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The meaning of professional nurse caring: The experience of family members of critically ill patients.

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THE MEANING OF PROFESSIONAL NURSE CARING: THE EXPERIENCE OF FAMILY MEMBERS OF CRITICALLY ILL PATIENTS

by

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A DISSERTATION

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ABSTRACT OF DISSERTATION
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Caring has been described as the essence of nursing (Leininger, 1984), and mechanisms to foster humane caring in the high-tech critical care environment have been described (Harvey et al., 1991). The meaning of caring from the perspective of critical care nurses and critically ill patients has been described, but in only one study were nursing behaviors perceived as caring explored from the perspective of family members (Henry, 1991). Therefore, a phenomenologic study was conducted to describe the meaning of professional nurse caring as experienced by family members of critically ill patients. Six females and three males (n=9) who were parents or spouses of critically ill patients admitted to one of three critical care units were asked to describe the meaning of caring and noncaring and how they felt when each was experienced. Four themes categories, (a) the way the nurse is, (b) meeting patients' needs first, (c) meeting family members' needs, and (d) feelings evoked by demonstrations of caring and noncaring, emerged from the data. Personality characteristics, expressive behaviors, and professional attributes of the nurse are themes included in the first category, the way the nurse is. Providing continuous and vigilant monitoring, communicating emotional care/encouragement, giving physical care/comfort, providing an opportunity for and assisting with healing, and maintaining patients' dignity and providing privacy are the themes comprising the second category, meeting patients' needs first. Themes within the third category, meeting

family members' needs, include taking care of the critically ill loved one; offering honest and consistent information; facilitating access to the physicians; providing access to the patients; allowing family members to participate in patient care; providing physical, emotional and spiritual support/comfort; and recognizing and acknowledging family members. When caring is experienced family members feel relieved of stressors, security in knowing the patient will be safe, connected to the nurses, and cared for. When noncaring is experienced they feel an uneasiness with the situation and fearful of sanctions. Conclusions, implications for nursing practice and education, and recommendations for further research are offered.

Abstract Approved by: Committee Chairman Kathleen C. Brown

Program Director Elizabeth Stuffenbarger

Date 12/13/93 Dean of Graduate School [illegible]

DEDICATION

This dissertation is lovingly dedicated to the memory of my grandparents, Elton Jacob Erford (1897-1949), Lila Olive Smith Erford Iversen (1898-1991), Leonard Miers (1900-1991), and Hazel Fern Duffy Miers (1903-1968), and to the honor of my parents, Willard and Wanda Erford Miers.

To each, my love and sincere appreciation.

"Doc"

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CHAPTER I

INTRODUCTION

The healthcare system of today is in crisis. In the decade of the 1980s, 700 hospitals closed; 900 others are currently on the endangered list; and it is predicted that by the year 2000, 450 more hospitals will close. Whether individuals receive healthcare depends not on their need for care but on their financial ability to pay. The healthcare system of today is driven by the cost of its services (Johanson, 1992).

One factor leading to the high cost of healthcare is technology. Consumers take high-tech healthcare for granted, and they expect it to be available when they need it. Hospital marketing departments are aware of these attitudes, and they use the latest technology and newest machines as tools for attracting patients, critical care nurses, and physicians to their institutions (Evans, 1991).

The high-tech nature of the present day hospital, and more specifically its critical care units, has led to the need for an increased number of nurses to care for the critically ill whose lives are, in part, dependent on that technology. There are approximately 223,000 critical care nurses in the United States. Approximately 36,000 more critical care nurses are needed to fill current openings in 4500 hospitals, and it is predicted that by the year 2000, as hospitals increasingly become centers for the acutely and critically ill, approximately 400,000 critical care nurses will be needed (Evans, 1991).

For every critically ill patient who is cared for by one of these 223,000 nurses, there is probably, at the least, one family member or loved one who also must experience the technologic environment of the critical care unit and who is also dependent on the critical care nurse for care. A news anchor, who had recently spent

three and one-half weeks with a family member in a cardiac surgery intensive care unit, recalled "My mother never left the unit alive, but I left with the understanding that without the tenderness and the touch, the technology means nothing" (cited in Johanson, 1992, p. 11). Writing about her experience in the emergency room after the accidental death of her 17-year-old daughter, a mother wrote:

> Please search yourselves for resources to deal helpfully with others like us. Seek ways to make the few moments available for deeply troubled persons times of healing rather than destruction. Plan ways of staffing your facilities with people who are full of heart and wise in the administration of compassion. We need caring so desperately. (cited in Reilly, 1978, p. v)

These examples represent experiences of the critical care environment from the perspective of family members of critically ill patients. Although each lived experience was different and each family member responded to the critical care environment in an individual manner, each noted, either directly or indirectly, the need for care or caring from the critical care unit staff. Urban (1988) identified a "caring approach" first on a list of nursing interventions for family responses to the critical care environment (p. 109). What constitutes a caring approach from the perspective of the family members of the critically ill?

Aware of the current shortage of professional nurses in critical care units, the complexity of the critical care environment, and the toll the combination of these factors takes on one's ability to provide humane care, the Society of Critical Care Medicine (SCCM) in 1989 sponsored an invitational *Consensus Conference on Fostering More Humane Critical Care — Creating a Healing Environment*. "The purpose of the Consensus Conference was to develop guidelines for healthcare professionals to consider in creating a healing critical care environment that fosters humane care" (Harvey et al., 1991, p. 202). Concerning the issue of caring, Conference participants stated, "consumers and healthcare professionals often perceive that the typical critical care environment makes the provision of humane care difficult. Humane care strives to integrate caring practices into the highly technical critical care environment" (Harvey et al., 1991, p. 205).

To address the concept of caring practices in the critical care environment, the Conference participants suggested that hospitals adopt changes that transform the critical care unit into a more home-like environment; keep the care and therapy focused on the person, not on the illness; and recognize that the critically ill patient, regardless of age, may be childlike in needs. The conference members further suggested that hospitals create opportunities whenever possible for children, friends, pets, and other loved ones to communicate with the patient when direct visitation is not feasible; assure daily communications by having the nurse or other qualified person contact the family at specified intervals to give a report on the patient's status and to acknowledge the stress on the family caused by the critical care experience; and explore mechanisms to follow-up with the patient and/or family after the critical care experience (Harvey et al., 1991). Would these practices be considered demonstrations of caring from the perspective of family members of critically ill patients?

Families of the critically ill have been a concern to critical care nurses throughout the last 15 years. Identification of family needs and interventions developed to meet those needs have received a great deal of attention in the critical care nursing literature (Alpen & Halm, 1992; Curtis, 1983; Gardner & Stewart, 1978; Hickey & Lewandowski, 1988; Kasper & Nyamathi, 1988; Kleinpell, 1991; Leske, 1986; Molter, 1979; O'Keefe & Gilliss, 1988; Rasie, 1980). Some have specifically addressed the visiting needs of family members of the critically ill (Owen et al., 1988; Stillwell, 1984). The concept of caring has received much less attention in the critical care literature, even though the root of the word exists in the identity of probably every critical care unit and in the names of many of the popular critical care journals.

Since the time of Nightingale, the terms care and caring have been used to convey the primary value guiding the practice of nursing. Interest in the concept of caring has been fostered recently by transcultural nursing research (Leininger, 1979)

and by the development of nursing theories based on the humanistic philosophy and the ethic of caring (Leininger, 1984; Paterson & Zderad, 1976; Watson, 1985). Caring is recognized as the essence of nursing (Leininger, 1979) and as the central, unifying focus for the practice of nursing. Yet, it seems that caring is taken for granted in nursing and is something that is recognized more by its absence that its presence. Healthcare consumers complain that something is happening to the humanistic, caring approach of professional nurses and other healthcare providers. Switzer (1985) described the lack of caring in the treatment of her mother, saying the treatment was "not only inadequate but humiliating and uncaring enough to break her spirit and deprive her of the will to live" (p. 47). Many question whether the image of the profession is emerging as uncaring (L. S. Kelly, 1988). This concern is of particular importance in the current cost competitive, high-tech, healthcare environment where nursing care quality is an attraction.

Research aimed at defining the behaviors of caring and the components involved in a caring nurse-patient interaction has increased. However, only 11 studies were identified in which caring from the perspective of those with experiences in the critical care environment was addressed (Barr, 1985/1986; Cronin & Harrison, 1988; Devries, 1991; Greiner & Harris, 1992; Harthcock, 1991; Henry, 1991; Huggins, Gandy, & Kohut, 1993; Miers et al., 1991; Ray, 1987; Semenza, 1991; Semonin-Holleran, 1991). Only one study was identified in which family members of the critically ill were the exclusive population of concern (Henry, 1991). Because caring is viewed by nurses as an important underpinning of critical care nursing practice and because the reported research literature on the family member's perspective of the meaning of professional nurse caring is sparse, this research study was conducted.

Statement of the Purpose

The purpose of this study was to identify, analyze, and describe the meaning of professional nurse caring as experienced by family members of critically ill patients.

Research Question

The research question for this investigation was: What is the meaning of professional nurse caring as experienced by family members of critically ill patients.

Definition of Terms

For the purpose of this investigation, the following terms were defined:

Meaning - Descriptive statements of the lived experience of professional nurse caring. Meaning was determined by interviewing family members of critically ill patients to elicit descriptive statements and by systematically analyzing their reported experience as recipients of professional nurse caring.

Professional nurse caring - Those behaviors or direct and indirect activities, processes, and decisions of licensed registered nurses that were described by family members as being caring.

Family members - Those adults (>18 years) related to a critically ill patient by marriage, blood, or adoption.

Critically ill patients - Those persons who, because of acute or chronic illness, injury, or trauma, were admitted to a critical care unit for eight or more hours.

Experience - Subjects' reports of having lived through the events and circumstances associated with being recipients of professional nurse caring.

Framework

The framework guiding the development and implementation of this study is phenomenology. Described as a philosophy, approach, and method (Knaack, 1984; Omery, 1983), phenomenology was selected because it provides for the study of the appearance or meaning of things rather than things themselves (Cohen, 1987). "Man only knows the appearance of things, never the things themselves: that is to

say he can only ever know 'phenomena' and never 'noumena'" (Roche, 1973, p. 193). Phenomenology, then is the method of choice when one desires to investigate a particular phenomenon as it occurs in human experience (Sherwood, 1988). Phenomenology as a philosophy is addressed here; phenomenology as a research approach and method is discussed in detail in Chapter III.

The term phenomenology was first used in a scientific context by Immanuel Kant in 1764 (Spiegelberg, 1976) and the history of the "Phenomenological Movement" has been divided into three phases: (a) the preparatory phase, (b) the German phase, and (c) the French phase (Spiegelberg 1960, 1976, 1982). A dynamic philosophy, phenomenology has changed considerably across different philosophers and within each philosopher. Major contributions from the preparatory phase include the idea of describing and clarifying before undertaking causal studies and the demonstration of the scientific rigor of phenomenology (Cohen, 1987).

The German phase of the Phenomenological Movement was dominated by Edmund Husserl and Martin Heidegger. Husserl aspired to achieve a philosophy without presuppositions, and he emphasized the essences of things. The concepts of bracketing, intersubjectivity, and lived experience have their origins with Husserl and his students (Cohen, 1987). According to Cohen, Heidegger viewed phenomenology as concerned with being and with time; Heidegger's greatest contribution may have been the inspiration he provided for the French phase of the Movement.

The French phase of the Phenomenological Movement began during and after the conclusion of World War II. Key figures of this phase were Gabriel Marcel, Jean-Paul Sartre, and Maurice Merleau-Ponty. Marcel and Sartre never identified themselves as phenomenologists, yet they have been identified as such by others. Sartre was more interested in the practice of phenomenology than in the theory or science of it; he took a more literary than scholarly approach to the philosophy. Merleau-Ponty, on the other hand, was noted to be more interested in the science of

phenomenology. His interest was in demonstrating that a science of human beings was possible; perception was the matrix of that science. In his text *Phenomenology of Perception*, Merleau-Ponty (1962) described how the phenomenological approach added valuable insights into the experience of individuals that could not be obtained with the positivist approach to science (Cohen, 1987).

Concurrent with the philosophical development of phenomenology was the use of the phenomenologic approach in the clinical work of psychology and psychiatry. It is from this perspective that phenomenology was introduced into nursing. Members of the human science and clinical disciplines of sociology, psychology, and nursing are interested in seeing patients as they really are, knowing them in their own reality, and understanding their perspectives about their experiences (Cohen, 1987).

Within the context of this study, phenomenology allows one to look at the phenomenon of professional nurse caring from the perspective of family members of critically ill patients.

Significance of the Study

Personal experience, as the daughter of a critically ill patient, left me with many varied observations. Limited visiting times, five minutes every hour on the half-hour, often having to be asked to leave at the end of that visiting time, and long anxious waits between visits were the norm. I was severely chastised for lowering and sitting on a near-by empty bed when no other place to sit was provided. After being called back to the hospital because my father's heart rhythm was very rapid and erratic, I wondered why, if the rhythm was so serious, it took more than an hour to obtain and administer the medication that had been prescribed by the physician and requested from the hospital pharmacy. From my observations, the unit was not overly busy at 3:00 a.m. on that particular day. In other instances the nurses told me that my father had been asking for me and had said he wanted me there to assure him that everything was okay. They expressed their concern for my father's physical

condition and that of the other two patients in their unit, and they consoled the bereaving family of one of their patients.

On another occasion at a local hospital I heard over a loud speaker in a critical care unit, "Visiting hours are now over. Please leave the unit via the northwest door." The announcement was initiated when a family member became upset because some families had been allowed to remain in the unit longer than others. The unit's administration and the hospital's risk management staff apparently determined that it would be in the best interest of everyone if the nursing staff established and equitably maintained strict visiting hours for everyone. I remember questioning how such a message "from above" and other behaviors of critical care nurses were perceived by the patients in the unit and by their family members. This experience prompted an earlier study in which coworkers and I phenomenologically described professional nurse caring as perceived by critically ill patients (Miers et al., 1991; Burfitt, Greiner, Miers, Kinney, & Branyon, 1993).

My most recent lived experience as the observer/recipient of nurse caring was in 1991 when I visited, in a midwestern hospital, my 91-year-old terminally ill grandfather. I remember the frustration, disbelief, and anger I felt because there did not seem to be enough sound nursing judgement being used in his care. I wondered where the caring was; the technical care was provided, he was neat, clean, frequently turned, and so forth, but there seemed to be something missing.

My experiences are, unfortunately, not unique (Alspach, 1992; Evans, 1992). The hospital, and most especially, the critical care environment is increasingly criticized as a highly technical healthcare arena where the human factor is underrecognized and humane care is underdemonstrated. The primary focus in critical care has been on the patient in the critical phase of illness or injury. Little attention has been given to the lived experience of the patient, and much less to the critically ill patient; to the lived experience of the family of the critically ill patient; or to the other social relationships that exist for the patient.

Dracup (Dracup & Clark, 1993) reminded us that "patients come from the context of a family and they are going to go back to that context" (p. 4). In his text *Patients Have Families*, Richardson (1945) wrote, "To say that patients have families is like saying that the diseased organ is part of the individual" (p. vii). Just as we are unable to treat the diseased organ without considering the whole individual, we should not attempt to care for and about the critically ill patient without also caring for and about the patient's family. However, in today's complex, fast-paced, critical care unit, "the challenges of dealing with family issues, in fact even getting to know the family and knowing what their concerns are, are greater than they have ever been" (Dracup & Clark, 1993, p. 4).

Significance for Nursing Research

Efforts to dispel criticisms of the high-tech, low-touch nature of critical care have produced a heightened interest in the human experience of the patient and family in the critical care environment. Humanistic caring has become an aim of all disciplines involved in the provision of critical care to patients and their families (Harvey et al., 1991). Noddings (1984) indicated that caring does not occur unless it is perceived as such by the recipient. Only one study has been identified that addresses the question of professional nurse caring from the perspective of families of critically ill patients. Therefore, the findings of this study should contribute a much needed empirical view of family members in critical care. In addition, they will add to the growing body of knowledge about the concept of caring, and particularly to our knowledge of caring as demonstrated by professional nurses.

Significance for Nursing Practice

Wanting to provide a caring approach in all their therapeutic efforts, critical care practitioners will gain insight into the lived experience of the family members of their patients. If they are able to "live" the experience of professional nurse caring from the perspective of family members by reading descriptions of the experiences provided in the report of this investigation, perhaps more caring interactions

will take place between nurses and family members. Sensitization to the experiences of families may prompt nurses to review their policies, procedures, and practices with regard to families and to alter the same so that the family's perspective, along with that of the patient, is considered and placed at the center of their nursing care. If practice behaviors are changed because of this sensitivity, it is possible that the critical care unit will be viewed as a more humane environment.

