistical Package for the Social Sciences (SPSS) software was the program used to analyze the data using frequency distributions, Pearson's *r* test and *t*-tests.

Sample Description

The data obtained from the participants included responses to the research instrument, the Caring Behaviors Inventory and demographic information. The total convenience sample size was comprised of 48 ($n = 48$) participants. Thirty two females and 16 males met the inclusion criteria. The participants ranged in age from 65 to 94 years old. The mean age of the participant was 79.5 standard deviation (SD) 7.78. Ethnicity of the participants was mostly Caucasian comprising 85.4 % of the sample. Educational level of the participants ranged from those who completed high school or less to those who have more than three years of college. Length of stay in the facility ranged from less than a year to more than five years with 45.8 % of the sample have

stayed in the facility between 1-3 years. Demographic data from the sample is presented in Appendix A, Table 1.

Reliability Analysis

The Caring Behaviors Inventory, a six-point Likert type scale was used to measure residents' perceptions of which caring behaviors they want exhibited by the nursing staff in the ECFs. Responses ranged from a "6" representing always to "1" representing never.

The Cronbach's Alpha reliability assessment for the internal consistency on overall items and on each of the subscales was computed. The reliability coefficient for the overall items was 0.92. The reliability coefficient for the five subscales ranged from 0.61 (attentiveness to other's experience subscale) to 0.79 (assurance of human presence subscale). Appendix A Table 2 presents the reliability coefficients for each of the five subscales from this study.

Results

The following are the results of the statistical analyses pertaining to each research question.

Research Question 1

"Which caring behaviors elderly residents want exhibited by the nursing staff in extended care facilities?"

Individual item responses of the CBI were summed to calculate the total Caring Behaviors Inventory (CBI) score. (See Appendix A Table 3). Mean scores (M) and

standard deviations (SD) were calculated for each of the 42 items on the CBI. The individual items are included within the CBI's identified five nurse caring dimensions that are congruent with Watson's Theory of Transpersonal Care. Total mean scores were calculated for each of the item in the five dimensions of the CBI. The highest ranked nurse caring dimension was "professional knowledge and skill" with a mean of 5.53 (SD .65). Items included in this dimension were behaviors such as knowing how to give shots, IVs etc, demonstrating professional knowledge and skill and giving my medications and treatments on time. This was followed by the "attentiveness to other's experience" (M 5.23 SD .82) which included items such as paying special attention to me during first times such as hospitalization, treatments, relieving my symptoms and giving good physical care. "Assurance of human presence" dimension was ranked third (M 5.06 SD.67) which included items such as being sensitive to me, helping me and providing a reassuring presence. "Positive connectedness" was ranked fourth (M 4.97 SD .74) which included items such as touching me to communicate caring, being hopeful for me and trusting me. The lowest ranked caring dimension by this study's sample was "respectful deference to others" (M4.95 SD .63) which included items such as attentively listening to me, giving instructions or teaching me and spending time with me. (See Appendix A Table 4).

Research Question 2

"Which caring behaviors are perceived as important and least important?"

Mean scores and SD were calculated for each of the 42 items on the CBI. Mean scores ranged from a high of 5.75 (SD 0.60) for the item, "being honest to me" as the most important caring behavior the participants want exhibited by the nursing staff to a

low of 3.48 (SD 1.15) for the item, “spending time with me”. The rank ordered five most important caring behaviors elderly residents of this study wants from the nursing staff were: (1) being honest with me (M 5.75; SD .60), (2) giving my treatments and medications on time (M 5.71; SD .58), (3) treating patient information confidentially (M 5.69; SD .78), (4) appreciating me as a human being (M 5.67; SD .75) and (5) giving good physical care (M 5.65; SD .89). (See Appendix A Table 5).

The rank ordered five least important caring behaviors elderly residents want exhibited by the nursing staff were: (1) spending time with me (M 3.48; SD 1.15), (1) touching me to communicate caring (M 3.85; SD 1.38), (3) giving instructions or teaching me (M 3.92; SD 1.44), (4) talking with me (M 4.13; SD 1.48) and (5) attentively listening to me (M 4.40; SD 1.33). (See Appendix A Table 6).

Research Question 3

“Do demographic variables of age, gender, ethnicity, level of education and length of stay in this facilities influence these perceptions?”

To find out if demographic variables of age, gender, ethnicity, level of education and length of stay in the extended care facilities (ECFs) influence the participants perceptions, the Pearson’s r and the independent t test were utilized. Demographic variables were compared with the total CBI scores. Pearson’s r was used to determine if age was related to perceptions of caring behaviors. There was no significant relationship between age and perceptions on the total CBI scores ($r = -.098, p = 0.509$) and on the five caring dimensions. (See Appendix A Table 7 & 8). The demographic variables level of education and length of stay were collapsed and recoded into two groups to allow for statistical computation and independent t test was utilized to find out if there

was a difference in the participants perceptions of caring behaviors. There was no significant difference between gender and perceptions ($t = .86$, $df = 46$, $p = .39$) when tested on the total CBI scores. (See Appendix A Table 9). However when the variable gender was tested on each of the five caring dimensions there was a significant difference in the perceptions of caring behaviors. A significant difference was found in the variable respectful deference to others dimension. Females scored higher (M 60.92) than males (M 56.44) indicating that elderly women perceived caring behaviors under this dimension more important than men did. (See Appendix A Table 10). No significant difference was found on perceptions and educational level ($t = -.569$, $df = 46$, $p = .572$). (See Appendix A Table 11). There was no significant difference on perceptions and length of stay ($t = -.45$, $df = 46$, $p = .64$). (See Appendix A Table 12).

The data on the variable ethnicity significantly skewed to allow for statistical computation.

Summary

This chapter addressed the data analysis of the results of the study. Results of the statistical tests that were utilized in the present study for the three research questions were discussed as well as the reliability of the data collection tool.

CHAPTER 6

INTERPRETATION, DISCUSSION, RECOMMENDATIONS AND SUMMARY

Introduction

This chapter summarizes the study and discusses the significance of the study findings related to the three research questions and the theoretical framework. The limitations of the study, conclusions, implications for nursing, and recommendations for further study are discussed in the latter portion of the chapter.

