

Do they Really Care? How Trauma Patients Perceive Nurses' Caring Behaviors

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ABSTRACT

Applying the theory of Nursing as Caring can help the nurse provide care that is perceived as caring by moderately to severely injured trauma patients. The Caring Behaviors Inventory was administered in a 1-to-1 interview format to hospitalized trauma patients in a level 2 trauma center. Nurses were positively perceived in their caring behaviors with some variation based on gender and ethnicity. The modified Caring Behaviors Inventory is quick to use and is reliable and valid.

Key Words

Attentive nurturing, Caring behaviors inventory, Nursing as caring, Trauma patients

The purpose of this descriptive study was to assess how trauma patients with multiple injuries requiring hospitalization perceive caring behaviors in their nurses.

Florence Nightingale wrote that caring is the foundation of nursing practice.¹ Boykin and Schoenhoffer developed the theory of Nursing as Caring, in which caring is seen as a dynamic process that exists within shared experiences between the nurse and the patient.² The 2008 Essentials of Baccalaureate Education from the American Association of Colleges of Nursing states that nurses practice from a "holistic, caring framework."³ There is very little research, however, on how caring is perceived by patients, especially those in critical care areas of the health care arena. Research conducted on caring with injured patients has included patients who have fairly minor injuries. Less research has examined how the most critically injured patients perceive caring behaviors in their

nurses. The current study used the Caring Behavior Inventory (CBI)⁴ with moderately to severely injured trauma patients requiring hospitalization.

BACKGROUND

The highly charged environment of a trauma unit can place a priority on the technical skills of the nurse, yet the patient's psychological needs are also in critical need of attention at the time of a traumatic event. The ability to attend to psychological needs as well as physical needs of patients is essential to nursing practice. Providing both highly technical, life-saving interventions, while meeting the psychosocial needs of patients, represents the science and art of nursing. Caring is an essential aspect of the art of nursing practice and has been identified as a predictor of overall satisfaction by hospitalized patients.⁵ Caring behaviors in nursing are not clearly defined and may vary widely depending on location, patient need, and the nurse's own personality and experience. Leininger posits that the meaning and demonstrations of nurse caring are not always clear and frequently lack cultural sensitivity.⁶

A number of researchers have attempted to capture the nature of nurse caring behaviors. Riemen did a phenomenological study of what nurse behaviors were most important to male and female patients.⁷ There were a number of similarities and differences found on the basis of gender. Males identified such things as being physically present, feeling valued by the nurse coming to the room without being called, having the nurse help them feel comfortable and secure before attending to tasks. Females identified behaviors such as listening to them, feeling valued as unique human beings, and not just a diagnosis or room number, and providing care to make them feel comforted, relaxed, and secure, and that made them want to reciprocate.

Larson developed the Caring Assessment Report Evaluation Q-Sort (CARE-Q) to better understand how patients perceived and rated nurse caring behaviors.⁸ The CARE-Q contained 50 behavioral items divided into 6 subscales that highlighted actions such as explaining procedures, providing comfort, anticipating needs, and following through. Using the CARE-Q, 57 cancer patients identified a number of nursing behaviors that, they felt,

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demonstrated caring. These included knowledge and expertise with treatments and equipment, being organized, putting the patient first, listening and talking to the patient, and checking on them frequently.

Wolf examined the literature to identify words or phrases that meant caring in the development of the original CBI.⁴ Five dimensions of caring were initially identified: respectful deference to others, assurance of human presence, positive connectedness, professional knowledge and skill, and attentiveness to the experiences of others. The tool has been further refined from 75 items to the current 42-item survey.

Boykin and Schoenhoffer developed the theory of Nursing as Caring, which can be lived in nursing situations and practiced alone or in combination with other theories.² Caring is a process. Each person throughout his or her life grows in the capacity to express caring. Nursing as Caring is based on the following assumptions:

- Persons are caring by virtue of their humanness.
- Persons are caring, moment to moment.
- Persons are whole or complete in the moment.
- Personhood is a process of living grounded in caring.
- Personhood is enhanced through participating in nurturing relationships with caring others.

The nurse-patient relationship is built on these concepts of nurturing and caring. A number of studies have compared the perceptions of caring by patients and by their nurses and have found that patients and staff may value caring behaviors in different ways.⁹⁻¹¹ Chang et al used the CARE-Q tool to examine the importance of various caring behaviors in cancer patients and their nursing staff.¹² There were statistically significant differences between the 2 groups on 3 of the 6 subscales. Staff rated “comforts” and “explains and facilitates” as more important than did patients who rated “monitors and follows through” in a higher rank. Both groups ranked “being accessible” as the number 1 item.

There are also studies of how patient families view caring behaviors in the nurses assigned to their loved ones. A review of the nursing literature by Pryzby indicates that “there is incongruence in nurses’ assessments and families’ perceptions of what constitutes caring behaviors” in intensive care units (ICU).^{13(p16)} Nurses tend to underestimate things that family members consider most important; nurses believe that support and comfort are more important, while family members place higher value on information, proximity to the patient, and assurance.