Significance for Nursing Education

Inasmuch as only one previous study that addressed professional nurse caring from the perspective of the family could be identified, the findings from this investigation will add a new and perhaps different dimension to the growing body of knowledge about the experience of caring. Educators involved in the preparation of critical care practitioners, whether in academic settings or continuing education settings, will have empirical data upon which to base instruction about caring for families of critically ill patients. Critical care practice behaviors that are perceived as caring by family members can then become foundational to the critical care nurse's practice.

Assumptions

This study was based on the following assumptions:

1. Caring is a positive force essential for human growth and development (Sherwood, 1988).

2. Professional nurse caring is expressed or demonstrated by professional nurses in critical care units.

3. The nature of the critical care unit may influence the expressions or demonstrations of professional nurse caring.

4. Family members are able to recognize and describe experiences in which they were the recipients of professional nurse caring.

CHAPTER II

REVIEW OF RESEARCH

According to Cobb and Hagemaster (1987) the literature review in phenomenological investigations should be delayed until analysis is complete to assure that the study is truly grounded in the data rather than in any preconceived framework imposed by the investigator. Therefore, to avoid researcher bias in the data collection and analysis phase of the study, a thorough review of the literature pertaining to perspectives about the meaning of caring, and more specifically professional nurse caring, was delayed until after data collection and analysis were complete (Oiler, 1982).

Consistent with the purpose of this study, which was to identify, analyze, and describe the meaning of professional nurse caring as experienced by family members of critically ill patients, research literature concerned with nurse caring was identified and reviewed. Chapter II contains a review of research that addressed caring from the perspective of nurses or students of nursing, patients, and families members of patients. Nurse caring as perceived by those in the critical care environment is highlighted.

Patients' and Families' Perspectives of Nurse Caring

A number of empirical studies that have explored the concept of nurse caring from the perspective of the patient have been reported; few reported studies have dealt with nurse caring from the perspective of patients and the patients' families. Henry (1975) was the first to identify and describe the behaviors perceived by patients as indicators of nurse caring. Fifty patients from a home health care agency were interviewed in their homes by the investigator, who asked the patients to

describe what nurses did or said that made them feel the nurses cared for or about them. A total of 214 responses were given; the average number of responses per subject was 4.2. The responses were classified into three categories, which included (a) what the nurse does, (b) how the nurse does, and (c) how much the nurse does. Within the category what the nurse does were six subcategories including (a) assessment and observation, (b) nursing procedures, (c) informs and activates other care resources, (d) gives information to the patient, (e) person to person communication, and (f) accessibility/availability. The category how the nurse does contained five subcategories including (a) patient, (b) gentle, (c) friendly, (d) interested and concerned, and (e) conveys human qualities. The subcategory does extras was included within the category of how much the nurse does. Fifty one percent of the responses fell within the category of how the nurse does and 37 percent were placed in the category what the nurse does. Limitations of the study were that only home health care patients were included as subjects and no control was made for length of illness, frequency of nurse-patient contacts, or patient's diagnosis, age, and sex (Henry, 1975).

In a study of 50 hospitalized adults with non-life threatening medical or surgical conditions, Brown (1981/1982, 1986) investigated nursing behaviors perceived by hospitalized patients to be indicators of nursing care. Using a phenomenologic approach to gain an understanding of caring as it is perceived and experienced by the patient recipient, Brown recorded responses to an open-ended question designed to ascertain information about what nurses did or said that made patients feel they had been cared for or about. Brown also asked participants to describe a specific incident or experience they had had in which they felt cared for or cared about by a nurse; they were asked to describe the incident in terms of what they needed and what the nurse did. A 20-item Likert-type instrument was developed and used by the investigator to determine the importance of different kinds of nursing behaviors rated by the participants as indicators of care.

Brown (1981/1982, 1986) identified eight care themes including (a) recognition of individual qualities and needs, (b) reassuring presence, (c) provision of information, (d) demonstration of professional knowledge and skill, (e) assistance with pain, (f) amount of time spent, (g) promotion of autonomy, and (h) surveillance. Further analysis of the themes revealed two patterns of combined themes. Demonstration of professional knowledge and skill, surveillance, providing information, and assisting with pain comprised the first pattern of the themes, which Brown labeled as what the nurse does. Recognition of individual qualities and needs, promotion of autonomy, reassuring presence, and amount of time spent were themes included in the second pattern of how the nurse does.

According to Brown, the process of care is a four-part process that includes a patient perception of a need or wish that the patient cannot satisfy, recognition and acknowledgement by the nurse of the patient need, action taken to satisfy the need, and conveying to the patient the nurse's recognition and appreciation of the patient's worth and competency to know and attend to self. The investigator categorized nursing activities into instrumental, that is meeting treatment needs, and expressive, that is protecting and enhancing the unique identity of the individual. The perception of care was not significantly related to patient variables of sex, diagnosis, days of hospitalization, or number of hospitalizations but was related to patient's age (Brown, 1981/1982, 1986).

Important nurse caring behaviors perceived by patients with cancer were the focus of a study by Larson (1984). The investigator designed the Caring Assessment Report Evaluation Q-Sort (CARE-Q) from two samples of professional nurses who provided care to patients hospitalized for treatment of cancer. The instrument, which consists of 50 behavioral items ordered in six subscales of caring and ranked by importance, measures patient and nurse perceptions of nurse caring behaviors. Subscales of caring include (a) accessible, (b) explains and facilitates, (c) comforts, (d) anticipates, (e) trusting relationship, and (f) monitors and follows through. The

individual behavioral items of the CARE-Q are sorted by the subjects into seven categories ranging from most important to not important.

Fifty-seven patients, all undergoing one or more treatments for cancer, were asked to sort the 50 items of the CARE-Q into one of the seven coded categories. The most important behaviors were knows how to give shots and how to manage the equipment and knows when to call the doctor (Larson, 1984). The two lowest rated items were asks patient what name he/she prefers to be called and checks out the best time to talk with the patient about changes. The investigator reported considerable divergence in the patients' perceptions of the most important behavior that made them feel cared for and little agreement on the least important behavior. The majority of patients indicated that competence in performing skills precedes the patient's need to be listened to by the nurse; the latter skills, although highly valued by nurses, are important to patients only after their basic physiologic needs are met (Larson, 1984).

Riemen (1983) conducted a phenomenologic study in order to ascertain the essential structure of a caring nurse-client interaction. Using Colaizzi's (1978) method of data collection and analysis, Riemen interviewed and analyzed the verbatim transcripts of five men and five women. The subjects, all of whom had experienced prior interactions with registered professional nurses, were asked to describe a personal interaction they had had with a registered nurse that they felt was caring and a personal interaction with a registered nurse that they felt was noncaring. In each instance they were also asked to describe how they felt in that interaction.

Common themes of the caring interaction were grouped into the clusters of nurse's existential presence, client's uniqueness, and consequences. The nurse's physical and mental presence are available for the client's use not only when the client calls for it but also when the client needs the nurse's presence but does not solicit it. Nurses recognize the client's uniqueness by really listening and responding to the client as a valued individual. The client perceives being treated by the nurse

as a valued human being. Consequences of caring interactions are clients who feel comfortable, secure, at peace, and relaxed.

Clusters of common themes for the noncaring experience are similar to those of the caring experience, but the statements supporting the themes differ. The noncaring nurse is physically present to get the job done. The client perceives that the nurse is physically available briefly or not at all, even when the nurse's presence is solicited. The nurse in the noncaring experience is not aware of the client's uniqueness because she does not 'really listen' and appears 'too busy' to pay attention to the client as an individual; the client feels devalued as a unique individual by the degrading and belittling actions of the nurse. Clients feel frustrated, scared, depressed, angry, afraid, and upset in response to the noncaring interactions. Riemen concluded that caring is not only what the nurse does in the way of physical acts of assistance, but it is also what the nurse is. Patients consider being existentially available and really listening to them as important aspects of caring.

Knowlden (1986) studied the meaning of caring as a dimension of the nursing role. Nurses and patients associated with home health care agencies separately observed their videotaped nurse-patient interaction and then explained their perceptions of the caring component that they observed in the interaction. Content analysis facilitated the analysis of the recorded verbatim responses. Twenty theme categories, ten of which were similar for both nurses and patients, were identified.

The categories were integrated into the two categories, content and relationship, that are basic to communication theory. Responses reflecting nursing content included health teaching, assessment, physical care, advocacy, knowledge, supplying resources, planning for the future, and safety. Relationship oriented responses included concern, progress and hope, listening, the personal relationship, building self-esteem, touching, laughter and humor, specific attributes of the nurse, gentle and careful, telling what the nurse found, considerate, understanding, collaborating, and counseling. The investigator concluded that the findings supported

communication theory, because caring in nursing facilitated the communication and nursing processes (Knowlden, 1986).

Luegenbiehl (1986) explored the essence of a caring nurse-patient relationship during labor and delivery as perceived by patients, their personal attendants, and nurses. Using a phenomenologic approach, the investigator interviewed and analyzed the descriptions of nurse caring from nine subjects, three each from the subject groups previously stipulated. Themes of nurse caring identified from the transcripts of all subsets of subjects included competence/knowledge; help/reassurance/support; presence; talk, touch, and comfort; and personal characteristics. Although there was agreement on the elements of nurse caring, there were differences in the emphasis placed on them by the various groups of participants. The themes were eventually condensed into the patterns knowledge/competence and helping, reassuring, and supporting.

Of particular note in this study was the inclusion of personal attendants as subjects. All personal attendants were husbands of the women going through the birth process. These family members emphasized the knowledge component underlying the caring actions more than did the mothers. The investigator concluded the differences in perspective were based on the role of the participant in the caring interaction. She suggested further exploration of this notion in different clinical settings.

With 28 oncology nurses and 54 cancer patients, Mayer (1987) replicated Larson's (1984) earlier study using the CARE-Q instrument. Patients in Mayer's study identified the following five nurse caring behaviors as most important: (a) knows how to give shots, etc. and to manage the equipment; (b) is cheerful; (c) encourages the patient to call if the patient has problems; (d) puts the patient first, no matter what else happens; and (e) anticipates that the first times are the hardest and pays special attention to the patient during the first clinic visit, hospitalization, or treatment. Least important behaviors identified by patients were helps the

patient establish realistic goals and checks out with the patient the best time to talk with the patient about changes in his or her condition.

Nurses rated (a) listens to the patient, (b) allows the patient to fully express feelings about the patient's disease and treatment and treats the information confidentially, (c) realizes that the patient knows himself or herself the best and whenever possible includes the patient in planning and management of his or her care, (d) touches the patient when the patient needs comforting, and (e) perceives the patient's needs and plans and acts accordingly as the most important caring behaviors. Least important behaviors rated by the nurses included volunteers to do little things for the patient and is cheerful. Nurses and patients agreed that (a) professional appearance/wearing appropriate identifiable clothing and identification, (b) asks the patient what name the patient prefers to be called, and (c) suggests questions for the patient to ask the doctor were not important caring behaviors (Mayer, 1986, 1987).

Swanson-Kauffman (1986) conducted a phenomenologic study of 20 married women who experienced miscarriages prior to 16 weeks gestation to identify what constitutes caring in the instance of miscarriage. Professionals and non-professionals conveyed caring to women who miscarried through the categories of knowing, being with, doing for, enabling, and maintaining belief. Knowing was communicated as personalized, comforting, supportive, and healing care. Individuals who were non-knowing were perceived as mechanical, routine, impersonal, and often cruel. Closely related to knowing was being with, which goes beyond knowing to feeling with the woman who miscarried. The category doing for was selected to describe the woman's need to have others do things for her at the time of her loss. Enabling was described as caring that allowed and assisted the woman to grieve and get through the loss. Information was key to this process and often validated the woman's right to grieve. The final category of caring, maintaining belief, indicated that others believed in her capacity to get through the loss and to ultimately become

pregnant and give birth. If the woman made a decision to stop trying to bear a child, others maintained belief in her capacity to make a decision for tubal ligation.

Dory (1987/1989) reported a study designed to explore nursing behaviors perceived as caring by elderly individuals who had been recently discharged from an acute care hospital. Thirty-one participants between the ages of 65 and 95 were interviewed within four-weeks of discharge. One hundred sixty-eight meaningful responses were analyzed and divided into three groups. The first group consisted of responses about nurses' actions perceived as caring; the second group of responses dealt with nurses' words that were experienced as caring; and the third group was comprised of a mix of responses that described both actions and words of a particular behavior perceived as caring. The findings were compared to Leininger's (1981) caring constructs.

Keane, Chastain, and Rudisill (1987) reported a study in which 26 rehabilitation patients and 26 nurses used the CARE-Q to identify the most and least important nurse caring behaviors. Both nurses and patients rated knows when to call the doctor and monitors and follows through as the most important subscale of caring behaviors. A fair amount of consistency across the sample for least important behaviors was found with the exception that patients rated tells patient of support systems available much lower than nurses rated the behavior. Volunteering to do little things for patient and suggesting questions for the patient to ask the doctor were rated lowest by the two groups combined. The researchers reminded readers that the choices for the sort were forced, such that caring behaviors rated as least important are not necessarily unimportant but are relatively less important than others.

Sherwood (1988) conducted a phenomenologic study of five males and five females who were recovering from general surgery. The aim of the study was to explore perceptions of what the nurse did for and with patients that demonstrated caring. Patterns that emerged from the descriptions of caring were (a) assessing needs–what was needed or expected; (b) planning care–preparation and knowledge

for managing care; (c) intervening–response to needs; (d) validating–evaluating nursing action and participant's condition; and (e) interactional attitude–positive, growth producing interactions. Patients described mental and physical feelings or outcomes to caring. The investigator concluded that the impact of caring on the recovery of patients needed further study, caring nurses were valued by study participants, and expressions of caring are essential components of nursing practice that fall within the nursing process.

Swanson-Kauffman (1988) also studied eight young mothers enrolled in the Mental Health Intervention Group associated with the Barnard Clinical Nursing Models Project. The purpose of this phenomenological study was to explore how participants recalled and described the nurse-patient relationship four years after a long-term intensive nursing intervention. The five caring processes identified in her earlier study (Swanson-Kauffman, 1986) were confirmed or slightly refined, as in the instance of the category maintaining belief. Based on the findings of these two studies and another one conducted with neonatal intensive care unit (NICU) caregivers (Swanson, 1990), Swanson proposed a definition, which indicates caring is "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson, 1991, p. 162).

The CARE-Q was used by Quinn and Renaud (1989) to study what nurses and elder patients in a rehabilitation center value in nursing care. Twenty-four patients and 23 registered nurses rated caring behaviors; nurses rated listening to the patient as the most important behavior, whereas patients rated giving the patient's treatment and medications on time highest. Nurses valued expressive activities of nursing highest; patients placed more value on behaviors consistent with instrumental activities.

In another study in which the meaning of caring from the perspective of the patient was the focus of investigation, Frieswick (1991) studied patient experiences that were perceived as caring or noncaring and attempted to understand the

significance of those experiences for the patients. Metaphors were used to present the findings. Five metaphors described experiences of caring: (a) Caring is treating one like a member of a family; (b) caring is treating one as person, not a patient; (c) caring is understanding how I feel; (d) caring is putting one back together: the power to heal; and (e) caring is going out of your way. The metaphors that described noncaring included (a) noncaring as abandonment, (b) noncaring as a lack of competency, (c) noncaring as not listening to what I'm saying, and (d) noncaring as shame and humiliation.

Hierarchies of patient needs for medical and nursing care were suggested in the data. In many instances, patients' needs had to be met before the caregiver was perceived to be caring. Providing frequent surveillance and assisting patients with their physical needs were described as actions of the caring nurse by 78% of the subjects. Findings appeared to indicate that nurses may not fully realize the patient's desire for surveillance. Caring nurses viewed the patient holistically and demonstrated an understanding of the patient's personal needs. The primary responsibility of the physician was seen as his/her curing/healing ability (Frieswick, 1991).

In a phenomenologic study of eight men and women, Weaver (1991) sought to gain further insight into the meaning of caring from the patient's perspective. Using the phenomenological method described by van Manen (1984), the investigator identified the following themes of the caring process: nurse's knowledge, nurse's presence, involvement, and commitment. Expressions of caring were identified as subthemes and included decision making, competent clinical skills, nurse's true presence, nurse's availability, accepting, understanding, helping, and informing. A model of caring was developed and presented.