The purpose of this study was to describe elderly residents' perceptions of which caring behaviors they want exhibited more often by the nursing staff in extended care facilities. It also sought to identify which caring behaviors are important and least important to the residents.

Discussion and Interpretation

The first research question asked, "Which caring behaviors do elderly residents want exhibited by the nursing staff in extended care facilities?". The participants in this study identified those behaviors under the professional knowledge and skill dimension of the CBI (M 5.53 SD 0.65) as being the most important for nursing staff to display. This dimension focuses on nurse caring as proficient, informed and skilled (Wolf et al,1994).

Behaviors that exhibit competency on the part of the nurse highlight this dimension.

The results of this study, although using a different data collection instrument and patient population, support the findings of Larson (1984), Rosenthal (1992), Cronin & Harrison (1988), Mayer (1986), Huggins, Gandy & Kohut (1993), (Parsons, Kee & Gray (1993). These studies found that the patients in acute care settings ranked the items in the human assistance subscale highest. These items focus on nurse caring behaviors that provide gratification of human needs such as nursing staff knowing what they are doing, knowing how to give shots, knowing how to manipulate equipment etc. Although the patients in the current study were in long-term care settings, they were similar in how they perceive caring behaviors from nursing staff and what behaviors they expect from nursing staff as well.

In studies which have been done utilizing samples similar to the current study, the results are similar. Munn (1995) and Marini (1997) found that patients identified the human needs assistance subscale as the most important nurse caring behavior. In a qualitative study conducted by Santo Novak (1997) the elderly participants ranked 3 main themes of caring. The knowledgeable category was ranked highest over the caring and attentive categories. The participants in Novak's study expected the nurse to be knowledgeable, to recognize patient needs, to explain procedures and provide information, to be competent with skills, and to show competent technical and professional behaviors.

It is not surprising that the sample in this study identified the professional knowledge and skill nurse caring dimension as the behaviors they wanted to be exhibited most often by the nursing staff in ECFs similar to studies previously

mentioned. The basic physiologic needs come first before other higher level needs such as self actualization, self esteem can be met (Maslow, 1970). The results also suggest that elderly residents in ECFs expect nursing care to be given by qualified and competent nurses and nurses aides. Ford (1996), in a study to determine what older people in long-term care settings value in nurses, found that the participants gave clear reasons of how qualified nurses can make a difference both in terms of technical care and their quality of life.

The participants in the current study identified those behaviors under the 'attentiveness to other's experience' dimension as second to the professional knowledge and skill dimension. The attentiveness to other's experience dimension focuses on nurse caring behaviors that incorporates an appreciation and engrossment in the other's perspective and experience (Wolf et al, 1994). This current study's participants value the ability of the nursing staff to experience their life space and be familiar with their condition and experiences. The nursing staff's true presence and knowledge of the resident's condition coupled with their intention, will and nursing actions during the caring occasion, maintains human dignity and integrity which is important for the institutionalized resident. This supports Watson's (1995) view of caring as a moral ideal directed toward the preservation of humanity.

Nurse caring behaviors grouped under the respectful deference to others dimension reflect items that incorporated a courteous regard for the other. This dimension was given the lowest priority by the sample in this study. This finding was further supported by the five least important nurse caring behaviors identified by the sample. Three out of the 5 behaviors belonged under the respectful deference to others

dimension. This finding is in contrast to the findings of Wolf et al (1998) where patients ranked this dimension as the highest. This contrast could be attributed to the difference in population and setting in which the caring interaction occurred. The Wolf et al 1998 study assessed discharged medical-surgical patients' perceptions of caring while the current study assessed elderly residents' perceptions in ECFs. In addition, patients in Wolf et al (1998) sample evaluated the care that they received from the nursing staff while in the current study participants identified which caring behaviors they wanted from the nursing staff. This difference in study purpose may be responsible for the differences in the results.

The second research question asked "Which caring behaviors are perceived as most important and least important?". The five most important caring behaviors elderly residents in this study wanted from the nursing staff were: (1) Being honest with me, (2) Giving my treatment and medications on time, (3) Treating patient information confidentially, (4) Appreciating me a human being and (5) Giving good physical care. The elderly residents in this study wanted the nursing staff to be honest with them. This is in agreement with the findings of Smith and Sullivan (1997). Utilizing a similar sample, they found that patients in the long-term care setting indicated a desire for honesty combined with informed dialogue about their condition and treatments. Mayeroff (1971) identified honesty as one of the major ingredients of caring. It can be noted that these five caring behaviors were a combination of both expressive and instrumental activities supporting Watson's view of transpersonal human caring transactions (Watson, 1985). The participants also valued having their medication and treatments on time and getting good physical care. These findings also support

Maslow's (1970) hierarchy of human needs where biophysical needs comes first over psychosocial needs. This hierarchy of needs was adapted by Watson (1985) in the formation of her carative factors. This finding might be expected as residents are in a nursing care facility because they are not able to take care of themselves alone. For this sample, patient confidentiality and being appreciated fully as a human being were also given priority. For elderly residents in institutionalized settings, their personhood continues to be undiminished and fully worthy of continuing respect despite the infirmities and loss of function that brought them to the facility (Collopy, Boyle, & Jennings, 1992).