Hayes and Tyler-Ball¹⁴ interviewed 70 trauma patients to determine their perceptions of nurse caring behaviors, using the Caring Behaviors Inventory.⁴ They were able to identify which caring behaviors were ranked most highly

and which left some room for improvement. They did not find any differences based on the gender or ethnicity of the patients.

Hayes et al¹⁵ surveyed 100 family members of moderately to severely injured trauma patients, using a modified version of the Caring Behaviors Inventory for Elders developed by Wolf et al.¹⁶ The modified version used in their study was the Caring Behaviors Inventory–Family. It consisted of 23 items rated on a 3-point Likert Scale of rarely, sometimes, and often. Eight items, including “Helping you and your family make decisions,” “Being honest with you,” and “Helping you feel comfortable,” were highly rated by family members.

In a separate study, semistructured interviews were conducted with 10 family members of moderately to severely injured trauma patients to explore and describe the behaviors that were perceived as caring to them while their loved ones were hospitalized at a level II trauma center.¹⁷ Subjects were asked to describe behaviors that were caring and behaviors that were not caring. Explaining and interpreting information by nurses was the behavior most consistently identified as caring by family members. Behaviors reported as being not caring were appearing hurried and abrupt.

In summary, a number of both quantitative and qualitative studies have identified nurse behaviors that seem to indicate caring. Instruments that have been developed have been successfully used in a variety of care settings with both patients and their family members. Studies have primarily focused on patients in the emergency department¹⁸ and in a variety of nursing care units in the hospital setting such as oncology. There have been very few studies examining how patients who have experienced serious trauma view caring behaviors in their nurses. To provide high-quality, patient-centered care, it is essential that nurses understand what actions, attitudes, and behaviors on their part will provide the most therapeutic and healing environment. It is also important to research demographic differences to provide culturally sensitive care during patient encounters with health care providers. The goal of this study was to investigate these issues within a level II trauma center.

METHODS

A descriptive study using an interview format was conducted at a 136-bed regional medical center in northern Colorado. A convenience sample of 105 moderately to severely injured adult trauma inpatients at the level 2 trauma center agreed to participate in the study. For the purposes of this study, the patients are defined as having multiple injuries requiring hospitalization. The trauma team manager identified possible subjects on the basis of scoring criteria used in that facility. Patients with injury severity scores of 15 or fewer were considered to have

a minor trauma and were excluded from consideration. Patients considered for the study had trauma scores of 15 to 20 (major trauma) or greater than 25 (critical trauma). In a 1-to-1 interview format, a researcher read 42 items describing nursing behaviors from the Caring Behaviors Inventory⁴ to the patient and asked the patient to indicate his or her response on a 6-point Likert scale from “never” to “always.” One hundred three patients completed the inventory. This was an adequate sample size according to the Kaiser-Meyer Olkin Measure of Sampling Adequacy. Thirty-four (32.4%) women and sixty-nine (65.7%) men completed the interviews. Marital status varied with 36 (34.3%) of the sample group single and 51 (48.6%) married. Ten (9.5%) were divorced and 5 (4.8%) were widowed. The majority of participants (93 or 88.6%) were non-Hispanic white. There was 1 Asian (1%), 4 Hispanics (4%), and 1 Native American Indian (1%). Two subjects (1.9%) identified their race as “other.” Subjects ranged in age from 18 to 90 years. The mean age was 43 years. Patients were interviewed either in the surgical/trauma ICU or on the post-ICU trauma unit.

The original 75-item CBI was developed by Wolf¹⁹ in 1981 and later revised into a 43-item tool. This, in turn, was further reduced to a 42-item survey. This study used the updated 42-item tool with a 6-point Likert rating scale with options ranging from never, almost never, occasionally, usually, almost always, to always. Each of the 42 items describes nursing behaviors that are further grouped into 4 subscales: assurance, knowledge and skill, respectfulness, and connectedness. Bartlett’s Test of Sphericity shows that all the questions were related to the null hypothesis ($P = .0001$). Internal consistency was demonstrated by a Cronbach alpha of .974. This accords with findings of a study done by Hayes and Ball,¹⁴ who used the tool with more than 200 trauma patients in a southeastern US hospital. Their Cronbach alpha was .98. Examples of items from the survey include the following:

- Being hopeful for you,
- Providing reassurance,
- Demonstrating professional knowledge and skill,
- Attentively listening to you,
- Treating you as an individual,
- Talking with you,
- Spending time with you.

Potential participants were identified by the trauma nurse coordinators. A researcher explained the procedure to each patient and elicited their informed consent. Only English-speaking patients older than 18 years were invited to participate. If the patient agreed to participate, the researcher gave the patient a clearly written answer sheet containing the 6 optional answers. Each question was then read to the patients and they either answered

verbally or pointed to their answer choice. All patients were interviewed in either the surgical-trauma ICU or the posttrauma care unit. Data collection continued until an adequate sample size was met.