Summary

Fifteen studies of the meaning of caring from the perspective of patients were reviewed. In five of the studies, the investigators included patients and nurses

in the study sample (Keane et al., 1987; Knowlden, 1986; Luegenbiehl, 1986; Mayer, 1987; Quinn & Renaud, 1989); in only one of the studies were family members of patients included in the sample (Luegenbiehl, 1986). Populations of interest were patients from home health care (Henry, 1975; Knowlden, 1986), oncology (Larson, 1984; Mayer, 1987), obstetrics/gynecology (Luegenbiehl, 1986; Swanson-Kauffman, 1986, 1988), rehabilitation (Keane et al., 1987; Quinn & Renaud, 1989), and medical-surgical settings (Brown, 1981/1982; Dory, 1987/1989; Sherwood, 1988). The specific patient population studied was not specified in three of the reports (Frieswick, 1991; Riemen, 1983; Weaver, 1991).

Findings from the studies appear to indicate that the meaning of caring for patients encompasses what the nurse is and what the nurse does. Themes or behaviors indicative of the former include: being patient, gentle, and friendly; being interested and concerned; conveying human qualities, recognizing the patient as an individual; promoting autonomy and self-esteem; offering a reassuring presence; spending time with the patient; being knowledgeable and technically skilled; and putting the patient first. Themes or behaviors associated with what the nurse does include: assessing and surveilling; informing and teaching; communicating; providing physical care; doing more or going out of one's way; assisting with pain; identifying and responding to patients' needs; touching, joking, and laughing; treating the patient like a family member; and putting the patient back together. Patients who felt cared for or who experienced caring were comfortable, secure, relaxed, and at peace. Family members were not adequately represented in these studies to allow the researcher to evaluate the meaning of caring for them; further investigation with this population is necessary to gain understanding of professional nurse caring from their perspective.

In those studies where nurses' and patients' perceptions of nurse caring were identified and compared, there was often disagreement regarding indicators of

caring. Patients placed more emphasis on instrumental behaviors, whereas nurses emphasized the expressive behaviors of caring.

Nurses' Perspectives of Nurse Caring

Nurses' perspectives about the phenomenon of caring have also been the focus of nursing research efforts. Ford (1982) conducted a study to assess nurse professionals' definition of caring, descriptions of their caring behaviors, and examples of how they model these behaviors in their respective nursing roles. A one-page, investigator developed questionnaire was sent to 192 nurse professionals who were in education, clinical practice, or members of a state nurses' association; 81 (42.2%) returned responses for analysis. The investigator analyzed each questionnaire separately, and the raw data were summarized into units of content. Content units were classified into categories; all three subsamples agreed on two categories in the definition of caring, that being genuine concern for the well-being of another and giving of yourself. There was agreement from two subsamples for the categories of helping and empathy.

In describing the behaviors that were caring, the subsamples agreed only on the category of listening. Nurse educators and practicing nurses also described helping and showing respect as caring behaviors. Many nurse members also described the caring behavior category of supporting the actions of others. Listening was identified by all subsamples as a way in which they modeled caring. Helping, communicating, demonstrating, assessing and meeting all needs, providing support for staff, promoting the professional organization, and supporting the actions of others were also ways in which nurses modeled caring behaviors. Ford (1982) cautioned against generalizing these results to all professional nurses because of the sampling technique used in the study.

For the purpose of analyzing the meaning of caring expressions and behaviors related to nurses, Ray (1982, 1984) used an inductive research approach. She classified 1362 caring responses from 192 participants (87 nurses and 105 non-nurse

hospital staff members and students) into four categories and nine subcategories. The categories were psychological, which included cognitive and affective subcategories; interactional, which included social and physical subcategories; practical, including the subcategories technical and social organization; and philosophical, which included spiritual, ethical, and cultural subcategories.

The investigator concluded that the findings reflected a shift in the humanistic-religious dimension of caring to practical dimensions of caring that are influenced by the bureaucratic dominant American social structures. According to Ray, the two theoretic frames of reference, differentiation and bureaucratization, "demonstrated the complex meaning and structure of caring in a contemporary hospital culture" (1982). She concluded that the ideal nursing models of caring were replaced by a bureaucratic model. This shift in focus created professional conflict for the majority of the nurses studied (Ray, 1982).

Wolf (1986) reported the results of a pilot study in which she asked a convenience sample of 97 nurses from secondary and tertiary care settings to rank, using a four-point Likert-type scale, 75 caring words or phrases included in the Caring Behavior Inventory (CBI). The ten highest ranked caring behaviors included: attentive listening, comforting, honesty, patience, responsibility, providing information so that the patient or client can make informed decisions, touch, sensitivity, respect, and calling the patient or client by name. Wolf suggested that the findings of her study reaffirmed that caring is a complex, multidimensional phenomenon. The investigator suggested the findings be used as a basis for writing an operational definition of caring in nursing.

Again using the CARE-Q instrument, Larson (1986) studied 57 nurses who provided care to patients with cancer in two acute care settings. These nurses identified affective behaviors as important for making patients feel cared for. Listening, touching, allowing expression of feelings, individualizing care, and talking to patients were behaviors selected as most important for demonstrating caring.

In a comparison of the findings from the study of nurses and the study of the patients, Larson (1987) demonstrated differences between the two groups for three of the subscales in the CARE-Q. Items categorized under the monitors and follows through subscale were rated significantly higher by patients than by nurses. Nurses rated items under the comforts and trusting relationship subscales significantly higher than did patients. Larson (1987) concluded that caring can be addressed on a scientific level and that after further validation and/or refinement, the CARE-Q subscales will offer additional classifications for the growing taxonomy of the constructs of caring.

Condon (1987/1988) reported a study in which she explored and described the meaning of the experience of being caring in a nurse-client interaction from the caring nurse's perspective. Twenty caring nurses were interviewed, and the transcriptions of their recorded descriptions were analyzed using Colaizzi's (1978) phenomenological method. Four themes, common to all descriptions of caring, emerged from the data: (a) the client's existential presence, (b) nurse-client/family encounter, (c) the nurse's availability, and (d) consequences for the nurse and client. Themes that emerged from the noncaring descriptions included (a) the client's existential presence, (b) nurse-client/family alienation, (c) the nurse's availability, and (d) consequences for the nurse and client.

Kahn & Steeves (1988) used a hermeneutical design to explore the meaning for nurses of the caring relationship between nurses and patients. A purposive sample of 19 female and six male incoming graduate students was selected for the study. Each had at least 1 year of experience in nursing practice. An open-ended interview was conducted by one of the two investigators. Three heuristic questions guided the inquiry of the transcripts: (a) "What is the meaning of caring?", (b) "What conditions elicit caring?", and (c) "What conditions limit caring?" (1988, p. 203). Twenty-nine categories describing the nature and structure of the nurse-patient, caring relationship emerged from the analysis of the data.

The intellectual background or the ideological context of nursing was one of the four themes; it contained five categories. Caring (a) underlies professional identity, (b) requires seeing persons as unique individuals, (c) requires compassion and empathy, and (d) relationships are therapeutic. Caring is limited by the need to maintain objectivity. The second theme focused on the relationship between liking and caring and included six categories. Caring (a) is characterized by "fitting with" someone, (b) is evaluated in terms of liking someone, (c) includes friendship, and (d) is reciprocated through personal recognition. The absence of caring is characterized by a mutual inability to "get along" and can be characterized by animosity. The actions of the nurses in face-to-face encounters with patients, that is praxis, was the third theme identified. Seven categories were identified within this theme. Caring includes (a) physical nursing actions, (b) nonphysical nursing actions, (c) insisting on patient independence, (d) actions that improve conditions for patients, (e) nursing actions related to communication, and (f) being an advocate and liaison. The absence of caring is indicated by performing in a routine way. The fourth and final theme was identified as attributions for caring. Caring is elicited when (a) patients are in dire circumstances; (b) patients have multiple, psychosocial problems; (c) patients rely on the nurse; (d) patients are alert and personable; and (e) the nurse can make a temporal investment. Temporal circumstances, factors that are the nurse's responsibility, patients' actions that cause problems, patients' unwillingness to communicate, and patients' poor self images limit caring. The investigators discussed some of the fact versus value issues and the moral and ethical implications identified in the descriptions (Kahn & Steeves, 1988).

Ingle (1988/1989) studied professional nurse caring from the perspective of men in nursing. Twelve baccalaureate prepared men were interviewed by the investigator, and their tape-recorded and transcribed descriptions of caring were subjected to content analysis. The business of caring was identified as the overriding theme. Three categories with subcategories were presented as follows: "supporting

physical well-being (enacting skills, maintaining safety, and surveillance); supporting psychological, emotional, and spiritual well-being (verbal and nonverbal support of time and being there, touch, listening, eye contact, and facial expressions); and, supporting individuality (advocacy and respect)" (pp. iii-iv). Ingle concluded that men enter nursing with caring attitudes or feelings toward others. These attitudes and feelings are not learned in nursing school and are reflected in nursing actions. Antecedent to professional nurse caring are professional experience and professional education. A model for the business of caring was developed and the investigator advised further testing of the model.

Nineteen female nurse administrators served as subjects in a study conducted by Cody (1989) to explore nurse administrator's beliefs about and experiences of caring. A content analysis of the responses to three open-ended questions revealed words and themes that were grouped into categories. The following five statements reflect the descriptions of caring: (a) Caring involves thoughts and actions directed toward meeting the needs of another, (b) caring involves demonstrations of compassion, kindness, warmth, and concern toward another, (c) caring is perceiving and understanding the needs of another and responding while putting another's needs first, (d) caring behaviors include spending time with and communicating with another, and (e) caring is the effort or intention to support and help another to feel good about themselves and to maintain dignity and self-esteem.

Forrest (1989) conducted a phenomenologic study of 17 registered nurses to investigate their experiences of caring. Colaizzi's (1978) method of data analysis was used to identify and describe the meaning of caring from transcriptions of tape recorded interviews. Two broad classifications of meanings, "What is caring?" and "What affects caring?", were apparent in the data. Within the class of what is caring there were two theme categories, involvement and interacting, and seven theme clusters. Twenty-one theme clusters were grouped into five theme categories in the broad class of what affects caring. The five categories were (a) oneself, (b) the

patient, (c) frustrations, (d) coping, and (e) comfort and support. The investigator concluded that caring involvement and interaction incorporates a preference for "being with" the patient rather than "doing to" the patient, however routines of task-related nursing take precedence when the patient is "hard to care for".

Chipman (1991) conducted a qualitative study of 26 second-year nursing students to obtain their perceptions the meaning and value of caring in the practice of nursing. Participants described critical incidents in which nursing behaviors were observed to have been conducted in caring and noncaring ways. Giving of self, meeting patients' needs in a timely fashion, and providing comfort measures for patients and their families were identified to be caring nursing behaviors. None of the participants identified technical competence as a caring nurse behavior. Noncaring behaviors were the antithesis of the caring behaviors, thereby lending credibility to the caring behaviors.

Perceptions of caring by nurse educators was the focus of a study by Komorita, Doehring, and Hirchert (1991). A sample of 110 nurse educators completed the CARE-Q to rate caring behaviors they believed made patients feel cared for. Listening to the patient was rated as the most important caring behavior; being professional in appearance was rated the least important behavior. Subscales of comforts, trusting relationships, and explains and facilitates were most highly rated by the educators. Interestingly, these nurses rated the subscales of monitors and follows through and accessible as the least important. These findings are in direct opposition to what patients in earlier studies by Larson (1984) had rated as most and least important subscales. The investigator concluded that nurses value behaviors that indicate they "care about" the patient, whereas patients value activities that indicate they are "cared for". Possible explanations for the differences between nurse educators and patients' perceptions were offered.

Mangold (1991) identified and compared the perceptions of effective caring behaviors of student nurses and professional nurses. The CARE-Q was given to 30

senior baccalaureate nursing students and to 30 professional nurses with one or more years of experience. The Mann Whitney U was used to test the significance of the difference between the two groups, and results indicated agreement between the groups in all categories except trusting relationship. Both groups rated listens to the patient as the most important behavior; professional nurses identified professional in appearance as the least important behavior, and the student nurses chose puts the patient first, volunteers to do little things, suggests questions to ask the doctor, and is professional in appearance as equally unimportant.

Morrison (1991) reported a qualitative study designed to explore nurses' perceptions of caring in relation to nursing practice. Personal construct theory and the repertory grid interview technique were used to elicit views of caring from 25 British professional nurses. Verbal descriptions or constructs were identified from the interviews and were analyzed into similar areas of content. Seven categories emerged to provide the description of caring: (a) person qualities, (b) clinical work style, (c) interpersonal approach, (d) level of motivation, (e) concern for others, (f) use of time, and (g) attitudes. The investigator noted that few constructs related to the physical aspects of care.

In a phenomenologic study of 12 professional nurses, Green-Hernandez (1991) explored the experience of caring in professional nursing, and of caring outside of nursing as lived by the nurse. Using Colaizzi's (1978) method for data collection and analysis, the investigator identified six themes descriptive of the experience of natural caring that included (a) being there, (b) touching, (c) social support, (d) reciprocity, (e) time/extra effort, and (f) empathy. Fourteen themes of professional nurse caring were also identified. They were (a) holism, (b) touching, (c) technical competence, (d) communication, (e) listening, (f) being there, (g) professional experience, (h) empathy, (i) social support, (j) reciprocity, (k) involvement, (l) time, (m) formal and informal learning, and (n) helping. All themes of natural caring were also identified as themes of professional nurse caring, indicating that

natural caring serves as the basis of and is integrated into professional nurse caring. The investigator believed professional caring to be a direct and intentional process. Furthermore, she indicated professional nurse caring is transmitted through specific therapeutics. She differentiated the goals of natural caring and professional nurse caring by noting that the intention of nurse caring is to be professionally therapeutic. This therapeutic aspect is dependent on technical competence and professional experience in nursing and is fostered through nursing education.

Clarke and Wheeler (1992) chose the phenomenologic method of Colaizzi (1978) to investigate the meaning of care from the experience of six British nurses in nursing practice. Four theme categories derived from the data were being supportive, communicating, pressure, and caring ability. Clusters within the category of being supportive included loving concern, valuing people, respect, trust, giving of self, awareness of patient's needs, prompting independence, and being firm. The category of communicating included talking, information giving, listening, touching and hugging, and presence. Personal problems that affect caring, frustrations to affect care, difficult to care for patients, and quality affected were the theme clusters comprising the category of pressure. Caring ability included the clusters of origin of care and coping. The investigators summarized their findings into an exhaustive description of caring and a statement of the essential structure of caring.

Summary

Nurses' perspectives about the phenomenon of caring were the subject of the fifteen research reports reviewed in the preceding section. Subjects for the studies included male and female professional nurses and graduate and undergraduate students of nursing. Nurse educators, administrators, and clinicians were represented in the study samples described. Two studies included professional nurses from Great Britain (Clarke & Wheeler, 1992; Morrison, 1991). Male nurses were the sole participants of one study (Ingle, 1988/1989). Dominant themes among the

findings of the studies included: the nurse's presence, helping others, listening to patients, and meeting needs of others.

Nurse Caring in Critical Care

The experience and meaning of caring has been studied from the perspective of patients and nurses, but relatively fewer studies have explored caring from the perspective of critical care nurses, critically ill patients, or family members of the critically ill. Following is a review of the 11 reported studies where caring was experienced in critical care units.

Perspective of Critical Care Nurses

Barr (1985/1986) used Colaizzi's (1978) method of phenomenology in the conduct of a study to describe caring from the perspective of critical care nurses and to identify factors that critical care nurses believe positively and negatively affect caring. Fifteen critical care nurses were interviewed and asked two open-ended questions, "What does the term 'caring' mean to you?" and "Can you give me some of your feelings about caring in the critical care setting?" (p. 97). The investigator collected additional data pertaining to the following areas: (a) uncaring behaviors of nurses, (b) factors perceived by nurses to promote or inhibit caring in the critical care setting, and (c) rewards nurses perceive they receive for caring.

Eight theme clusters, which described caring in the critical care setting, were identified by Barr. Clustered themes included (a) totality of care, (b) priority of care: anticipation and validation of needs, (c) nature of caring, (d) blending attitude with action, (e) recognition of patient's individuality, (f) involvement of family, (g) teaching and communication, and (h) patient perceptions of outcomes. In addition, eight elements that positively influenced caring were identified as were ten components that negatively influenced caring. Barr submitted that critical care nurses described caring as a "multi-faceted phenomenon which addresses patients' physical, psychosocial, cognitive, and spiritual needs" (p. 61). Not surprisingly, physical needs were described as the priority of two-thirds of the participants.