The five least important caring behaviors elderly residents reported they wanted from the nursing staff were: (1) spending time with me, (2) touching me to communicate caring, (3) giving instructions or teaching me, (4) talking with me and (5) attentively listening to me. For the participants in the current study, the behavior 'spending time with me' was identified as the least important caring behavior for the nursing staff to demonstrate. This findings is in contrast to Aventura's (1991) findings. Utilizing a similar sample, the participants in her study identified that caring interactions were few and they wanted more meaningful contact with the nursing staff. The behavior 'touching me to communicate caring' was also given a low priority by the current study's sample. This is in agreement with the finding of Marini (1997,1999) where using a similar sample, touch was also given lowest priority. This may be due to the cognitive states of the participants involved in both studies. Purdy (1978), cited that touch was very important to the elderly residents who presented with some disorientation and that touching by holding the resident's hands during conversation

appears to aid concentration. Touching as a caring behavior was given less importance in the current study possibly due to the intact cognitive state of the participants. The caring behavior 'giving instructions or teaching me' was also given lowest priority by the participants in this study. This is in agreement with the findings of Munn (1995). Munn (1995) indicated that elderly residents do not perceive a great need to be taught about their illness or to help them set goals for their health compared to patients who expect to be discharged in acute care settings. The behaviors 'talking with me' and 'attentively listening to me' were also given the lowest priority. This could be attributed to the current study's sample where majority of participants were still able to perform simple activities of daily living and that they were cognitively intact. Some comments made by participants during data collection referred to nursing staff having so much to do. The participants in this study expressed that they did not want to bother the nursing staff and that there were other patients needing more attention and care than they did. The majority of the participants in the current study indicated that having nursing staff talk with them and listen to them becomes important only when they need it.

The third research question was "Do demographic variables of age, gender, level of education and length of stay in the facility influence perceptions of caring behaviors?" There was no significant relationship found between age and perceptions of caring behaviors in the current study. There were also no significant differences found between level of education or length of stay in the facility and the perceptions of caring behaviors for the participants in the current study. This finding is supported by Cronin and Harrison (1988) and Parsons, Kee & Gray (1993). Although there was no significant difference in perceptions of caring behaviors by gender on the overall CBI

scores, a significant difference was found in the perceptions of caring behaviors under the 'respectful deference to others' dimension. The elderly women perceived caring behaviors under this dimension as more important than men in the current study. This suggests that perceptions of caring behaviors may be influenced by gender. This finding supports those of Poole and Rowat (1994), Marini (1997,1999), and Munn (1995).

The Cronbach's alpha reliability assessment for the internal consistency on overall items of the Caring Behaviors Inventory (CBI) for this study was 0.92. The internal consistency reliability of the CBI was established at 0.96 in the Wolf et al (1994) study. The 5 caring dimensions alpha coefficient reliabilities in the 1994 study by Wolf ranged from .8157 to .9221. Wolf et al (1998), utilizing a revised CBI where the directions of the tool were changed, found the overall internal consistency reliability of the CBI 0.98. The CBI's 5 caring dimensions' alpha coefficient reliability ranged from .91 to .96. In the current study, the CBI's 5 caring dimensions' alpha coefficient reliability ranged from .6142 to .7966. This is lower than the CBI's established alpha coefficient. This finding may be attributed to the changes that were made in the wording and directions of the CBI to fit the current study.

Limitations of the study

The results of this study cannot be generalized to the target population of elderly residents in extended care facilities because data from this study is primarily descriptive. The sample was relatively small, N=48, and participants were from only one geographic area. Another limitation of the study is that the data collection instrument used consisted of a forced choice format possibly limiting the participant's

answers. The least important caring behaviors reported by participants may not necessarily mean unimportant but rather that they are less important relative to other caring behaviors. Another limitation with regard to the data collection tool was that the participants tended to focus on the actual care they receive from nursing staff rather than the care they would like to receive from the nursing staff. It is possible that the CBI may not be appropriate to use for the purpose of the current study.

Conclusions

In light of the study's findings and limitations, the following conclusions are drawn from the results of this study:

1. The elderly residents in this sample want the nursing staff to exhibit professional, knowledgeable, skillful and competent behaviors.
2. The elderly residents in this sample expect honesty from the nursing staff.
3. Important nurse caring behaviors identified by the elderly residents were both instrumental (technical) and expressive (affective).
4. Gender differences exist in this sample's perceptions of nursing staff caring behaviors
5. Demographic variables of age, educational level and length of stay did not influence this sample's perceptions of caring behaviors.

Implications for Nursing

The following implications for nursing education, practice and administration can be drawn from this study.

Nursing Education

The current study sought to determine which caring behaviors elderly residents in ECFs wanted from the nursing staff. Findings from this study demonstrate that this sample of elderly residents in ECFs want professional, knowledgeable, skillful and competent caregivers. Nurse educators and educators of nurse assistants should take heed of this finding. It should be emphasized to undergraduate nursing students that taking care of the elderly population is complex because of the biological age-related changes that occurs along with multiple pathology and psychosocial changes. A strong knowledge base of the care needs of the elderly in ECFs needs to be included and integrated into their curriculum. Caring behaviors as identified by caring recipients can therefore be taught to students. Jean Watson's theory of transpersonal care is based on the ten carative factors. Nursing interventions guided by the ten carative factors can bring about a caring interaction that is beneficial to the caregiver and the caring recipient. This study's sample identified five most important caring behaviors which consists of a combination of instrumental (technical) and expressive (affective) behaviors. The physical, technical and behavioral dimension of nursing can be taught within this caring framework to educate and orient nursing students and nurses aides to view caring as a tangible rather than an abstract concept.

The long term care setting provides a more intimate and extended length of interaction between nurse/nurses aides and patient over a continuous period of time and will provide the students with a significant awareness into how caring behaviors can be practiced and the intended intention of the caring act can be evaluated. The clinical instructors are also challenged to be role models for the students by exhibiting

behaviors desired by the elderly residents in the ECFs and instructors should take the opportunity to promote a meaningful long term care experience and make the care of the elderly in ECFs attractive to the student.

Nurse practitioner students should also include the long term care setting for their related learning exposures to enrich their experience in the care of the elderly. This will allow them to better understand chronicity and chronic health problems and to practice a caring demeanor to promote a caring environment in the ECFs.

Nursing Practice

Extended care facilities, particularly the long term care setting are places where the aim is to provide the elderly resident with the highest quality of life possible in their remaining years. Long term care nurses and nurses aides are the core caregivers in the ECFs and plays a significant role in making a difference in the residents' quality of life.

The results of this study should guide the long term care institutions' staff development education department to focus on the very essence of nursing practice in the long term care setting – the care of the elderly. This will hopefully decrease the incongruency in how caring behaviors are viewed by nurses, nurses aides and patients and focus on what elderly residents expect from their caregivers and direct the education of the nursing staff toward these expected behaviors. This study's results should also aid in implementing nursing care that is congruent with the elderly residents' expectations and could significantly enhance the quality of life and resident satisfaction in the long term care setting.