FINDINGS

Patients rated the caring behaviors of their nurses very highly ($M = 5.45$, range of averages 4.52-5.75). The lowest rated items were “Touching the patient to communicate caring” and “Being hopeful for the patient.” The highest rated items were “Meeting the patient’s stated and unstated needs,” “Being confident with the patient,” and “Giving the patient’s treatments and medications on time.” Exploratory factor analysis demonstrated that 1 factor explained 51.85% of the total variance as determined by an Eigen value greater than 1 on the correlation matrix. The next factor accounted for only 4.77%. Varimax rotation identified 8 possible factors with the eighth factor explaining only 2.75% of the variance. The 8 factors together accounted for 75.47% of the total variance. A scree plot of the factor analysis demonstrated that the inflexion of the curve clearly indicates 1 major factor.

The following nurse behaviors were identified as components of factor 1 in order of ranking. Together, these items can be summed up as Attentive Nurturing:

- Providing a reassuring presence,
- Helping the patient,
- Being sensitive to the patient,
- Being patient or tireless with the patient,
- Being cheerful with the patient,
- Making the patient physically or emotionally comfortable,
- Attentively listening to the patient,
- Watching over the patient,
- Giving the patients treatments and medications on time,
- Responding quickly to the patient’s call,
- Showing concern for the patient,
- Showing respect for the patient,
- Treating the patient as an individual, and
- Being empathetic or identifying with the patient.

These behaviors seem to fit well into 2 of the 5 dimensions of caring identified by Wolf⁴: assurance of human presence and positive connectedness. The concept of attentive nurturing also fits well into the assumptions upon which Boykin and Schoenhoffer’s² Theory of Nursing and Caring is based. The patients in this study valued nurse behaviors that demonstrated patience and attention to their individual needs in a nurturing interpersonal environment.

Unlike many of the previous studies, chi-square analysis demonstrated that there was a significant deviation from

the hypothesis that gender would make any difference to the interpretation of nurse caring behaviors ($\chi^2(1) = 11.893, P < .001$). Men placed a higher value ($P \leq .05$) on “Attentively listening to the patient” and “Putting the patient first.” A similar deviation from the hypothesis that ethnicity would not make a difference was also found ($\chi^2(4) = 328.257, P < .001$). Six items were rated significantly higher in Latino patients, but there were only 4 Latinos in the study. However, these findings accord with the data found in a companion family study¹⁵ and bear a closer investigation with a larger Latino sample size in the future. The 6 nurse caring behaviors ranked significantly more valuable by Latino patients were “Being sensitive to the patient,” “Allowing the patient to express about his or her disease and treatment,” “Including the patient in planning his or her care,” “Appreciating the patient as a human being,” “Giving good physical care,” and “Giving the patient’s treatments and medications on time.” Only this last item was also on the most highly rated behaviors valued by the white participants (Table).

CONCLUSIONS

Moderately to severely injured patients perceive nurses as caring with differences noted on the basis of gender and ethnicity. Patients seem to value competence in their trauma nurses. This is hardly surprising, given their need for technically accurate nursing care in intensive care areas. One set of items accounted for more than 50% of the total variance and this factor includes nurse behaviors that

made these patients feel well attended to and nurtured. Meeting physiological needs in a confident and timely manner was highly rated by the non-Latino white patients. Most patients seemed to place slightly less value on touch as an indication of caring or on the more esoteric nature of the nurse demonstrating hopefulness toward them.

Further studies need to be conducted to examine ethnic differences using larger sample sizes. It would be especially important to include non-English-speaking patients. The data from this study indicate that moderately to severely injured Latino patients might need a slightly different approach to their nursing care that focuses more on strengthening their sense of being heard and included in decision making. Only a larger sample could confirm that. Gender differences in these populations should also be examined more closely. With the small sample size, it was not possible to determine specific gender differences in the Latino subjects.

It is often not clear to us how we appear to others and for nurses this can be a challenging dilemma. Caring is the heart and artistry of nursing so understanding what actions, attitudes, and behaviors convey caring is essential to good practice. Appearing both competent and caring to a wide variety of patients who come from multiple cultural backgrounds is difficult. This study will add to the knowledge that critical care nurses need to provide sensitive, high-quality care to their vulnerable patients.

Finally, the modified Caring Behaviors Inventory is quick to use and has been shown to be both reliable and valid. It could be adapted to a variety of clinical settings and might be especially useful in units that serve a variety of different ethnic groups. It could help guide nurses as they strive to provide patient-centered culturally sensitive care.

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TABLE Highest Rated Items From the Caring Behaviors Inventory: White and Latino Patients

Highest Rated Items by White Patients
• Meeting the patient’s stated and unstated needs
• Being confident with the patient
• Giving the patient’s treatments and medications on time
Lowest Rated Items by White Patients
• Touching the patient to communicate caring
• Being hopeful for the patient
Highest Rated Items by Latino Patients
• Being sensitive to the patient
• Allowing the patient to express about his or her disease and treatment
• Including the patient in planning his or her care
• Appreciating the patient as a human being
• Giving good physical care
• Giving the patient’s treatments and medications on time

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