All participants in Barr's study emphasized the importance of family involvement, attending to the needs of the family, and teaching the family as well as the patient in critical care. Participants were aware of the stressful experience of family members who had a loved one in a critical care unit. The investigator recommended that future investigators study "families' perceptions of caring, including the families' reactions to increased involvement in the critical care setting" (p. 76).

Ray (1987) used interviewing and observation techniques of phenomenology to collect data from eight nurses employed in a critical care setting in one suburban medical center. The purpose of the study was to uncover the meaning of caring for nurses working in critical care. Five themes, maturation, technical competence, transpersonal caring, communication, and judgement/ethics, expressed human caring in this setting. Critical care nursing was identified as a moral and ethical process in which both human and technocratic aspects are displayed. The common denominator of these critical care nurses' experiences was their "ability to apply ethics and morality in distinguishing right from wrong in the attitudes and behaviors associated with the uses of technology" (p. 167-168).

Harthcock (1991) implemented a descriptive qualitative approach to describe the NICU nurses' perceptions of caring. Twelve female nurses, the majority of which were employed in a level III NICU, were interviewed for the study. Participants were asked about the meaning of caring to them in the NICU and about behaviors they perceived as demonstrating caring in that critical care unit. Seven themes of caring were identified by the investigator, who concluded that a model of caring would have a positive influence on nursing practice, education, and administration in the NICU.

Perspective of Critical Care Patients

In an effort to identify nursing behaviors perceived as indicators of caring by patients who had had a myocardial infarction (MI), Cronin and Harrison (1988) developed the Caring Behaviors Assessment (CBA) instrument, a questionnaire that

lists 61 nursing behaviors ordered in seven subscales congruent with Watson's (1985) carative factors. Seventeen men and five women with an MI, who were patients on one of two transitional care units, were asked to rate on a five-point Likert-type scale the degree to which each of the behaviors communicated caring to them. The subjects were also asked to describe what things nurses did or said that made them feel cared for and about while they were in the coronary care unit. The open ended question was designed to elicit perceptions of care indicators without the bias of a preconstructed list and to allow for a full perspective of the phenomenon of interest.

Behaviors most indicative of caring included (a) know what they are doing; (b) make me feel someone is there if I need them; (c) know how to give shots IVs, etc.; (d) know how to handle equipment; (e) know when it is necessary to call the doctor; (f) do what they said they will do; (g) answer my questions clearly; (h) be kind and considerate; and (g) teach me about my illness (Cronin & Harrison, 1988). Least indicative of caring were the following behaviors: (a) visit me when I move to another hospital unit, (b) ask me what I like to be called, (c) ask me how I like things done, (d) do not become upset when I am angry, (e) try to see things from my point of view, (f) talk to me about my life outside the hospital, (g) touch me when I need it for comfort and understand when I need to be alone, (h) help me see that my past experiences are important. Subscales of the CBA ranked highest by the subjects were human needs assistance and teaching/learning; those ranked lowest were expression of positive/negative feelings and helping/trust. In all but one instance demographic variables had no significant influence on the rankings. The subscale expression of positive/negative feelings was ranked significantly higher by those who had previously been in a coronary care unit than by those who had not.

A content analysis of the responses to the open-ended question revealed findings similar to those obtained by the CBA except that two behaviors were identified as being different from items already in the CBA. Behaviors indicating

gentleness and cheerfulness were included in the subscale supportive/protective/ corrective environment.

The investigators concluded that because of the nature of the illness of the subjects, it was not surprising that they would rate close attention and competent care as important indicators of nurse caring. Cronin and Harrison (1988) suggested that the high visibility of the nurse could enhance the patient's sense of well-being and security. Although the CBA was determined to be a valuable tool for use in a variety of patient populations, further testing and refinement was recommended.

The emergency department (ED) was the setting of interest in a study of patients' perceptions of nurse caring by Semonin-Holleran (1991). A theoretical framework in which caring is composed of the three constructs of caring activities, caring behaviors, and caring experiences; previous caring research; and the investigator's experience as an ED nurse guided the development of a 30-item instrument. The validity of the tool was established by administering it to ten individuals who had received care in the ED. The Cronbach's alpha was 0.9 for the instrument. Based on analysis of the data, subjects agreed with items on the instrument that considered caring activities, behaviors, and experiences. The investigator concluded that the instrument did identify caring from the patient's perspective in the ED, and the patient's perception of caring by the ED nurse is contextual and relational. Caring in the ED "is the recognition of the patient having a need for nursing care, the nurse meeting that need, and the nurse recognizing the patient as [a] fellow human being" (p. 751).

Devries (1991) conducted a study to examine which nurse caring behaviors in the critical care unit were perceived as most and least important by patients with a myocardial infarction. Forty-four subjects responded to the Caring Behaviors Assessment scale and to an open-ended question. Behaviors that meet human needs and that are humanistic, sensitive, and reassuring were perceived as very important by the patients in this sample. Patients who had had one or more previous

admissions to the critical care unit ranked behaviors that met human needs, facilitated the expression of feelings, and showed sensitivity and respect higher than did those who had no prior admissions to a critical care unit.

Miers et al. (1991; Burfitt et al. 1993) reported a phenomenologic study of 13 patients who had transferred from one of three critical care units. The purposes of the study were to describe critically ill patients' perceptions of caring exhibited by professional nurses and to describe the meaning of these demonstrations of professional nurse caring to the patients. The major concepts of the caring process were identified as vigilance, healing, and mutuality. The investigators described caring as attentive, vigilant nurse behaviors that incorporated highly skilled, technical practices as well as basic nursing practices and practices that went beyond the basics of care. Nurturance was also a part of vigilant care. Caring was viewed as a healing process of which lifesaving actions of the nurse are a part. Important in the mutual process were the personal attributes of the nurses, patients, and family members engaged in the caring experience.

Cronin and Harrison's (1988) Caring Behaviors Assessment tool was used by Semenza (1991) in a study of 101 post cardiac intensive care telemetry patients. The purpose of the study was to quantitatively measure caring based on Watson's (1985) theory of human science and human care. The investigator concluded that caring is subjective and abstract, and therefore, "not amenable to quantitative methods" (p. 650). Her findings were in opposition to Watson's theory in that the patients in this study were more concerned with physical aspects of their care than they were with their psychosocial needs.

Finding no previous research in which caring was described from the perspective of critically ill psychiatric patients, Greiner & Harris (1992) interviewed nine patients who had been hospitalized in a critical care area of a private psychiatric hospital. Interviews were conducted within 48 hours of transfer from the area, and a phenomenologic approach was used to analyze the data. The investigators

found that caring in the critical phase of psychiatric illness involved the concepts of vigilance and mutuality. Constancy, tasks, time, and talk were concepts that comprised vigilance, and mutuality encompassed the concepts of sensing, trust, respect, and a shared humanity. Expressions by patients about the meaning of work were also revealed in the analysis of data.

Identification of behaviors performed by ED nurses that were perceived by patients as important indicators of caring was the goal of a study conducted by Huggins, Gandy, and Kohut (1993). Within 30 days of discharge, 288 former ED patients were interviewed by telephone; the Caring Behaviors Assessment tool was used to rate indicators of caring. Patients were divided into three triage categories, emergent, urgent, and nonurgent. Subjects in all groups rated technical nursing behaviors as the most important indicators of caring. Overall rankings by subscale compared very closely to those described by Cronin and Harrison (1988). Limitations of the study included only patients with telephones participated, patient proxies were used, and the passage of time between discharge and interview may have affected the accuracy of the recall for patients.

Perspective of Family Members of the Critically Ill

Only one study was identified in which family members were the singular focus group studied in an effort to understand the meaning of caring. Using a modified version of the CBA developed by Cronin and Harrison (1988), Henry (1991) conducted a study to identify the nursing behaviors perceived as caring by parents of critically ill children. Thirty subjects, 18 mothers, 11 fathers, and one foster mother, with children in a pediatric intensive care unit (PICU) were given the CBA and were asked to rate the nursing behaviors they perceived to be the most important and the least important indicators of caring. Seventeen items on the CBA tool were modified to reflect the family member perspective rather than the patient perspective for which it was originally designed.

Caring behaviors rated most important by the subjects were (a) give my child's treatments on time, (b) know what they're doing, (c) really listen to me when I talk, (d) treat me with respect, (e) check my child's condition closely, (f) answer my questions clearly, and (g) know when it is necessary to call the doctor (Henry, 1991). Rated least important as indicators of caring were the behaviors (a) help me feel good about myself, (b) don't become upset when I'm angry, (c) encourage me to talk about how I feel, (d) touch me when I need it for comfort, (e) visit me when my child moves to another hospital unit, (f) talk to me about life outside the hospital, and (g) ask me what I like to be called. Further analysis of the data demonstrated no significant differences in perceptions of caring behaviors between mothers and fathers, single and married parents, and natural and adoptive parents. Age or birth order of the child was not a significant factor influencing perceptions of the parent nor was type of previous hospitalization. Planned versus emergency admission to the PICU also did not affect the perception of caring behaviors. Length of the PICU stay did significantly affect the perception of caring in the existential/phenomenological/spiritual forces subscale but was not a significant variable in the other six subscales of the CBA tool.

Henry (1991) concluded that the seven most important indicators of caring focused on behaviors associated with demonstrating close monitoring of the child, professional competence, and personal interactions between the nurse and the parent. Behaviors rated as least important indicators of caring focused on behaviors linked to the feelings of the parents. Limitations of the study include the small sample size, the use of only one PICU, and the inclusion of only English speaking parents. Additionally, data were collected after transfer from the PICU or on the day of discharge, so it is possible the results did not reflect the true PICU experience.

Summary

Eleven studies in which caring in the critical care setting was the phenomenon of interest were reviewed. In three of these studies critical care nurses comprised the study sample (Barr, 1985/1986; Harthcock, 1991; Ray, 1987). Critical care patients' perspectives were the focus of seven of the studies (Cronin & Harrison, 1988; Devries, 1991; Greiner & Harris, 1992; Huggins et al., 1993; Miers et al., 1991; Semenza, 1991; Semonin-Holleran, 1991). Parents of critically ill children were subjects for one study (Henry, 1991). Recognizing and meeting needs, vigilance, and technical skill and competence seemed to be important indicators of caring across all populations.

Summary

Review of research indicates that at least 41 studies addressing the experience of nurse caring have been completed. Twenty-seven of these studies were qualitative in nature (Barr, 1985/1986; Brown, 1981/1982; Chipman, 1991; Clarke & Wheeler, 1992; Cody, 1989; Condon, 1987/1988; Dory, 1987/1989; Ford, 1982; Forrest, 1989; Frieswick, 1991; Green-Hernandez, 1991; Greiner & Harris, 1992; Harthcock, 1991; Henry, 1975; Ingle, 1988/1989; Kahn & Steeves, 1988; Knowlden, 1986; Luegenbiehl, 1986; Miers et al., 1991; Morrison, 1991; Ray, 1982, 1987; Riemen, 1983; Sherwood, 1988; Swanson-Kauffman, 1986, 1988; Weaver, 1991). The phenomenologic method was dominant (59%) among the qualitative studies reported (Barr, 1985/1986; Brown, 1981/1982; Clarke & Wheeler, 1992; Condon, 1987/1988; Forrest, 1989; Green-Hernandez, 1991; Greiner & Harris, 1992; Luegenbiehl, 1986; Miers et al., 1991; Ray, 1982, 1987; Riemen, 1983; Sherwood, 1988; Swanson-Kauffman, 1986, 1988; Weaver, 1991). Content analysis was used in four studies (Cody, 1989; Ford, 1982; Ingle, 1988/1989; Knowlden, 1986). Other approaches, including grounded theory, hermeneutical, and symbolic interactionism designs, were used in the remainder of the qualitative studies.

Fourteen of the reported studies used quantitative methods to study the meaning of caring (Cronin & Harrison, 1988; Devries, 1991; Henry, 1991; Huggins et al., 1993; Keane et al., 1987; Komorita et al., 1991; Larson, 1984, 1986; Mangold, 1991; Mayer, 1987; Quinn & Renaud, 1989; Semenza, 1991; Semonin-Holleran, 1991; Wolf, 1986). Of these, seven used Larson's (1984) CARE-Q instrument (Keane et al., 1987; Komorita et al., 1991; Larson, 1984, 1986; Mangold, 1991; Mayer, 1987; Quinn & Renaud, 1989) and five used Cronin and Harrison's (1988) CBA tool (Cronin & Harrison, 1988; Devries, 1991; Henry, 1991; Huggins et al., 1993; Semenza, 1991).

Nurses' and/or nursing students' perceptions were the focus of 17 studies; patients' perceptions were the focus of interest in 19 studies; and five studies reported perceptions of nurses and patients and/or others. Only one study was identified in which family members of patients were selected exclusively for the study sample (Henry, 1991). Critical care nurses and/or patients were studied in four other studies. Sample sizes ranged between 8 and 110 subjects in the studies reviewed.

An examination of the research available to date reveals several points worthy of consideration:

1. Patients appear to value what the nurse does to meet physical needs as the most important aspects of caring. Concepts cited frequently in the literature which support this notion include surveillance; demonstration of competence, knowledge, and skill; and being physically present with and for the patient. Psychosocial or expressive aspects of caring are also important, but patients appear to want nurses to attend to their physical care needs before they address other needs such as support, teaching, mental presence of the nurse, building self-esteem, touching, and humor and laughter. Patients also describe caring as personality attributes of the nurse.

2. Nurses generally value the psychosocial aspects of caring more highly than do patients. Behaviors such as listening to the patient, helping and showing respect, touching, allowing expression of feelings, comforting, assessing meeting all needs, promoting independence, and talking to patients have been mentioned by nurses as important to the demonstration of caring.

3. Qualitative research designs have been valuable to the study of caring. Approximately 66% of the studies reported the use of qualitative methods.

4. Relatively few studies (26.8%) have addressed professional nurse caring in the critical care environment. Findings indicate that critical care nurses and critically ill patients both describe or rate behaviors directed at meeting physical needs as most important to the meaning of caring. Investigators explained this as being consistent with the nature of the nursing care required in the critical care environment.

5. In only one reported study were family members of patients the exclusive population of concern (Henry, 1991). Participants of this study, in which a quantitative design was used, were parents of critically ill children.

6. No research with the specific purpose of describing the lived experience of professional nurse caring from the perspective of family members of critically ill patients has been identified. The description of these experiences is needed to provide a broader understanding of the meaning of professional nurse caring.

CHAPTER III

RESEARCH METHODOLOGY

The purpose of this study was to identify, analyze, and describe the meaning of professional nurse caring as experienced by family members of critically ill patients. The purpose was achieved by asking several questions designed to elicit the meaning of professional nurse caring. The specific research method is described in this chapter.

Phenomenologic Method

The research approach employed for this inductive, descriptive study was the qualitative method of phenomenology. The phenomenologic method "seeks to uncover the meaning of humanly experienced phenomena through the analysis of subjects' descriptions" (Parse, Coyne, & Smith, 1985, p. 16). Spiegelberg (1976), an historian of the Phenomenological Movement, has identified seven steps of the phenomenological method, the first three of which are accepted by all those who subscribe to the phenomenological method. The seven steps are (a) investigating particular phenomena, (b) investigating general essences, (c) apprehending essential relationships among essences, (d) watching modes of appearing, (e) watching the constitution of phenomena in consciousness, (f) suspending belief in the existence of the phenomena, and (g) interpreting the meaning of phenomena. The conduct of the first three steps was most in keeping with the purpose of this study. A more detailed description of these three steps follows.

Investigating particular phenomena includes three closely related but distinct operations identified as "phenomenological intuiting" (Spiegelberg, 1976, p. 659), "phenomenological analyzing" (p. 669), and "phenomenological describing" (p. 672).

These same three operations, although at a different level, are also appropriate to investigating general essences.

The operation of phenomenological intuiting requires complete concentration on the participant's description of the phenomena without becoming so immersed in the experience as to be unable to look at it critically. Spiegelberg (1976) suggests that the researcher remain open to the experience by intently looking at, listening to, and feeling the phenomena as they appear in the participants' descriptions. Oiler (1982) views this operation as "looking at the experience with astonishment" (p. 180).

Phenomenological analyzing is an analysis of the phenomena rather than the expressions that refer to them. This process allows the researcher to discover or uncover equivalent expressions and to construct new expressions using a smaller number of terms so as to trace the elements and the structure of the phenomena (Spiegelberg, 1976). Constituents of the phenomena are distinguished and relationships between the constituents and other phenomena are examined.