Long term care nurses must be equipped with the appropriate knowledge and skills to be able to deliver quality care. Effective nursing of the elderly requires a thorough knowledge base concerning biological and functional changes of aging. The elderly of today demand expertise in their care and it should be the aim of professional practice to provide the highest standard of care. This standard of care can be met by providing formal orientation and continuous regularly scheduled in-service education on basic physiological and psychosocial needs of the elderly by a qualified educator. This education will ensure the nursing staff's competency and awareness of the needs of the elderly resident.

Increased utilization of nurse practitioners in long term care settings could benefit the residents as well as the nursing staff because of their advanced training and understanding of chronic health conditions. Knowledge gained from this study should guide nurse practitioners in their practice in meeting the care needs of the elderly.

Nursing Administration

Nursing administrators of long term care facilities should hire qualified and competent personnel to provide nursing care to the residents. They should not succumb to the myth that it doesn't take much nursing skill to work with the aged. This study has shown that the elderly residents in ECFs want competent and skillful nurses and nurses aides to care for them. Administrators should also ensure that continuing in service education will be provided to the nurses and nurses aides with focus on nursing knowledge, skills and attitudes in the care of the residents. Administrators must find ways to facilitate caring practices in their facilities. Knowledge gained from this study

should also guide their facility mission statements to promote a caring environment for its residents. Finally, administrators should also realize the positive contribution nurse practitioners can provide regard to staff education and patient care considering their advanced knowledge and training in the care of the elderly and chronic health problems.

Recommendations

The following recommendations are suggested.

1. This study should be replicated using a larger sample from different geographical location to further examine and validate the findings of this study.
2. Gender differences in perceptions of caring behaviors by elderly residents should be explored.
3. Evaluation of elderly perceptions of caring behaviors in relation to their quality of life in the ECFs could significantly impact the growing knowledge base of nurse caring.
4. Measurement tool development geared to assess perceptions of caring behaviors provided by nursing staff to the elderly population particularly in long term care needs to be developed
5. A combined quantitative and qualitative research design in evaluating elderly perceptions of caring behaviors in ECFs would be advantageous and would assist in uncovering caring's complete meaning in the context of long term care.

Summary

This chapter addressed the interpretation, discussion and recommendations based on the results of this study.

With the projected demographic increase in the number of people over 65 years old in the years to come, this study identified caring behaviors elderly residents want nursing staff to demonstrate in extended care facilities. These findings should decrease the incongruence that exists in the perceptions of caring behaviors between nurses and patients. Nursing care should be directed to the expectations of the elderly residents. In doing so, the elderly residents' holistic needs can be met and they can be provided with a caring environment which should decrease the incidents of non-caring interactions between the residents and the nursing staff in the long-term care setting.

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APPENDIX A

TABLES

Table 1 Frequency Distribution for Demographic Characteristics of the Sample (N=48)

Characteristics	Frequency	Percent
Sex		
Male	16	33.3 %
Female	32	66.7%
Total	48	100%
Age		
65-75	15	31.2%
76-85	22	45.8%
86-95	11	23%
Total	48	100%
Ethnicity/Race		
African-American	5	10.4%
Asian	1	2.1%
Caucasian	41	85.4%
Native American Indian	1	2.1%
Total	48	100%

**Table 1(cont) Frequency Distribution for Demographic Characteristics of the Sample
(N=48)**

Characteristics	Frequency	Percent
Educational Level		
Grades 1-8	7	14.6%
Grades 9-12	25	52.1%
1-2 years college	12	25%
More than 3 years college	4	8.3%
Total	48	100%
Length of Stay		
< 1 year	19	39.6%
1-3 years	22	45.8%
3-5 years	5	10.4%
> 5 years	2	4.2%
Total	48	100%

Table 2 Reliability Coefficients for the CBI Subscales

Subscale	Number of Items	Cronbach's Alpha
Respectful deference to other	12	0.7855
Assurance of human presence	12	0.7966
Positive connectedness	9	0.7615
Professional knowledge and skill	5	0.6902
Attentiveness to other's experience	4	0.6142

Table 3 Total CBI Score

Variable	N	M	SD
Total CBI Score	48	213.42	24.20

Table 4 Total Mean Scores for each Dimension of the Caring Behaviors Inventory

Question number/item	Mean and Standard Deviation
Professional Knowledge and Skill (5 items)	5.53 (SD .65)
19. Knowing how to give shots, IVs, etc.	
20. Being confident with me	
22. Demonstrating professional knowledge and skill	
24. Managing equipment skillfully	
38. Giving my treatments and medications on time	
Attentiveness to Other's Experience (4 items)	5.23 (SD .82)
39. Paying special attention to me during first times, as hospitalization, treatment	
40. Relieving my symptoms	
41. Putting me first	
42. Giving good physical care	
Assurance of Human Presence (12 items)	5.06 (SD .67)
16. Being sensitive to me	
18. Helping me	
26. Allowing me to express my feelings about my disease and treatment	
29. Providing a reassuring presence	
30. Returning to me voluntarily	
31. Talking with me	
32. Encouraging me to call if there are problems	
33. Meeting my stated and unstated needs	
34. Responding quickly to my call	
35. Appreciating me as a human being	
36. Helping to reduce my pain	
37. Showing concern for me	
Positive Connectedness (9 items)	4.97 (SD .74)
1. Touching me to communicate caring	
2. Being hopeful for me	
7. Trusting me	
8. Being empathetic or identifying with me	
9. Helping me grow	
17. Being patient or tireless with me	
21. Using a soft, gentle voice with me	
23. Watching over me	
25. Being cheerful with me	
Respectful Deference (12 items)	4.95 (SD .63)
3. Attentively listening to me	
4. Giving instructions or teaching me	
5. Treating me as an individual	
6. Spending time with me	
10. Giving me information so that I can make a decision	
11. Showing respect for me	
12. Supporting me	
13. Calling me by my preferred name	
14. Being honest with me	
15. Making me physically or emotionally comfortable	
27. Including me in planning my care	
28. Treating patient information confidentially	

Table 5 Most Important Caring Behaviors Elderly Residents want from the Nursing Staff

Behavior	Mean	SD
Being honest with me	5.75	.60
Giving my treatments and medications on time	5.71	.58
Treating patient information confidentially	5.69	.78
Appreciating me as a human being	5.67	.75
Giving good physical care	5.65	.89

Table 6 Least Important Caring Behaviors Elderly Residents want from the Nursing Staff

Behavior	Mean	SD
Spending time with me	3.48	1.15
Touching me to communicate caring	3.85	1.38
Giving instructions or teaching me	3.92	1.44
Talking with me	4.13	1.48
Attentively listening to me	4.40	1.33

Table 7 Pearson Correlation Coefficient Between Age and Total CBI Score (N=48)

Variable	N	<i>r</i>	Sig.(2-tailed)
Total CBI Score	48	-.098	.509

Table 8 Pearson Correlation Coefficients Between Age and the 5 Caring Dimensions of CBI (N=48)

Variable	N	<i>r</i>	Sig.(2-tailed)
Total CBI Score	48	-.098	.509

Table 9 T-test Results Comparing Perceptions of Caring Behaviors with Gender (N=48)

Variable	Gender	N	M	SD
Total CBI Scores	Female	32	215.56	22.81
	Male	16	209.13	27.03
Variance	t	df	Sig. (2-tailed)	
Assumed Equal	.867	46	.391	

**Table 10 T-test Results Comparing Gender and the CBI Dimension of Respectful
Deference to Others (N=48)**

Variable	Gender	N	M	SD
Respectful deference to others	Female	32	60.97	6.65
	Male	16	56.44	8.66
Variance	t	df	Sig. (2-tailed)	
Assumed Equal	2.009	46	.050	

Table 11 T-test Results Comparing Perceptions of Caring Behaviors with Educational Level (N=48)

Variable	Educational Level	N	M	SD
Total CBI Scores	High School Diploma or less	32	212.00	23.88
	Some college or more	16	216.25	25.37
Variance	t	df	Sig. (2-tailed)	
Assumed Equal	-.569	46	.572	

Table 12 T-test Results Comparing Perceptions of Caring Behaviors with Length of Stay (N=48)

Variable	Length of Stay	N	M	SD
Total CBI Scores	Less than a year	19	211.42	24.81
	More than a year	29	214.72	24.14
Variance	t	df	Sig. (2-tailed)	
Assumed Equal	-.459	46	.649	

APPENDIX B

DATA COLLECTION INSTRUMENT

DEMOGRAPHIC INFORMATION OF PARTICIPANT

DIRECTIONS for residents: Please complete the following information. Kindly circle or write your answer.

1. Gender: 1. Female 2. Male

2. Age: _____ Date of Birth: _____

3. Ethnicity/ Race:

1. African-American
2. Asian
3. Caucasian
4. Hispanic
5. Native American Indian
6. Other, please specify _____

4. Educational Level:

1. Grades 1-8
2. Grades 9-12
3. 1-2 years college
4. More than 3 years college

5. Length of Stay in the Facility

1. Less than a year
2. 1 – 3 years
3. 3 – 5 years
4. more than five years

Directions:

Please read the list of items below that describe behaviors by nurses. Please circle the answer that best describe how often you want the nurses or nurses' aides to show each behavior to you.

1. Attentively listening to me.

never almost never occasionally usually almost always always

2. Giving instructions or teaching me.

never almost never occasionally usually almost always always

3. Treating me as an individual.

never almost never occasionally usually almost always always

4. Spending time with me.

never almost never occasionally usually almost always always

5. Touching me to communicate caring.

never almost never occasionally usually almost always always

6. Being hopeful for me.

never almost never occasionally usually almost always always

7. Giving me information so that I can make a decision.

never almost never occasionally usually almost always always

8. Showing respect for me.

never almost never occasionally usually almost always always

9. Supporting me.

never almost never occasionally usually almost always always

10. Calling me by my preferred name.

never almost never occasionally usually almost always always

11. Being honest with me.

never almost never occasionally usually almost always always

12.Trusting me.

never almost never occasionally usually almost always always

13.Being empathetic or identifying with me.

never almost never occasionally usually almost always always

14.Helping me grow.

never almost never occasionally usually almost always always

15.Making me physically or emotionally comfortable.

never almost never occasionally usually almost always always

16.Being sensitive to me.

never almost never occasionally usually almost always always

17.Being patient or tireless with me.

never almost never occasionally usually almost always always

18.Helping me.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

19.Knowing how to give shots, IVs, etc.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

20.Being confident with me.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

21.Using a soft, gentle voice with me.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

22.Demonstrating professional knowledge and skill.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

23.Watching over me.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

24. Managing equipment skillfully.

never almost never occasionally usually almost always always

25. Being cheerful with me.

never almost never occasionally usually almost always always

26. Allowing me to express feelings about my disease and treatment.

never almost never occasionally usually almost always always

27. Including me in planning my care.

never almost never occasionally usually almost always always

28. Treating patient information confidentially.

never almost never occasionally usually almost always always

29. Providing a reassuring presence.

never almost never occasionally usually almost always always

30. Returning to me voluntarily.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

31. Talking with me.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

32. Encouraging me to call if there are problems.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

33. Meeting my stated and unstated needs.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

34. Responding quickly to my call.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

35. Appreciating me as a human being.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

36. Helping to reduce my pain.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

37. Showing concern for me.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

38. Giving my treatments and medications on time.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

39. Paying special attention to me during first times, as hospitalization,treatments.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

40. Relieving my symptoms.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

41. Putting me first.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

42. Giving good physical care.

never	almost never	occasionally	usually	almost always	always
-------	--------------	--------------	---------	---------------	--------

APPENDIX C

APPROVAL LETTERS

DATE: April 5, 2001

TO: Ludy Llasus
Nursing
M/S # 3018

FROM: Dr. Jack Young, Chair
UNLV Biomedical Sciences Institutional Review Board

RE: Status of Human Subject Protocol Entitled:
"Perceptions of Caring Behaviors by Elderly Residents in Extended Care Facilities"

OPRS #501s0401-001

This memorandum is official notification that the protocol for the project referenced above has been reviewed by the Office for the Protection of Research Subjects and has been determined as have having met the criteria for exemption from full review by the UNLV Biomedical Sciences Institutional Review Board. In compliance with this determination of exemption from full review, this protocol is approved for a period of one year from the date of this notification and work on the project may proceed.