The ultimate goal of the final operation of phenomenological describing is to communicate meaning of the experience in a language appropriate to the science (Omery, 1983). Describing refers to stating the quality or attributes of the phenomenon in such a way that they serve as a reliable and unmistakable guide to the reader's own actual or potential experience of the phenomena (Spiegelberg, 1976). The process of phenomenological description aims to describe new phenomena or new features of known phenomena in order to isolate their uniqueness or essences (O'Hearn, 1987). Spiegelberg suggests negation and metaphor as possible methods for this operation.

Investigating general essences, Spiegelberg suggests, is "lining up particular phenomena in a continuous series based on the order of their similarities" (1976, p. 678). Perception and imagination are used to identify the elements, and certain groups of phenomena are observed to "cluster around cores that stand out as nodal

points or vertices in the sequence of phenomena" (Spiegelberg, p. 678). The clustering of groups is not arbitrary but natural because of the similarity of the elements of the cluster to each other. One should be able, then, to look at particular elements or constituents of each cluster and see the general essence that unites them within the cluster. Arbitrary or artificial lines do exist, though, in the transition areas between several clusters.

Phenomenological study of essences "includes the discovery of certain essential relationships or connections . . . pertaining to such essences" (Spiegelberg, 1976, p. 680). The relationships may be within a single essence or between several essences. In the former instance, the investigator is concerned with "whether the components are or are not essential" (Spiegelberg, p. 680) to the essence of the phenomenon; in the latter instance, the investigator keeps one essence constant and tries "to combine it with various other essences, leaving off some of its associates, substituting others for them, or adding essences not hitherto encountered together with them" (Spiegelberg, p. 682). If the omission or substitution of associated essences proves impossible, an essential necessity is identified; when they prove at least compatible with one another, an essential possibility exists; when they repel each other, the relationship is an essential impossibility (Spiegelberg). Regardless of whether the essential relationships are within one essence or among several essences, it is important to remember that the investigator is concerned with what is or is not included in the referents of a concept, in this case professional nurse caring, not with what is included in the concept itself. According to Spiegelberg, the "question at issue is whether or not several essences stand in relationships not contained in either of them alone, but entailed by them jointly" (p. 682).

Study Participants

A combination of purposeful and quota sampling techniques was used to collect the data. Purposeful sampling refers to "selecting the best informant who is able to meet the informational needs of the study" (Morse, 1989, p. 117). Glaser

and Strauss (1967) describe purposeful, or theoretical, sampling as "a procedure whereby researchers consciously select additional cases to be studied according to the potential for developing new insight or expanding and refining those already gained" (p. 123). Quota sampling refers to the *a priori* selection by the researcher of one or more variables that will ensure heterogeneity of the sample (Morse, 1989).

Participants were purposefully selected from the available family members of critically ill patients hospitalized in three of the eight designated critical care units of an 850+-bed, state-owned, not-for-profit university hospital in the southeastern area of the United States. To account for any potential effects of a particular critical care environment on the expressions or demonstrations of professional nurse caring, efforts were made to select an equal number of participants who were related by marriage, blood, or adoption to patients hospitalized in either the Coronary Care Unit (CCU), the Medical Intensive Care Unit (MICU), or the Cardiovascular Surgical Intensive Care Unit (CICU). Interviewing participants who experienced professional nurse caring in different critical care environments was expected to provide an opportunity to obtain a more comprehensive picture of professional nurse caring in critical care.

Because critical care unit policies restricted visitation to only immediate family members and to only two family members per visit, only one individual family member per patient was accepted as a participant. This was done to aide the researcher in identifying the best informant among family members and to assure clarity during the interview process. The Family Services Representatives in the CCU Waiting Room and unit staff were helpful in identifying the family member of each patient who had had the most experience with professional nurses and who would mostly likely be willing to fully participate in the study.

Because the institution used for data collection is a tertiary referral center that admits patients referred from non-English speaking countries, the following

additional criteria were used to ensure that participants would be "articulate, reflective, and willing to share" with the researcher (Morse, 1989, p. 117).

1. Patients related to the participants had been hospitalized in a critical care unit for eight or more hours and were still in the critical care unit at the time of the interview.

2. Participants had some interaction with one or more professional nurses working in the associated critical care unit(s).

3. Participants were able to speak English and to participate in the study, both mentally, emotionally, and physically.

The adequacy of the sample was evaluated by the quality, completeness, and amount of information offered by the participants (Martin, 1989/1990).

A total of 13 family members were approached by the researcher and were asked to participate in the study. Three individuals, two African-Americans and one Caucasian, declined the request. Another Caucasian family member agreed to participate, but just prior to beginning the actual interview, the researcher was notified that this individual's critically ill father expired unexpectedly. The interview was immediately discontinued, and the researcher assisted the physician in informing the participant and her mother that their father and husband had expired. Bereavement care was continued until the family left the hospital.

Nine family members, three from each of the designated critical care units, agreed to participate and were subsequently interviewed by the researcher. In two instances, the family member being interviewed requested that a spouse or child be present during the interview, not to participate but to provide emotional support. In both instances the request was considered to be acceptable and non-threatening to the quality of the study. The family members were allowed to be present during the interview, and in only one brief instance did the second family member speak during the interview or contribute to the data.

Setting

Efforts were made to conduct the confidential interviews in a setting most amenable to achieving participant comfort and to obtaining sufficient and quality data. Interviews were privately conducted in conference rooms, lounges, or offices associated with the particular critical care units used for this study.

Protection of Human Subjects

Approval to conduct the study was obtained from the Institutional Review Board of the University of Alabama at Birmingham (Appendix A) and from the Nursing Research Committee of the participating hospital (Appendix A). Written informed consent of all participants was obtained (Appendix B), and consent to participate was confirmed at the beginning of the taped interview. Throughout the investigation, participants' confidentiality was maintained; any identifying information inadvertently included on the tape recordings was replaced by a blank line on the printed transcripts. Participant recordings and transcripts were identified by a number code, and the names and associated code numbers of the participants are known only to the researcher. Audiotape recordings of the participant interviews were destroyed at the conclusion of the study. Verbal or written reports of the study will not include any data that could reveal the identity of the study participants.

Data Collection

Prior to the collection of data, the researcher prepared a description of her perspective about the phenomenon of concern in this investigation. This bracketing or suspending of any previous knowledge, assumptions, and experience that could bias the researcher's ability to collect or analyze the data aided in optimizing the trustworthiness of the study.

Arrangements for data collection were made with the head nurse of each of the three critical care units. An explanation of the study was offered, and advice as to the best approach for identifying potential participants was sought. In addition,

arrangements were made to use a unit or near-by conference room, lounge, or office for the conduct of the interviews.

Potential participants were contacted by the researcher after consultation with unit staff. In most instances, participants were first approached by a clinical specialist, professional nurse, or family services representative familiar to them and were asked if they would be willing to speak with the researcher. The researcher then explained the study and discussed the consent form and the issue of confidentiality. Participants were informed that the interview would be audiotaped and that the tapes would be erased at the conclusion of the study. The researcher answered questions about the study, and if the family members agreed to participate, they were asked to sign the written consent form (Appendix B). After obtaining permission to interview the family members, a time and location for the interview that was convenient to both the participant and the researcher was determined. The unit staff and the volunteers or staff in the visitors' lounges were informed of where the participant could be found if the need arose.

Prior to the conduct of the actual interview, participants were asked to complete a brief demographic data profile (Appendix C). They were reminded of the intent to audio-tape the interview, a small clip on microphone was attached, and the quality of the recording was tested. As much as possible, the tape recorder was placed out of the view of the participants so as to decrease any potential discomfort associated with the act of being recorded.

The interviews began with the researcher stating the predetermined code number for the participant and the time the interview began. The participants were once again asked if they understood they were being recorded and if they agreed to participate in the study. The semi-structured interview consisted of questions posed to elicit a discussion about the meaning of professional nurse caring from the experience of the family members of critically ill patients (Appendix D).

Initially, participants were asked to think about their experiences with the nurses while their family members were in the critical care unit. Participants were then asked if they found the nurses to be caring and to describe the meaning of caring to them. Next they were asked to describe how nurses demonstrated caring in what they did for or with the family members and the critically ill patients. Follow-up questions were asked in an attempt to elicit the meaning of professional nurse caring and the effect professional nurse caring had on the participants. In addition, participants were asked to describe interactions with nurses in which professional nurse caring was not experienced by the participant. They were also asked to describe how those interactions affected them (Appendix D).

Throughout the interviews, participants were asked to clarify and/or expand their descriptions when the researcher was unclear about the meaning or if the description appeared vague or unfocused. Some participants were asked if they had had an experience similar to that of previously interviewed family members, but the researcher did not suggest meanings or coax the participants to answer in any way that fit some preconceived notion of the investigator. Brief notes were kept during the interview or written immediately following the interview to record objective expressions of the participants that were observed by the researcher and to record reflective thoughts or insights that came to mind during or after the interview.

The interview continued until the participant expressed a desire to stop or until the researcher believed additional questioning would reveal no further description or data. In addition, the researcher ended the interview if the participant was observed to be tired or ready to stop. In several instances, attempts to draw the interview to an end for this reason only resulted in further discussion and description by the participant. At the conclusion of the interview, the time was recorded, the recorder was turned off, and the microphone was detached from the participant. The researcher thanked the participants for their time and effort in assisting with

the study and offered to walk them back to the patients' rooms, the visitors' lounge, or some other area in the hospital.

The tapes were transcribed by the researcher via a Microcassette™ Transcriber (Panasonic® RR-930) and a computerized word processing program (Microsoft® Word, Version 5.0). Transcriptions were compared to the recordings to assure accuracy. Corrections were made and the tapes were stored in a desk drawer at the researcher's home office. All tapes were erased at the conclusion of the study.

Transcription of tapes began after the conclusion of the interviews. Therefore, data analysis of early interviews overlapped with data collection from other participants later in the data collection process. The researcher maintained notes of helpful questioning techniques and other information that would be useful in subsequent interviews to obtain more complete descriptions of experiences.

Analysis of Data

The mechanics of data management were assisted by the use of the software package THE ETHNOGRAPH (Versions 3.0). The data were analyzed using Sherwood's (1988) interpretation of the Spiegelberg (1976) description of phenomenological method. The initial phase of data analysis focused on undistracted reading and rereading of the transcripts to identify the meaning of professional nurse caring from the lived experience of family members of critically ill patients. The following steps were employed:

1. The researcher reviewed the bracketing of previous knowledge, assumptions, and experience that may have biased her ability to intuit, analyze, and describe the experiences of the participants. This step was repeated as necessary throughout the data analysis phase.

2. The entire transcript of the description of the experience was read to get a sense of the whole.

3. The researcher reread the description more slowly and contemplatively, rigorously searching for occurrences of professional nurse caring. A yellow marker was used to highlight on the transcripts any descriptive expressions that completed an idea about the experience of professional nurse caring. Markers of other colors were used to highlight recurrent data of a secondary nature so that these elements would not be lost in the data of primary interest and could be retrieved and separately analyzed at a later time. The researcher intuited, analyzed, and began to describe professional nurse caring as experienced by the participants and formulated statements of meaning from the descriptive expressions.

4. Multiple readings of the highlighted transcripts were performed to eliminate any redundancies in the descriptive expressions, to identify major characteristics of the phenomenon, and to search for patterns and themes among the descriptions.

5. The researcher studied characteristics, patterns, and themes and divided them into categories or clusters that established the essence of the meaning and structure of the experience.

6. Categories were related to each other and to the whole by clarifying and elaborating their meanings.

7. The researcher validated themes and theme categories of the phenomenon of professional nurse caring with a selected study participant whose family member survived the critical illness and was eventually discharged from the institution and with a family member of a critically patient who had not previously participated in the study. The former was asked to review the themes and theme categories and to indicate whether the researcher's interpretation of the experience adequately represented his/her experience with the phenomenon. The participant was invited to offer suggestions as necessary that would make the interpretation more representative of the experience. The latter was asked to review the themes and theme categories and to indicate whether he/she could recognize his/her

experience of professional nurse caring within the researcher's interpretation of the experiences of others. This family member, too, was given the opportunity to suggest additions to or deletions from the interpretative statement of the meaning of professional nurse caring.

8. The themes and categories were summarized into a language appropriate for communication, confirmation, and critique by others in the discipline of nursing.

9. Existing literature concerning the concept of caring was analyzed and related to the meaning of professional nurse caring from the experience of family members of critically ill patients and to the meaning of the concept from the perspective of others.

Validity

Field and Morse (1985) define validity in qualitative research as "the extent to which the research findings represent reality" (p. 139). Reality in the phenomenological framework is subject to the perspective and perception of the participant or the one experiencing the phenomenon (Merleau-Ponty, 1962). The aim of phenomenological description is to guide the reader to his or her own actual or potential experience of the phenomenon. The ultimate tests of validity, then, are whether the description of the findings can be "recognized to be true by those who live the experience" (Oiler, 1982, p. 181) and if the reader has not actually experienced the phenomena, can the experience "be recognized after having read only a description of it" (Oiler, p. 181).

To optimize validity of the study, the researcher employed the following controls (Field & Morse, 1985; Knaack, 1984; Oiler, 1982; Sandelowski, 1986):

1. The researcher acknowledged and stated her perspective of the phenomenon of concern. The description of the researcher's perspective was reviewed periodically throughout data collection and analysis and compared to the

participants' perspective to assure that researcher bias had not been entered into the collection or analysis of data.

2. The researcher selected participants who had experienced professional nurse caring in the critical care environment.

3. The researcher conducted the interviews as soon as appropriate after the caring experience to allow for short term recall.

4. The researcher avoided suggestive or coaxing questioning during the interview.

5. The researcher obtained the assistance of an outside reader who was experienced in the phenomenologic method. The reader conducted an independent analysis at the completion of steps 3 and 7, and those analyses were compared to the researcher's for agreement. With only minor exceptions, the reader agreed with the analysis of the researcher. The reader's comments were incorporated into the analysis process.

6. The researcher reviewed the interpreted meaning of caring derived from the analysis of data with one selected participant and one non-participant family member of a critically ill patient for verification of content and meaning. Neither family member offered any suggestions for change and both expressed full support of the statement of meaning as it was presented to them.

Limitations

The following limitations were identified in this study:

1. Potential participants may have identified themselves as family members of a critically ill patient when in fact they were not related to that patient by blood, marriage, or adoption.

2. The nature of the patient's illness, injury, or trauma may have influenced the ability of the participant to freely and comfortably reflect upon and provide detailed experiential information about professional nurse caring.

3. The lived experience of the participants selected for interviewing may not have been representative of the population of family members of critically ill patients.

4. The quality of the data may have been influenced by the participants' memories of the experience or their attitudes about the illness or the treatment plan.

5. Some participants may have been better able to articulate their experience of professional nurse caring than other participants.

6. The researcher's ability to formulate the right questions to tap the participants' experiences, adequately listen to the descriptions, and to verify with the participants the researcher's understanding of the meaning of what ways heard may have influenced the quality of the data collected.

7. The researcher's ability to set aside previous knowledge, assumptions, and experience, that is bracketing any preconceptions or presuppositions, may have influenced the quality of data collection and analysis.

CHAPTER IV

ANALYSIS, FINDINGS, AND INTERPRETATION

This study was conducted for the purpose of identifying, analyzing, and describing the meaning of professional nurse caring as experienced by family members of critically ill patients. The research question for the investigation was: What is the meaning of professional nurse caring as experienced by family members of critically ill patients? The philosophy, approach, and methodological procedures of phenomenology guided the data analysis and interpretation. This chapter includes a profile of the participants and the theme categories, themes, and representative descriptive expressions of the meaning and structure of professional nurse caring from participants' experiences. Information not specifically asked for, but shared by the participants, is included as additional findings. These findings deal with physician caring in critical care and with participants' suggestions for making the critical care experience more caring for family members of patients.

Profile of Participants

The participants included in the study were family members of critically ill patients hospitalized in one or more of three critical care units in a large state-owned, not-for-profit university hospital in the southeastern portion of the United States. Nine individuals, six females and three males ranging in age from 38 to 64 years (mean = 54 years), were interviewed. All were Caucasian. All female participants and one male participant were related to a critically ill patient by marriage; two males were the fathers of critically ill patients. The length of stay for the critically ill patients at the time of the interview ranged from 3 to 308 days (see Table 1).

Table 1

Summary of Participant Demographic Data

Participant	Age	Sex	Cultural Background	Relationship to Patient	Length of Patient Stay in Critical Care Unit (days)
1	64	M	Caucasian	Father	308[a]
2	38	F	Caucasian	Wife	10[b]
3	63	M	Caucasian	Husband	4
4	63	F	Caucasian	Wife	56[a,b]
5	44	F	Caucasian	Wife	3
6	60	F	Caucasian	Wife	19[b]
7	52	M	Caucasian	Father	31[c]
8	54	F	Caucasian	Wife	53[a]
9	45	F	Caucasian	Wife	19

[a]These participants described experiences with critical care nurses in 2 units during this illness episode.
[b]The critically ill patients related to these participants expired after the interview, but during the same hospitalization.
[c]This participant described experiences with critical care nurses in an ICU in another hospital in the state prior to the transfer to an ICU at this institution.

Data Analysis

Nine taped and transcribed interviews were analyzed. The length of the interviews ranged from 13 to 45 minutes (mean = 29 minutes) and resulted in 190 pages of numbered, single-spaced lines of type arranged in vertical half-page columns. Initially each transcript was read for an overall impression and then reread for the purpose of identifying meaningful descriptions of the phenomenon of professional nurse caring. From the verbatim transcripts, 589 meaningful statements were identified and extracted for analysis; these included phrases, complete sentences, or combinations of sentences that expressed one or more elements or constituents of the phenomenon of professional nurse caring as experienced by the participants.

During multiple readings major characteristics of professional nurse caring were identified. Repetitive or redundant descriptions by a single participant were reviewed and the most descriptive expression was retained; the others were eliminated for the remainder of the analysis phase of the study. From the remaining descriptive expressions, the researcher interpreted the described experience of professional nurse caring and transformed the expressions into words or phrases, that is themes and subthemes, that retained the participants' perspective while clarifying the essential elements of the phenomenon.

The themes, and when present, their subthemes, were reviewed individually and as an aggregate. Commonalities within them were identified and clustered into four theme categories, which are (a) the way the nurse is, (b) meeting patients' needs first, (c) meeting family members' needs, and (d) feelings evoked by demonstrations of caring and noncaring. The theme categories and the corresponding themes are outlined in Table 2. For the purposes of the presentation of findings, all ahs, uhs, and uhms were removed from the participant descriptions. These words added nothing to the meaning of the description and their presence could be distracting to the reader.

Table 2

Theme Categories and Themes for the Phenomenon of Professional Nurse Caring

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I. Theme Category: The Way the Nurse Is

A. Personality Characteristics of the Caring Nurse
B. Expressive Behaviors of the Caring Nurse
C. Professional Attributes of the Caring Nurse

II. Theme Category: Meeting Patients' Needs First

A. Providing Continuous and Vigilant Monitoring
B. Communicating Emotional Care and Encouragement
C. Giving Physical Care and Comfort
D. Providing an Opportunity for and Assisting with Healing
E. Maintaining Patient's Dignity and Providing Privacy

III. Theme Category: Meeting Family Members' Needs

A. Taking Care of the Critically Ill Loved One
B. Offering Honest and Consistent Information
C. Facilitating Access to the Physicians
D. Providing Access to the Patients
E. Allowing Family Members to Participate in Patient Care
F. Providing Physical, Emotional, and Spiritual Support/Comfort
G. Recognizing and Acknowledging Family Members

IV. Theme Category: Feelings Evoked by Demonstrations of Caring and Noncaring

Caring Themes

A. Relieved of Stressors
B. Security in Knowing the Patient Will be Safe
C. Cared For
D. Connected to Caring Nurses

Noncaring Themes

A. Uneasiness with the Situation
B. Fearful of Sanctions

Findings

One of the assumptions of this study was that the nature of a specific critical care unit might influence the expressions or demonstrations of professional nurse caring, and it was for this reason that family members who had experience in one or

more of three different critical care units were selected for interview. Through their descriptions of professional nurse caring, participants affirmed the role the environment and the condition of the patient or the length of the critical care unit stay have on expressions of caring. One participant, whose mate had spent three and one-half weeks in one unit and four weeks in another unit, shared the following: "I guess you go back to the environment, the unit. I'm sure that has a lot to do with it 'cause . . . they get 'em stable and they move 'em out . . . . they just really don't have people up there that long."

Another participant, whose spouse was also transferred from one unit to another, expressed it this way:

> I was just thinking. You see the two units also are a little different. One is the [Unit A], would be, well that's pretty critical and of course that, you have one nurse to each patient. Now in the [Unit B], you have a nurse to two patients, which is the way it should be because he isn't quite as critical. He can, you know, is a little more, a little more on his own. He's able to tell them a few things, what he needs or if he needs things, with his emotions, with his eyes or his hands and things like that. So that caring is a little different than, but it's still just as good. The nurses are just as good, I think.

The participants did not judge the expressions of caring as better or worse in one unit or another, rather they noted that there was a difference in the expressions.

Family members' expectations influenced perceptions. One participant expressed the following: "Well, you know, I don't know how you can expect, like, a nurse that sees thousands of patients to really have to care. I don't really expect it." This perspective was evident in all his descriptions of professional nurse caring.

The Way the Nurse Is

When asked the question, "Did you find the nurses to be caring in their interactions with you?", all participants responded affirmatively and shared the following descriptions: "I thought they have been excellent"; "I think these nurses here are just, they're fabulous"; "They were just great"; and "They've been perfect". Terms such as "excellent," "fabulous," "great," "perfect," "wonderful," "super," "precious," and "terrific" were used often. Seeking a deeper understanding of the

caring interactions, the researcher asked, "Can you tell me what the nurses did with or for you that let you know they were caring?" This resulted in descriptions of the critical care nurse that clustered into three themes related to the way the caring nurse is; they include (a) personality characteristics, (b) expressive behaviors, and (c) professional attributes (see Table 3).

Table 3

Themes and Subthemes for Theme Category: The Way the Nurse Is

I.	Theme: Personality Characteristics of the Caring Nurse
II.	Theme: Expressive Behaviors of the Caring Nurse
	Subthemes
	A. Caring Behaviors
	B. Not Just a Job
	C. Going Beyond
	D. Empathy
III.	Theme: Professional Attributes of the Caring Nurse
	Subthemes
	A. Confidence
	B. Knowledge
	C. Technical Skill

Personality Characteristics of the Caring Nurse

One of the ways in which caring nurses were described was by their personality characteristics. One participant responded: "Well, you know, just their personality and their–the way they–their demeanor." Another said, "I think personality has a lot to do with it." Yet another participant offered, "It's the ability of that individual to be the way they are and their personality and everything, and they're made to be what they are."

Terms such as "calm," "cheerful," "compassionate," "congenial," "cooperative," "courteous," "dedicated," "efficient," "friendly," "gentle," "honest," "kind," "loving,"

"motivated," "nice," "patient," "professional," "special," "steady," "strong," "sweet," "tough," and "warm" were used to describe the personality traits of the caring nurse. These nurses were not "arrogant," "hateful," "jaded," or "snappy." Nurses that were perceived as being less caring or not caring "just didn't have a lot to say to you and didn't have a lot of personality".

Personality characteristics described as caring were not limited to female nurses. Two participants made a point to highlight their experiences with caring, male nurses. One offered the following:

> The male nurses were his pick. And I have found that to be true pretty much everywhere. The male nurses are so nice. I'm not sayin' females are not . . . . I haven't been used to male nurses and I'm not accustomed . . . . But they have just really, they have just really showed up good.

Another expressed it in this way:

> I'm not familiar that much with male nurses. This has been my first real experience with them. But even the male nurses, they're in there pattin' and rubbin' and reassurin' and I watched on Sunday, like with a week old baby and here's this big man with this little tiny infant and he just did everything, you know, and held the baby and rocked the baby . . .

Caring nurses were described as "angels of mercy" and were said to have a calling. "So I, I sorta after a while looked at it . . . that certain nurses are called to be nurses just like certain ministers are called to be ministers." "It's the way that they truly are. They care, you know, or maybe they wouldn't be in this profession."

Expressive Behaviors of the Caring Nurse

Not only did caring critical care nurses have a caring personality, but they expressed this personality in both verbal and non-verbal ways. The subthemes of "caring behaviors," "not just a job," "going beyond," and "empathy" support the theme of expressive behaviors of the caring nurse in critical care.

Caring behaviors. The personalities of caring nurses were demonstrated to family members through expressive behaviors. One participant had difficulty describing how she knew a nurse was caring: "I can't put it into words, I don't know, you know, they, you can just see in their faces, they truly care." Another said:

> You can tell by watching someone's actions whether or not it's just a job or it's a technical procedure or if they really care . . . . You have nurses that are quieter than others. You have nurses that are more bubbly than others. But even your quiet nurses, you can just tell by the mannerisms that they really care; they're not just doin' their jobs.

Other behaviors described are: "They speak kindly"; "They're just movin' constantly and you, you don't ever see 'em just lazing around like they're trying to kill time or anything"; and "They didn't worry whether they made lunch or whether they didn't make lunch or had a break or didn't have a break." Caring nurses spoke with a soft voice, "Everything's in a soft tone, it's a caring tone," as opposed to a stern voice of a noncaring nurse described by one participant: "She said it kinda, you know, kinda stern . . . . You could feel the, the tone in her voice." They expressed an openness to the family as identified by two participants. "They've been real open." "They're open for communication." They "don't mind doing things. They're not tired. They don't seem tired." "Well, they seem, they have more energy." Caring nurses showed respect to the patient and the family.

Not just a job. One participant who had difficulty describing the caring nurse indicated it is "the [expressions] that they use, that lets you know they truly care. It's not just a job with them, which families appreciate." Others shared similar observations. One female participant said, "They're not just here for a paycheck . . . they really care." A male participant offered this description: "They're not in it for the money, they're in it because that's what they really are . . . . They weren't in it because their husband wanted them to work." His comments appear to reflect a belief that some innate personality characteristics make the caring nurse what she or he is. Another shared the following:

> It means that they're not just doing their job. They're going a little beyond doing their job . . . . I really don't know how to describe it . . . . Caring comes from within, I guess, a person, and you can tell, you know, they are, they're caring . . . . They just, they're not there just to do their job. They seem to be there to do, to help the person. To help them get well and it surprises me how if they don't have my husband the next day, they'll be, have another patient, a little down the way, they'll still want to come over there and see how he's doing. With all their patients they seem to really, they're motivated to

> get them well, to get them out of there. And that to me, that's a real, real compliment to all of them.

The surprise expressed by this participant seems to indicate how prior expectations or impressions of nurses influence the perceptions of family members. The non-caring nurse "doesn't seem to be, to wanna be there."

Going beyond. Another subtheme of this theme is the notion of going beyond the job, as indicated above, or beyond the technical or physical aspects of care. In a sense it is the little extra things that nurses do to demonstrate they are caring. "Some have a little extra something on one thing they do and, you know, a little extra lotions they would put on and take care of the body and another would have a little extra appeal in another way." Another described this aspect of caring in the following way: "There's just lots of things that they do. They go get water; they take a damp cloth and wipe the forehead. You know, those things I guess are not really necessary, but they do it."

Along with going beyond the necessary to do the little extras, is the notion of getting past the physical aspects of patient care in order to see the human being lying in the bed. A family member, who has a daughter that is a nurse, was asked to comment on what she would tell her daughter to do that would make family members know and understand that she was a caring nurse. She stated:

> Such a basic thing, but just, you know, that that is a human being and that even though they have all the wires and plastic coming out 'em that, that's still somebody with a heart and soul and brain and . . . . a lot of family members.

When asked to describe the meaning of caring, this same participant said:

> Assuming a level that releases some of the technical aspect of it and relates it to a more personal aspect. I mean obviously, there is a lot of equipment that they're monitoring and things like that, but their responsiveness, the way they can just, the non-verbal actions, the way they try and approach things and make it as humanistic as possible.

This participant finished her thought with a description of caring as empathy.

Empathy. Caring nurses demonstrated an empathy for the patient and the family members. One described a nurse's empathy for the patient this way:

> When he had this arteriogram, she said he had to put his hands up over his head and she said, "Oh, it just hurt me as much as it hurt him and I'd hold his arms and tell them to hurry up and you're hurtin' us both. Hurry up." And he just, he just really feels that she cares.

Empathy for what the patient and family were experiencing was described by two other participants. The first, a female participant whose daughter is a nurse, offered this thought about caring:

> I guess, it's a feeling that maybe they've, they've either had the experience that we've had and know what it feels like and have tried to put themselves more into the place of the patient, in terms of if I were, if the roles were reversed, how would I want to be treated in that situation.

Another individual related the following:

> They always ask you how you are, how you're holding up. They've always got a warm smile on their face or a pat on the back. Somethin' just lets you know that they half-way understand what you're goin' through. As I said, most of us haven't been through this with a loved one, but we can imagine how much it must hurt.

Professional Attributes of the Caring Nurse

Not only did caring critical care nurses have a caring personality and express that innate nature to the family, but they had the ability to make the family believe that they knew what they're doing and that they were doing the right thing as professionals. Subthemes that come together to embody this theme are confidence, knowledge, and technical skill. A male participant described it in this way: "There's a personality, and a capability, and a smartness, and a confidence."

Confidence. In describing the caring nurse, one participant said it was "somebody that makes you feel they know what they're doin', that they're interested in their patient." This notion was identified in other descriptions: "Some had enough confidence that they, they knew they were doing the best they could." and "Yah, confidence, I guess that would be the word. Confidence that, you know, 'Hey I know what I'm supposed to be doing and I'm doing it'." Nurses perceived as less caring appeared to lack confidence as reflected by this description: "Even though they may have done the right things, they just were, they were out of their, out of their league, let's say."

Nurses who were confident freely identified themselves and their role in patient care and sought to learn more about each family member. One participant shared this perspective:

> Some of the nurses do a better job than others of identifying themselves, you know, introducing themselves, and also trying to find out who each of us are . . . . It's much more of a caring atmosphere when you have identified their roles . . . . Probably if there's a new one on who hasn't seen us before, I think it would be a caring gesture if they made a point to introduce themselves and describe what their role is.

Knowledge. The caring nurse knew the patient and knew what was necessary to take care of the patient. One participant shared this impression:

> This is the best facility that I have ever seen as far as trained people on how to take care of a sick person and how to make them feel like they are in control and nothing's going to happen to them, and yes, 'I care about you' . . . . They know everything that the doctor, you know tells them, everything from the chart . . . . The nurse is the one that is trained, I think, to keep him alive and keep him going while the doctor, you know, takes the necessary steps.

Another individual offered this description of the caring nurse: "The nurse that is truly there, knows her stuff, knows her machines, knows what they will do, knows what the respirator can [do], and knows her limits." The wife of a patient, when describing what her nursing student daughter should do to demonstrate caring, said this:

> Know your material, your patient, and all patients are different and you can't treat them all alike and it, you'd have to learn them and I guess that would be the hard thing to do, 'cause you don't, you're not always with them long enough to know exactly what they need.

Caring nurses knew the patient, knew the data in the patient's chart, and knew what each individual patient needed. They were there with and for the patient.

A lack of caring on the part of the nurse was perceived when the nurse was not knowledgeable about the patient. The following was encountered when one participant inquired about a medication her husband was receiving: "We asked the nurse. She says, 'Well, I don't know really. He hasn't said anything.' Well if she don't know, who's to know. How am I gonna find out?" From another participant, who was describing the reactions of some nurses to the complexity of his family

member's condition, came this: "Some weren't prepared for it and in turn they went to pieces."

Technical skill. The concepts of confidence, knowledge, and technical skill are tied together by the family members. The father of a critically ill patient said:

> It's their ability to take care of a situation . . . . There were some nurses that absolutely by the end of their . . . shifts, they were absolute nervous wrecks. I mean they just, they, [the patient] had 'em scared. They would do things and get things out of balance and then try to compensate here, and when somebody's on, 90 percent on a respirator you don't have much room for much error . . . . But the ones that were there were very cautious in what they did and really kept [the patient] in balance and did everything to bring it down and didn't, didn't, if things got out of balance, they just went around and did everything they could to suction _____, or whatever happened, they did, to clear those airways and get 'em workin' again . . . . The skill, that's right, and the confidence the individual has.

The nurse who had the combined attributes of confidence, knowledge, and technical skill was recognized by family members and others as a role model for nurses and students of nursing. Evidence of this can be found in these shared experiences.

> They're the ones that everybody in the unit will come to and say "Hey, look, I gotta, I can't get an IV in over here. Could you help me?" or "Should I do such and such?" and they all, and there's, you know, there are probably five of them that everybody came to, to get their help.

> I've been in here while there's been a couple of nurses in training. I've listened and they tell them, "Let's ask him this." or "Let's tell him that." So your older nurses are training your newer nurses to be like they are, which I think's great.