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 assistance, please contact the Office for the Protection of Research Subjects at 895-2794.

cc: OPRS File

Office for the Protection of Research Subjects
4505 Maryland Parkway • Box 451046 • Las Vegas, Nevada 89154-1046
(702) 895-2794 • FAX (702) 895-4242

UNLV

7 March 2001

LUDY LLASUS
8125 CHILTORN AVE
LAS VEGAS, NV 89129

Dear Ms Llasus:

The Department of Nursing Human Subjects Rights Committee met on your proposal "Perceptions of caring behaviors by elderly residents in extended care facilities" and give approval with the following changes.

1. Make all materials that are given to the participant 14 point. ✓
2. Print the questionnaire so that all of the Likert responses are on the same line. ✓
3. On the Informed Consent clearly state that no information provided by a participant will be shared with the nurses, aides, director etc. ✓
4. Please check for typos and awkward grammar.
5. Clearly identify how you want participants to respond on your demographic page. (see notes on the questionnaire).

If you make any changes in your study please inform the Committee of your proposed changes. It looks like a very interesting study.

Sincerely,

Margaret Louis, Chairperson
Human Subjects Rights Committee
Department of Nursing, UNLV

Department of Nursing
4505 Maryland Parkway • Box 453018 • Las Vegas, Nevada 89154-3018
(702) 895-3360 • FAX (702) 895-4807

**PROTOCOL FORM APPROVAL SHEET
FOR RESEARCH INVOLVING HUMAN SUBJECTS**

Log Number: 7 March 2001

Title of Project:

Perceptions of caring behaviors by elderly residents in extended care facilities

Investigator: Ludy S.M. Llasus & Cheryl Bowles

After reviewing this proposal, the members of the Department of Nursing, Human Subjects Rights Review Committee has indicated below their approval/disapproval of this proposal.

Signature of Committee Members

Approve Disapprove

Margaret Llasus

x

Cheryl Bowles

x

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

Date: 8 Mar 2001

Margaret Llasus
Committee Chairperson's Signature

Department of Nursing
4505 Maryland Parkway • Box 453018 • Las Vegas, Nevada 89154-3018
(702) 895-3360 • FAX (702) 895-4807

Ludy SM. Llasus BSN, RN

Department of Nursing
 University of Nevada, Las Vegas
 Tel. Number (702) 895-4106

Date

Administrator

Director of Nursing

Name and Address of Facility

Dear Sir/ Ma'am:

I am a registered nurse preparing for my master of science degree in Family Nurse Practitioner at the University of Nevada, Las Vegas. A part of our requirement for the degree is to write a research thesis.

As we have discussed previously, I am studying the perceptions of nurse caring behaviors by elderly residents in extended care facilities. The study involves having residents in long-term care answer a 42 item questionnaire about caring as well as demographic information. (See attached).

I would like to include the perceptions of residents in your institution. This research proposal will be reviewed and approved by the UNLV Research and Review Committee for protection of human subjects and carries no perceived risks to the residents who will participate in the study. I hope to obtain information that will be useful to nursing practice, education and administration.

The instrument to be used for data collection is a 42 item questionnaire dealing with types of caring behaviors. It will include demographic information such as age, sex, ethnicity, educational level and length of stay in the facility. A list of residents who meets the study's criteria will be requested from the Director of Nursing. Information from sections B,C and I of the Minimum Data Set will also be utilized to screen possible participants as cognitive function of participants needs to be intact for this study. Informed verbal and written consent will be obtained from each resident before data collection is started. I will be personally collecting all data. Participation in the study is voluntary and responses are confidential. Confidentiality and anonymity of the resident and your facility will be maintained.

Thank you very much.

Sincerely,

Ludy SM. Llasus

El Jen
Convalescent and Retirement
5538 West Duncan Drive Las Vegas, NV 89130
702-645-2606 Fax 702-645-1478

January 29, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

I, James Toomey, administrator, give my permission for you to collect data for your master's thesis at El Jen Convalescent and Retirement at 5538 West Duncan Dr., Las Vegas, Nevada contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

James Toomey

January 29, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

I, Robbie Williams, administrator, give my permission for you to collect data for your master's thesis at Cheyenne Care Center at 2856 E. Cheyenne, North Las Vegas contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

Robbie Williams

IHS - Cheyenne Care Center
2856 East Cheyenne Avenue • North Las Vegas, NV 89030 • 702-644-1885 • FAX: 702-644-2404

CHEYENNE RESIDENTIAL & NURSING CENTER

January 31, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

I, Linda Boggs, administrator, give my permission for you to collect data for your master's thesis at Cheyenne Residential & Nursing Center at 2860 E. Cheyenne Ave., North Las Vegas, Nevada contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

Linda Boggs

2860 E. Cheyenne Ave., North Las Vegas, Nevada 89030 • (702) 644-7777

January 31, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

I, Paul M. Boyar, administrator, give my permission for you to collect data for your master's thesis at The Plaza Regency at Sun Mountain Comprehensive Care Center at 6021 W. Cheyenne Ave., Las Vegas, Nevada contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

Paul M. Boyar

6021 W. Cheyenne Ave. / Las Vegas, NV 89108 / 702-658-9494 / Fax: 702-658-9419

6151 Vegas Drive / Las Vegas, Nevada 89108 / (702) 648-4900
FAX (702) 648-5227

May 9, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

I, Ira Kurtz, executive director, give my permission for you to collect data for your master's thesis at Life Care Center of Las Vegas at 6151 Vegas Drive, Las Vegas, Nevada contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

Ira Kurtz

North Las Vegas Care Center

An IHS Operated Facility

July 9, 2001

**Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas**

Dear Ms. Llasus,

I, Frank Bellinger, administrator, give my permission for you to collect data for your master's thesis at North Las Vegas Care Center at 3215 E. Cheyenne Ave., North Las Vegas, Nevada contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