Summary

The experience of professional nurse caring begins with caring nurses being the way they are. These nurses have and express innate personality characteristics that are perceived by family members as caring. To the family members, the expressions of caring nurses communicate that they are not just doing a job, but rather they do what is required by the situation and then much more. Caring nurses empathically place themselves in the patient's and family's position and treat them the way they would want to be treated. These nurses are present with and available to the patient, and they strive to know as much as possible about the patient and the

family members. Caring nurses possess and combine the professional attributes of confidence, knowledge, and technical skill. They demonstrate a competence that comes with experience and because of this, they serve as role models for others with less experience, knowledge, or skill.

Meeting Patients' Needs First

The next two categories of thematic elements of the phenomenon of professional nurse caring have to do with meeting needs. As one individual said, "Trying to meet your needs at the time you need it; that is caring." Family members differentiated between the needs of the patients, the needs of the family members, and the caring actions by or expressions of the critical care nurse that met those different needs. Family members readily acknowledged that the nurses' first priority is always meeting the needs and taking care of the patients. Evidence of this is reflected by this comment: "I think that they are, they're takin' the best care they can of him because I can see that he is their first priority and that makes me feel good." Meeting needs of patients involves the actions of providing continuous and vigilant monitoring, communicating emotional care and encouragement, giving physical care and comfort, providing an opportunity for and assisting with healing, and maintaining the patient's dignity and providing privacy. All are elements of caring (see Table 4).

Providing Continuous and Vigilant Monitoring

Patients are admitted to critical care units because of the need for continuous monitoring for life-threatening physiologic changes. Because of the nature of the visitation policies in the critical care units used in this study, family members did not have many opportunities to actually observe the life-saving/life-sustaining interventions of the nursing and medical staffs. However, they were aware that caring nurses were continuously present and intensely observant for any abnormalities needing rapid action. One participant said, "He never left the bedside." "The caring

Table 4

Themes and Subthemes for Theme Category: Meeting Patients' Needs First

I.	Theme: Providing Continuous and Vigilant Monitoring
II.	Theme: Communicating Emotional Care and Encouragement
	Subthemes
	A. Joking and Teasing B. Touching C. Connecting Past to Present D. Praising E. Explaining F. Reassuring G. Coaching
III.	Theme: Giving Physical Care and Comfort
	Subthemes
	A. Preparing Patients for Procedures B. Making Patients Physically Comfortable C. Serving as the Caretaker D. Advocating for Patients
IV.	Theme: Providing an Opportunity for and Assisting with Healing
V.	Theme: Maintaining the Patient's Dignity and Providing Privacy

part is that they check on him a lot and they're real conscientious about him" was the way another participant described the experience of professional nurse caring.

Participants in this study were very aware of the vigilance nurses maintained for the patients in their care. One offered:

> They come [sic] in a lot and checked on him and checked how his IVs were doing and everything, you know, checked on the monitor, his heart. They just keep a good check on him, and that's how I know that they are not just, you know, ignoring him, that they do care how he's doin'.

Another individual said:

> They can be right there checking them and yet they can be, standoff in the back writing their reports and you can still see they are very watchful, very, they have to just, and they do that, I've seen them do that. You think they're not really over them, working with them at the time, but they still do their job from afar by observing.

And from the father of a patient, came this: "Normally a nurse takes care of the patient, understands the patient, doesn't really prescribe unless, in case, that needs to be done but their real function is to assess the patient. And in all cases they did that."

Communicating Emotional Care and Encouragement

The communication of emotional care was a common theme identified in the descriptions of caring experiences. "I think it's important for my husband, who is the patient, to have the emotional support that he needs, because all this is so foreign to him" is a comment shared by one participant. Another participant shared this:

> He [her husband] says, "Are you gonna be with me?" [The nurse] says, "I'll be right there with ya." You can just see something leave his face, like she's gonna be here and everything's gonna be okay. She's gonna take care of me.

Joking and teasing. Joking and teasing are nursing actions that were observed to communicate emotional care and encouragement.

> It's just, like they joke with him, you know . . . make things kinda fun. Like, "Oh, we're gonna walk. Don't you run too fast; you're gonna run over me." And you know, it's not just all business, and no funnin' with it. They try to put fun in with it, and that helps too. That makes, probably, I guess maybe makes him a little bit more comfortable.

Touching. In addition to joking and teasing, caring nurses provided emotional support through the act of touch and other non-verbal expressions of caring. One patient's wife commented, "I guess little things that probably nobody else would think about. They might go by and pat him on the foot, just maybe a touch." Another said,

> The nurses touch him, they rub his hair, you know they comfort him, they call him sweet little things like honey, sugar, and baby, and I know that makes him feel better, 'cause when you're terribly sick like he is, the, if you know that someone that's taking care of you really cares about you, that makes you feel better . . . . I saw nurses hugging, I saw nurses kissing babies. I saw them walking babies when they really didn't have to and no one knew that I was watching. They just did this. So yes, they care.

Another participant said, "The way they can just, the non-verbal actions, the way they try and approach things and make it as humanistic as possible".

Connecting past to present. Other non-verbal expressions of caring include actions that offer emotional comfort in the presence or absence of the family and that connect the patient's past with the present. Evidence is provided by this experience:

> We brought in tapes and a tape recorder and certain nurses really were, were very good at, at trying to play his tapes. Others, you know, didn't do that. They were there when we went in, you know, and they let us, but then, it was always like, "Are we infringing on you because we want to play this tape?" So the ones that not only did it while we were there, but, you know, who would do it when we weren't there, we felt we were getting that degree of comfort trying to give him a little piece of home, while we couldn't always be in there with him.

Praising. Offering praise for the accomplishments or improvements that patients made was another technique perceived to be caring. A patient's wife shared the following:

> He just really feels that she cares and she just, you know, she says, "Oh, he's really sweet. He's just doin' so good and oh, I'm just so proud of 'im. I'm just tickled to death what he's doin'." And he likes, I guess we all like a little praise and I guess that's what it is, 'cause the whole family's just gotten kinda partial to her. You know, 'cause I guess he cares that much and he feels like she's doin' what she's suppose to, and he, he wrote a note, well right after he came up here, and he, there was two of 'em at the time . . . . He said, "They're the two best nurses up here."

Earlier in the interview the participant said: "You know, you just have to brag on somebody to get 'im to do something sometimes. Sometimes they have to coax him to get 'im to do a little extra".

Explaining. Along with the praise and bragging, caring nurses explained what was happening to the patient and what they were doing. One participant shared this experiences:

> She was not his nurse, but she came by, and she said, "Oh he looks like he's doin' great," and I said "But tell him he's doin' good. " And she began to talk to him about the ventilator, and she knew it was uncomfortable but, and she just went ahead to explain it.

Reassuring. Other examples of demonstrations of emotional support and encouragement took the form of reassurance. One shared this observation:

> I could tell it; when she got through, I could tell that there was a difference. He needed somebody to just tell him and explain it and reassure him that

> things were going to be okay. But the family couldn't do it because he knew we didn't know what was going on."

Another said, "They always reassure him when they move him around, whether he's awake or not. We don't really know if he hears us, you know. Everything that they're doing shows they care. Everything."

Coaching. Sometimes the reassurance and praise took the form of coaching, not unlike how the coach of a sporting team praises, encourages, and offers emotional support to boost the spirits of an athlete. For example, one participant offered this:

> Some of 'em'll come by, "Oh! I saw you walkin' this morning and you looked good! That's good, you're doin' a good job." It makes his ego go a little higher, you know . . . . She came down and she says, "Oh, you looked so good this morning. I'm so proud of you." You could just see him kind grinnin' in his eyes, you know. It means a lot.

Giving Physical Care and Comfort

The patients' physical welfare and comfort were attended to by caring nurses. A family member of one patient shared this:

> Their whole thing was to take care of _____. Now it wouldn't make a difference if it was _____ or somebody else, it was the exact same thing. If they were in serious condition, they were gonna stay right there and take care of [the patient].

Preparing patients for procedures. Family members connect preparing patients for procedures or interventions to the demonstration of caring. The same participant as above described it this way, "She kept close contact with _____, she always walked up and said '_____, I'm gonna have to stick ya.' Nothing was a surprise. _____, during her period of time was always calm." Another shared this:

> They have told my husband, you know when they do something, they tell 'im. That helps him not be frightened if they do something and something changes in his feelings or something. He says, "What's goin' on? What have they done?" They're good to say, "Hey we're going to do this and this might make you feel a little tired" or whatever it would be to him.

Making patients physically comfortable. Providing physical comfort measures was also perceived as an element of caring. One participant shared her experience:

> They straighten the sheets, they make sure there are no creases in there to make his, you know, back more comfortable. They get him up in the bed so he won't be sitting on his back when they set the bed up; he'll be sitting on his bottom. There're just lots of things that really they wouldn't have to do and probably would go unnoticed .... And they always explain what they're doing. "Let me pull you up in bed so that your back can have a rest." "Let's sit up for awhile, let's turn to the right or turn to the left." "I don't want you to be sick." "You know we need to do this; it will make you stronger." They don't have to say all that .... They're trying to make him understand we're doing this because we want you to be well.

Another said, "They talked to my husband, even though he's in a coma. They have been very gentle with him, trying to get him to move and respond . . .", and another noted, "I've noticed that when they have to take tape off of him, they really try and be careful because they know that that pulls on the skin and that hurts." Family members tied the provision of physical care and comfort to the provision of emotional care and encouragement and to going beyond the essentials of the job, as can be seen in the discussion of the subthemes of the theme giving physical care and comfort.

Serving as the caretaker. Family members were aware of the big role nurses played in assuring appropriate therapy; nurses were seen as the primary caretakers of the patients. One participant shared the following:

> Like I said, I don't want to take anything away from the physician, but I think the nurse's role is the biggest one. She is the caretaker. Just like the mother is a caretaker for a, you know, child. The nurse is the caretaker. She tells the doctor what is going on with him [the patient] on a day-by-day basis. Little things that maybe, maybe don't mean anything, but maybe they do, and I think her role is the biggest.

Advocating for patients. Caring nurses were perceived as being patient advocates by working as a team and doing things judged to be in the patient's best interest. As expressed by one participant:

> Caring, or caring about someone, is having their best interest at heart even if you have to tell a family member, no you can't stay at this time. I know that if, when they tell me that, it's for his good. They're caring about his total well-being, his recovery.

One woman explained that her husband had been moved into a private room:

> The nurses thought that would be in his best interest to move him into the little private room that he's in so that they could close the door somewhat

> and give him some time to sleep, relax, and get over some of his anxiety. His anxiety is from not being able to breathe well. The doctors that evening, when they came in, saw that he had been moved, asked the nurses why. They said they thought it was better for his mental well-being. So that was a decision that they made, and I think it was the right one, and I don't think the doctors disagreed with it; they just wanted to know why he had been moved to a private room. See that's another thing they did for him. No one asked them to do that. A private room had not been mentioned, but they noticed that he could not sleep; they thought it would be best for him so they took action.

Another participant shared this experience:

> They didn't tolerate the doctors saying, "Well, I'll be there in 10 minutes." They'd say, "No, that's not acceptable." But they did it so nicely, those doctors never even knew it.

Family members indicated that nurses new to patients were sometimes unfamiliar with or unprepared for the complexities of the patients' care needs. In these instances the nurses did not know the patients well-enough to fully advocate for or demonstrate true caring toward them. One participant described such experiences in this way:

> With the complexity of his situation, it was very unsettling to us to have somebody new taking care of him each time. We didn't think somebody coming in during a shift change could glean enough information from the nurse on duty to really be able to do the kind of job that was adequate for him with as many different situations as he has faced.

Caring nurses, though, made a special effort to assure that nurses unfamiliar with patients were given as much information as possible so that they could advocate for the patient. A family member offered this description of the caring nurse:

> When she took on somebody, when she left [the patient] and gave [the patient] to another nurse, I mean she'd take 35, 40 minutes so that that nurse, if that nurse wasn't familiar with _____, knew everything there was to know about _____ so that there was [sic] no surprises.

Providing an Opportunity for and Assisting with Healing

The fact that critically ill patients need the opportunity for and assistance in healing is obvious. Nurses who participated in meeting this need were perceived to be caring. One individual offered this:

> To me caring is getting this person in here, getting them well enough to leave here, to go on to other rooms or whatever and getting them back into normal

> life, as healthy as they can be. And I think that's what's happening here. I really do.

The following experience was shared by another participant:

> When he didn't want to sit up . . . she says, "Well, you need to sit as long as you can." He'd rather get back in bed, but she kept insisting that he sit a little longer. That was for his good. He probably didn't realize it. You know, he was tired, he wanted to get back in bed. I knew why she was doin' it.

Maintaining the Patient's Dignity and Providing Privacy

Other needs met by caring nurses were those of maintaining human dignity and having privacy. Both caring and noncaring experiences were described. One said, "They make sure that the patient has privacy when they're, you know, changing the beds or, or taking care of the bottom, so to speak." Another participant's experience was different. She shared this:

> The only thing I haven't cared for is they leave the patient laying sometimes without cover over 'em. And when you're a private person that don't get it with me, you know . . . . I think it would be a lot more humane to keep 'em covered with something, you know . . . . If he thought he's layin' in there without anything over him, he would die. I mean it'd kill 'im.

Nurses described as caring allowed family members and patients to have time alone together. One participant shared, "They . . . let us have a little time together, you know, alone, which is good."

Summary

Meeting the needs of the patient is experienced as caring. Nursing actions that family members described as meeting patient needs and that they experienced as caring include providing continuous and vigilant monitoring, communicating emotional care and encouragement, giving physical care and comfort, providing an opportunity for and assisting with healing, and maintaining the patient's dignity and providing privacy. However, meeting patients' needs was not all that caring nurses did. They also met needs of family members.

Meeting Family Members' Needs

Recognizing that the patient is the first priority, family members explained that caring nurses also focused attention on the needs of the families. One family

member commented: "The patient is first and that's the way it should be. But . . . there's a balance here. Even though the patient is first, they're still taking care of me and my feelings . . . and they're just doin' a great job." Another echoed this description with, "I know their main thing is the patients, but they seem to take time for the patients' families, which need some lookin' after ever' now and then. So I thought that was real impressive." Therefore, the third category of themes for the phenomenon of professional nurse caring is "meeting family members' needs." Themes and subthemes that comprise this category are shown in Table 5 and are described in detail on the following pages.

Taking Care of the Critically Ill Loved One

Taking care of the critically ill patients is perhaps the most important thing nurses do to meet the needs of family members. One female participant, who perceived at one point that she had been verbally chastised by a nurse, said, "As long as they take care of him, I don't care what they say to me. I can take it as long as they take care of him and make sure that he's gittin' the best care." Another said, "You know I didn't care whether somebody was nice to me or not, that didn't matter."

Offering Honest and Consistent Information

Next to taking care of the critically ill patients, the nursing action most frequently described as an element of caring was that of offering families information about their loved ones. One individual expressed the importance of providing information to the family in this way:

> And I think the information to the family, I mean the patient comes first, I understand that. But then the family are there and worried and stressed out and wonderin', "Hey what's goin' on?" and we need to be informed, and it's just as important as the patient knowin'.

Offering information without being asked was perceived as caring, whereas providing information only after being asked for it by family members was perceived

Table 5

Themes and Subthemes for Theme Category: Meeting Family Members' Needs

I.	Theme: Taking Care of the Critically Ill Loved One
II.	Theme: Offering Honest and Consistent Information
	Subthemes
	A. Informing the Family
	B. Educating the Family
III.	Theme: Facilitating Access to the Physicians
IV.	Theme: Providing Access to the Patients
V.	Theme: Allowing Family Members to Participate in Patient Care
VI.	Theme: Providing Physical, Emotional, and Spiritual Support/Comfort
	Subthemes
	A. Assuring Proper Nourishment and Rest
	B. Providing for Physical Comfort
	C. Assisting with Activities of Daily Living
	D. Hugging and Consoling
	E. Attending to Spiritual Needs
VII.	Theme: Recognizing and Acknowledging Family Members

as noncaring on the part of the nurse. One woman, whose husband had been in the hospital three days, described her experience.

> Right now, nobody has told me anything, not a nurse, not a doctor. They haven't even tried to contact me .... they at least should take the time out to let the family know what's goin' on 'cause each patient has its own nurse and they have a little responsibility, I think, to the family to, you know, let us know what's goin' on 'cause we're just as anxious to know .... I have waited three days, and I don't know what's goin' on. So, I am going to ask this time when I go back, if they don't, if he's still in the room .... The noncaring is not lettin' ya know what's goin' on with the patient.

A man, whose wife was in the same unit, described similar experiences.