Frank Bellinger

3215 E. Cheyenne Avenue • North Las Vegas, NV 89030 • 702-649-7800 • FAX: 702-649-2144

NEW VISTA
HEALTH SERVICES

IMPERIAL OASIS
Lic.#130804820
590 West Main St.
Brawley, CA 92227
(760) 344-7060

August 7, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

NURSING and REHAB CENTER
8647 Fenwick St.
Sunland, CA 91040
(818) 352-1421

I, Sally Sharifat, director of nursing, with the approval of Joel Waldman, administrator, give my permission for you to collect data for your master's thesis at New Vista Health Services, Post Acute Care Center West L.A. at 1516 Sawtelle Blvd., Los Angeles, California contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's Minimum Data Set (MDS) coordinator for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

OAK PARK MANOR
RESIDENTIAL CARE
Lic.#197801458
501 S. College Ave.
Claremont, CA 91711
(909) 626-0117

Sincerely,

POST-ACUTE CARE CENTER
WEST L.A.
1516 Sawtelle Blvd.
Los Angeles, CA 90025
(310) 477-5501

Sally Sharifat

NEW VISTA
HEALTH SERVICES

IMPERIAL OASIS
Lic. #130804820
590 West Main St.
Brawley, CA 92227
(760) 344-7060

August 7, 2001

Ludy Llasus
Department of Nursing
University of Nevada, Las Vegas

Dear Ms. Llasus,

NURSING and REHAB CENTER

8647 Fenwick St
Sunland, CA 91040
(818) 352-1421

OAK PARK MANOR
RESIDENTIAL CARE
Lic #197801458
501 S. College Ave.
Claremont, CA 91711
(909) 625-0117

I, Joel Waldman, administrator, give my permission for you to collect data for your master's thesis at New Vista Health Services, Post Acute Care Center West L.A. at 1516 Sawtelle Blvd., Los Angeles, California contingent upon the approval of the University of Nevada, Las Vegas Institutional Review Board. I understand that you will work with the facility's director of nursing and the Minimum Data Set (MDS) for identification of participants. The resident who agrees to participate in the study will be given a questionnaire to fill out regarding caring behaviors. Ms. Llasus has given me the assurance that the facility and the residents will remain anonymous in the documentation of the results of the study. Resident's response will be treated with confidentiality, the questionnaire and demographic form not bearing the resident's name or the facility.

Sincerely,

Joel Waldman

POST-ACUTE CARE CENTER
WEST L.A.
1516 Sawtelle Blvd.
Los Angeles, CA 90025
(310) 477-5501

Ludy Sta. Maria-Llasus

February 5, 2001

**Dr. Zane Robinson Wolf
27 Haverford Road
Ardmore, PA 19003**

Re: CARING BEHAVIORS INVENTORY

Dear Dr. Wolf,

You have given me the permission through e mail to use your tool the CBI for my master's thesis. I am also asking permission to change and modify the directions in the tool to fit my subjects and setting. I will be conducting my study in a long term care facility and I will be including the nurses' aides along with nurses for the perceptions of caring behaviors. It will be this way for my study:

Directions:

Please read the list of items that describe nurse caring. For each item, please circle the answer that stands for the extent that a nurse or nurses' aide made caring visible to you being a resident in this facility.

The word patient in each question will be replaced with the word me. For example Question 1 would read: 1. Attentively listening to me.

This changes is requested in consideration of my planned elderly subjects and also that the study will be done in a long-term care setting.

Enclosed is the release form for the CBI.

Thank you very much.

Sincerely,

**Ludy Sta. Maria-Llasus
University of Nevada, Las Vegas
Graduate Student, Department of Nursing**

February 12, 2001

Ludy Sta. Maria-Llasus
8125 Chiltern Avenue
Las Vegas, NV 89129

Dear Ludy:

You have my permission to modify the Caring Behaviors Inventory as stipulated in your letter of February 5, 2001. Please send a copy of the revised instrument for my files. As you know, it is an original instrument and I own the copyright. Please send an abstract of your completed study if you use the CBI in an investigation.

Best wishes to you for your future.

Sincerely,

Zane Robinson Wolf, PhD, RN, FAAN
Dean and Professor

May 17, 2001

**Dr. Zane Robinson Wolf
27 Haverford Road
Ardmore, PA 19003**

Re: Caring Behaviors Inventory

Dear Dr. Wolf,

I am asking permission to modify the directions in the tool to fit my subjects and setting. The purpose of my research is to describe which caring behaviors residents in extended care facilities want exhibited more frequently by nurses and nurses' aides. Consequently, I will be able to answer what caring behaviors are important and least important to the residents. My previously requested direction modification does not reflect what I aim to answer in my study. My previously requested change in directions reads this way:

Directions:

Please read the list of items that describe nurse caring. For each item, please circle the answer that stands for the extent that a nurse or nurses' aide made caring visible to you being a resident in this facility.

The word patient in each question will be replaced with the word me. For example Question 1 would read: 1. Attentively listening to me.

The current request for modification of directions in the tool will be:

Directions:

Please read the list of items below that describe behaviors by nurses. Please circle the answer that best describe how often you want the nurses or nurses' aides to show each behavior to you.

The word patient in each question will be replaced with the word me. For example Question 1 would read: 1. Attentively listening to me.

These changes is requested in consideration of my aim to measure which nurse caring behaviors are perceived to be important from the perspective of older adults' living in extended care facilities.

Thank you very much.

Sincerely,

**Ludy Sta. Maria-Llasus
University of Nevada, Las Vegas
Graduate Student, Department of Nursing**

LA SALLE UNIVERSITY**SCHOOL OF NURSING****PHILADELPHIA, PA 19141 • (215) 951-1430****OFFICE OF THE DEAN**

June 12, 2001

Ludy Sta. Maria-Llasus
8125 Chiltern Avenue
Las Vegas, Nevada 89129

Dear Ludy:

You have my permission to use the Caring Behaviors Inventory in your research and to revise it as indicated in your letter of May 17, 2001.

The CBI is an original instrument and I own the copyright. Please send an abstract of your completed study if you use the CBI in an investigation and also report alpha coefficients. Please also send a copy of the revised instrument as it is used in your study.

Best wishes to you for your future.

Sincerely,

Zane Robinson Wolf, PhD, RN, FAAN
Dean and Professor

LA SALLE UNIVERSITY**SCHOOL OF NURSING****PHILADELPHIA, PA 19141 • (215) 951-1430****OFFICE OF THE DEAN**

July 13, 2001

Ludy Sta. Maria-Llasus
8125 Chiltern Avenue
Las Vegas, Nevada 89129

Dear Ludy:

You have my permission to use the Caring Behaviors Inventory in your research and to revise it as indicated in your letter of May 17, 2001. This letter may be an additional letter to support your request.

The CBI is an original instrument and I own the copyright. Please send an abstract of your completed study if you use the CBI in an investigation and also report alpha coefficients. Please also send a copy of the revised instrument as it is used in your study.

Best wishes to you for your future.

Sincerely,

Zane Robinson Wolf, PhD, RN, FAAN
Dean and Professor

September 20, 2001

Dr. Zane Robinson Wolf
27 Haverford Road
Ardmore, PA 19003

*sent
9/24/01*

Re: CARING BEHAVIORS INVENTORY

Dear Dr. Wolf,

I am asking permission to include the Caring Behaviors Inventory, a copyrighted material of yours to be included in my master's thesis at the University of Nevada, Las Vegas. Enclosed is the university's standard form for permission to use copyrighted material.

Thank you very much.

Respectfully,

Ludy Sta. Maria-Llasus
Graduate Student
Department of Nursing
University of Nevada, Las Vegas

Permission to Use Copyrighted Material

University of Nevada, Las Vegas

I, Jane Robinson Wolf, PhD, RN, FAAN holder
of copyrighted material entitled Caring Behaviors Inventory
authored by Jane Robinson Wolf
and originally published in full text available from
27 Hanerford Rd Ardmore PA 19003
Appt. scale version drug: The Journal of Nursing Scholarship
(not whole text (1995) 26(2), 104-111)
hereby give permission to graduate student Ludy Sta. Maria-Llasus to use the above
described material in total or in part for inclusion in her master's thesis at the University
of Nevada, Las Vegas.

I also agree that requesting graduate student may execute the standard contract with
University Microfilms, Inc. for microform reproduction of the completed master's thesis,
including the materials to which I hold the copyright.

Jane Robinson Wolf PhD RN FAAN 9/24/01
Signature Date

JANE ROBINSON WOLF Dean and Professor
Name (typed) La Salle University Title
School of Nursing

herself
Representing

APPENDIX D

INFORMED CONSENT

**CONSENT TO PARTICIPATE IN A RESEARCH STUDY
UNIVERSITY OF NEVADA, LAS VEGAS
DEPARTMENT OF NURSING**

TITLE OF STUDY: Perceptions of Caring Behaviors by Elderly Residents in Extended Care Facilities

**RESEARCHER: Ludy Sta. Maria-Llasus R.N. B.S.N.
Graduate Student**

You are invited to participate in this research study. The following information is provided in order to help you make an informed decision whether or not to participate.

You are eligible to participate because you are a resident of an extended care facility and at least 65 years old.

The purpose of this research is to describe elderly residents perceptions of which caring behaviors they want exhibited more frequently by the nursing staff in extended care facilities. Nursing staff includes registered nurses, licensed practical nurses and nurses aides.

Participation in this study will take approximately 15 minutes of your time. You will be asked to complete a questionnaire that lists behaviors of nursing staff. You will be asked to rate how frequently you would like each behavior demonstrated to you by the nursing staff from a scale of "always" to "never". There are no right or wrong answers.

There are minimal risks of feelings of discomfort in answering the questionnaire associated with this study. Participation is voluntary and you can stop at any time. It will not affect your relationship with the researcher or the University of Nevada, Las Vegas. If you decide not to participate in this study, the care you receive from nursing staff will not be affected.

The information obtained from this study will help nursing practice, education and administration understand how you perceive caring behaviors and will help us in promoting a caring environment in extended care facilities.

The information obtained from this study will be kept confidential. Only the researcher will have access to responses you give on the questionnaire or personal information on the demographic profile. Your individual responses will not be shared with the nurses, nurses aides, director of nurses or other employees of your facility. Your identity and the facility's identity will not be included in the questionnaires or demographic profile. Results from the study will be presented in research meetings but will not include your name, the facility's name or its location. The questionnaires and demographic profile will

**Department of Nursing
4505 Maryland Parkway • Box 453018 • Las Vegas, Nevada 89154-3018
(702) 895-3360 • FAX (702) 895-4807**

be kept in a locked file by the researcher for three years after completion of the study and will then be destroyed.

You are encouraged to ask questions about this research before agreeing to participate in this study. I can be contacted at the Nursing Department, (702) 895-4106. You may also contact the UNLV Office for the Protection of Research Subjects for questions about your rights as a research participant in this study at 895-2794.

If you would like to receive a report of the results of this study, you may contact the researcher at the UNLV Nursing Department.

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

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

Signature of Participant

Date

Signature of Researcher

Date

VITA

**Graduate College
University of Nevada, Las Vegas**

Ludy Sta. Maria-Llasus

Local Address:

**UNLV Department of Nursing
4505 Maryland Parkway
Las Vegas, Nevada 89154-3018**

Degrees:

**Bachelor of Science in Nursing, 1991
West Visayas State University
Iloilo City, Philippines**

Special Honors:

**Sigma Theta Tau International, 2001
Zeta Kappa Chapter**

**Thesis Title: Perceptions of Caring Behaviors by Elderly Residents in Extended Care
Facilities**

Thesis/ Examination Committee:

**Chairperson, Dr. Cheryl Bowles, Ph.D.
Committee Member, Dr. Margaret Louis, Ph.D.
Committee Member, Dr. Sue Miner Ed.D.
Graduate Faculty Representative, Dr. Andy Fontana Ph.D.**