> Well, I don't, I haven't had any answers. I've had a lot of questions. That's the one thing, I don't know who to go to to find answers to questions about my wife .... I've not learned a lot about her condition except through her .... I, you know, she went to have this [procedure], and my only problem has

> been finding out what the results of that test was . . . . And I didn't know where to go to find out this information, and I've not found out anything.

Another individual said:

> They don't talk. They just go in and do their functions . . . . check the ventilator, apply a medicine, or give medicines, maybe adjust a pillow or something and leave and after they walk out you think,' What did they give him?' 'What are we doing here?' 'How is he?' You don't know.

Withholding information from family members, especially when the patient is not alert or is unable to comprehend the information offered, was a source of frustration and was experienced as noncaring. Following is an experience described by one individual.

> We have a daughter who is a nurse who was down here last week, and we only had one instance where just the normal questions she was asking every other nurse, all of a sudden this one said, "Well protocol says I can't give out that information, only the patient can have that information." And obviously at that point, our husband, or my husband was not even awake, so if I'm signing the consent form for his [procedures], then the immediate family members should not have had the road blocks . . . . Luckily we were able to contact the doctor and get the information that she wanted, but those points of frustration during, during the long term situation . . . . We should not have had to have gone to the doctor to get that taken care of. And obviously, you know, if you've got a person who's asking the right kinds of questions, I mean, if they had wanted, you know, to see identification that we were who we said we were, you know, I wouldn't have minded that as much as just being, you know, shut off.

Informing the family. Nurses who anticipated questions and provided the family with information about the patient's condition and about past, present, or future interventions were perceived as caring. Informing the family was perceived as a way to decrease fear and anxiety and to assist families with problem solving. This expression of caring is reflected by the comment: "They see that I'm anxious, that I have a lot of anxiety when I don't know what's going on, and they have answered all my questions. If they do not know the answer, they tell me." Another individual shared her experience:

> If you have a certain fear, they put your fear to rest. They tell you, you know, what to expect and what they were gonna do and what they were doin'. And to me that, I think that's a caring person, that relieves your mind of whatever, you know. They know about what questions you're gonna ask by dealing with it ever'day.

Another participant offered this:

> When I come in in the morning there's usually a nurse there and'll say "Oh, he's doing fine, his blood pressure is whatever, doesn't have any temperature." Just give you a general idea of what is going on, which makes a big difference when you're a family, and you need to know all these things.

It is important to family members that the information they receive is consistent from one visit to the next. Inconsistencies in the information provided was a source of frustration to family members. One family member shared this experience:

> One nurse had been either told or misunderstood from the prior shift that ____ had pulled his cath out three times, or four times, that particular day. He has pulled it out four times over the course of a week, but there's a, you know, a communication lag certainly that we felt uncomfortable when we could, you know, find that these pieces of information weren't quite the same from time to time.

Educating the family. Nurses who were perceived as caring took time to educate family members about the health problem or about the ways the problem was or could be treated. The father of one participant shared this experience:

> Of course they can't do recommendations, but they can in their own way help you find the best there is in that area, and nurses, nurses helped me a whole lot. They truly educated me. Like all of a sudden I get . . . a whole article . . . on hearts or a whole article on kidney and dialysis and, or whatever . . . . They helped educate me.

Facilitating Access to Physicians

Along with honest and consistent information from the nurses, family members needed access to physicians so they could obtain information they thought only the physician would have. Caring was experienced when nurses facilitated communication between family members and physicians. One family member shared these descriptions of caring:

> I haven't ask 'em to do anything, 'cause I live here, other than get me in touch with the doctors. Now they have done that. Hadn't been for them, I don't know that I'd ever saw [sic] one . . . . They would call me or they'd tell me they thought the doctors would be back [at] such and such. "If you want to see'em leave word with me, I'll make sure you see 'em." And that's anytime. They'd call me.

Caring nurses were seen as the "go between" for family members and physicians. A family member described an experience when her husband was going to have a surgical procedure: "One of the nurses called me downstairs and said, 'I thought you might just want to see him [the physician], see who's goin' to do it.'"

Providing Access to the Patients

Another family need met by caring nurses was that of having access to the critically ill patient. All of the critical care units used in the study had scheduled visitation times and strict visitation policies. When the schedule was equitably maintained or expanded, it was perceived as an experience of professional nurse caring. When the policies were violated, visitation times were delayed without explanation, or non-family members were given access to the patient, family members described an experience of noncaring. One family member offered this experience:

> They let us stay the length of time that we were . . . due to stay. [They] didn't rush us out before that time, in fact sometimes [they] let us stay a little longer if they thought everything was okay, you know, with the patient and with the other patients around.

Caring nurses appeared to take the individual needs of the patient and the family into account when making decisions about family visitation. A participant shared her experience:

> They work with families, of lettin', I mean makin' exceptions when a family, when a person is gettin' better or they see . . . their spirits are lifted when the family's in there . . . I know before when he was here 25 years ago, I sat in intensive care one night on the stool . . . for 24 hours, because his vital signs got so much better when I was in there.

As expressed by one participant, nurses adapted, when possible, to meet the individual needs of family members. One family member was allowed to remain at the bedside for hours at a time because "this is just what [was] required for him to be, to deal with the illness, so they adapted I think. I think you would say that the nurses adapted to the situation. And that's true caring." Another participant, who drove for one and one-half hours to and from the hospital everyday, shared this experience:

> They also, which I don't, maybe's against the rules, I don't know, but of course I drive back and forth every day and visitin' hours is at 4:30. They let me come up at 3:30 and I stay 'til 4, 10 after 4, then I can beat rush traffic getting out of town.

A participant, whose family member had an extended stay in the critical care unit, shared this experience when asked to described things nurses did that demonstrated they were caring:

> Well, in allowing us to stay in the room, and be with him, even on off hour times. They were real lenient, extremely lenient. We had privileges of almost coming and going as we needed to except late at night or something.

The participant went on to describe how nurses would arrange for the family to visit earlier than the posted schedule. Others described similar experiences of being allowed to visit early or to extend their visit beyond the regular time.

A source of frustration to families was the noncaring experience of unexplained inconsistencies in enforcing visitation policies. One family member shared this experience: "There have just been a few of them who've, you know, twenty minutes you're out of here. And if others can live with a longer time frame, it's hard to understand why some of the others have to feel so rigid about it." Another participant shared this, "There were nurses that did not like to have anybody else around. And they tried to, let's say push ya out or get rid of ya, or something like that."

When nurses allowed non-family members or non-authorized individuals to visit the critically ill patient, this was perceived as negligence and perhaps as noncaring. The effect of the behavior on the patient and the family is apparent from this participant's description:

> My husband's a very private person and we were with the understanding that nobody but the immediate family could go in, and one night they let a friend of our daughter's, her and her husband, up here at 9:30 when visitin' hours is at 9:00 . . . . If my husband had ventured to wake at that time and it had been them, now he knew' em', but he knows they don't visit us. It would have scared him to death, 'cause he would have thought we'd called in the family or called in the friends, that he was dying.

In further describing her experience, the participant said, "I would think that was negligent on their part, and it's like I said, they won't let us in at 9:30. Why did they let somebody that just walked through the doors in at 9:30?"

Unexplained delays in visitation were viewed as noncaring. Families said they understood there were times in the critical care situation when visitation would necessarily be delayed because of events with a particular patient or events in the unit as a whole. However, when these delays were frequent, when no explanation was offered, and when no provisions were made for the waiting families, they were a source of frustration, as noted in this description from one participant.

> One of the things that's really hard for the family members is the irregularity in terms of timing of the visiting hours. They're set up for certain times and we've been delayed more times than we've been on time, to the extent that one night it was 45 minutes late and that was because one of the other doctors was doing his rounds. It wasn't my husband's doctor. I'm in, you know, we're in a private room. Why his rounds had to delay our visit, you know, I don't understand . . . . We don't usually find out what the reason is. Usually it's just [she shrugged] . . . . Downstairs the volunteers are always calling up here, you know a few minutes before the appointed time, asking if it's gonna be on time and they're suppose to call back if it's not, but there's no communication that there will be a delay or that it's gonna be a sizable delay, so as a result, then, you know, we get up here, there's no, nowhere to be . . . . maybe that's a noncaring barrier that is a point of frustration because there isn't any room in the hall.

Allowing Family Members to Participate in Patient Care

Associated with the need for access to the patient is the need to spend time with and participate in the care of the patient. Family members experienced caring when they were allowed to assist in the care of their loved ones. When asked to talk about experiences with the nurses, the first experience one family member shared was the following:

> The nurses have been very kind to my husband and myself. Especially the Saturday night that he had to be re-vented once he had been taken off the ventilator for a couple, three days. He had a bad night. The nurse's name was _____. She was kind enough to let me help her with the things that I could do for him to comfort him. The nurses here have been wonderful as far as caring for my husband and caring for me . . . . The small things that I can do to help them, I was happy to, and I can't do that much 'cause I'm not trained, but the nurses have been wonderful.

Other participants described similar experiences:

> They didn't force us to leave if it was something we could handle. That was important from the standpoint that I could give my husband that little bit of support that he might need if he's got a little pain or whatever. At least he can squeeze my hand and he's not going through it alone.
>
> I was there at some points 10 hours at a time and participated in what took place .... In most cases, I'd say in 99.9% of the cases the doctor and the nurses that took care of ____ wanted us there because when it came to turning her, it came to doing the dressings, they'd not done the dressings and they'd sit there and say, "____, how'd they do this? Do they drain these bags? Do they flush this? .... And of course I knew what it was, so therefore, I helped; I helped out with all of that.

One participant noted that nurses were able to determine which family members could handle participating in care and which could not. She said:

> The nurses are real good, I thought, about reading those situations. They know who they can let stay and who they can't, I guess just based on watching people interact. I've had several comments that the, from the nurses, that I was good for my husband, that I was doing things that he liked, or I was able to do things for him. So that means that they were watching.

Providing Physical, Emotional, and Spiritual Support/Comfort

The experience of professional nurse caring was also described as having physical, emotional, and spiritual needs met. As one participant said, "When I'm in there they want to know if I need anything, if I'm okay, if everything's okay. They ask. They're kind enough to ask." Another said, "They're constantly asking me if there's anything they can do for me, you know."

Assuring proper nourishment and rest. Being asked about rest or nourishment or being offered food or beverage was perceived as caring. One participant shared the following:

> They've come in and said, "Would you like coffee?"; "Would you like some water?"; "Are you okay?"; Do you need to rest?" .... I've even been asked "What are you eating?"; "Are you eating well?"; "Are you eating balanced foods?"; and "How long did you sleep last night?"; "Did you get a nap today?" That kind of thing.

Providing for physical comfort. Caring was experienced when nurses made an effort to provide for the physical comfort of the family members. An example of this is offered in the description shared by one participant:

> That one little nurse'll say, "Oh let me get you a chair, let you sit down." I really don't have to have a chair ... and she'll say, "Well you can just sit and

> hold his hand and he'll be more comfortable." And you know they just, they want you comfortable while you're there.

Not attending to the comfort of family members, particularly while they were waiting to be allowed into the unit for the visitation time, was described as an experience of noncaring. One family member described what it was like to wait outside a unit before being allowed in to visit with the patient.

> And you're trying to lean up against a trash can, or a wall, and or a closet door, and somebody's gotta get in the closet, and you have to move or you try and sit on the floor, and it's not a comfortable surrounding.

Assisting with activities of daily living. Caring nurses assisted family members in placing telephone calls from the unit and in completing other necessary activities of daily living. From a participant came this description:

> I was just amazed at, you know, people offered to wash our clothes, to do all kinds of things to makes us more comfortable and all. In addition to their eight hours there as a nurse. And they were caring for everyone.

Hugging and consoling. Caring nurses also met family members' needs for emotional support by hugging and consoling them. "They don't hesitate to hug ya" was how one participant described her experience. Another individual described an experience that included her children who were visiting their father:

> One of my sons broke down and was really having a difficult time, and the nurse was just remarkably calm to him and calmed him down and was loving. I thought that was very humane. My son was leaning against the wall, you know, against the window crying, and she put her arms around him and soothed him, and things like just, just that little extra comfort.

Attending to spiritual needs. Participants also described experiences in which nurses assisted them with meeting their spiritual needs. One participant commented, "One day I got real upset and they asked me, did I want 'em to get _____ [the chaplain]." Another participant shared the following experience:

> One of the nurses mentioned the chapel to me. I believe it was _____, and I wasn't aware that it was there, and she was telling me how beautiful it was and quiet, where people could go in there and pray, and she says, "You know we have chaplains.", and I said, "Yes, I have met them.", and she was more or less telling me if you need any spiritual support, we have that for you, you know.

Recognizing and Acknowledging Family Members

Family members appreciated being recognized by critical care nurses, especially when that recognition occurred outside of the critical care unit. It was important for them to know that the nurses cared enough to follow-up with the patients' progress and with the well-being of the family members. One participant shared this experience:

> We've had a lot of recognition outside of the unit, you know, if we see them in the halls, and that's, there have been a number of them, you know, who have been on another floor or I've seen them in another capacity, who have tried to keep up with his progress through us rather than you know, just assuming the nurse at his bedside is taking care of everything.

Another family member shared this experience with the nurses from the first unit where his loved one was treated: "A bunch of 'em have been over here to see _____. And I stopped in there yesterday and saw all of 'em, and I mean they're proud of what they've done."

Summary

Caring is experienced when family members' needs are met. Nursing actions of taking care of the critically ill loved one; offering honest and consistent information; facilitating access to the physicians; providing access to the patients; allowing family members to participant in patient care; providing physical, emotional, and spiritual support/comfort; and recognizing and acknowledging family members were perceived and described as caring.

Feelings Evoked by Demonstrations of Caring and Noncaring

The experience of professional nurse caring had a variety of meanings for the family members participating in this study. Family members described the way the caring nurse was, what caring nurses did to meet patients' and family members' needs, and how caring nurses and the actions they demonstrated made them, the family members, feel. In this section, themes for the category "feelings evoked by demonstrations of caring and noncaring," which include "relieved of stressors,"

"secure in knowing the patient will be safe," "cared for," and "connected to the nurses," are presented. Family members also described how they felt when nurses were not caring and did not meet needs of either the patient or the family members. In these instances, family members expressed an "uneasiness with the situation" and were "fearful of sanctions from the nurses" (see Table 6).

Table 6

Themes for Theme Category: Feelings Evoked by Demonstrations of Caring and Noncaring

Caring		
I.	Theme:	Relieved of Stressors
II.	Theme:	Secure in Knowing the Patient Will be Safe
III.	Theme:	Cared For
IV.	Theme:	Connected to the Nurses
Noncaring		
I.	Theme:	Uneasiness with the Situation
II.	Theme:	Fearful of Sanctions

Relieved of Stressors

Family members described a feeling of relief from stress or worry about their loved ones that allowed them to focus attention on other concerns. One participant described her feelings in this way:

> Well, it gives me, it takes some of the pressure off from me. I can kinda relax and think about the next step, what's gonna happen. Because when you're away from home you're thinkin', how much money do you have, how much longer are ya gonna be here, you know. There's a lot on the patient's family bein' away from home and havin' to stay here.

Another said:

> It relieves the stress . . . some of the stress, not all of the stress . . . . But the least amount of stress that we can encounter helps us be able to get through the next five minutes at a time . . . . The comfort level we have when we leave

> the unit does have the impact of allowing us to be able to take care of ourselves better.

Family members' fears of the sights and sounds in the critical care environment were diminished by the information provided by critical care nurses. One participant shared: "When the alarms start going off, I'm not frightened . . . . That helps a family member. You're not so frightened because you see all of these pumps, screens, buttons, alarms. You understand; you're not so frightened."

Secure in Knowing The Patient Will be Safe

As noted in an earlier description, families who received demonstrations of caring were able to leave the unit with a sense of security that their loved one will be well cared for and safe until their return. A participant offered this description: "I trust them . . . when I leave that room, that he'll be checked on and looked after, and that makes me feel very good. It relieves my mind, at least, about that." Another said, "We can rest easier having that feeling that everything's going to be okay while we're gone." From another came this: "Well, it makes you feel real, that your husband or your loved one, who, whichever, is in good hands and if somethin' comes up they will call you." The following description indicates the family's trust and confidence in the caring nurse:

> It makes you feel good that "Hey, I've got somebody that cares and they're just not here." They're doin' all they can do . . . . You know you feel like they know what they're doin', and their confidence makes you confident in them . . . . They give that sense of trust when you watch 'em at work and, you know, everything goes well. You may say, "Hey, I trust them. They know what they're doin'. They're good nurses."

This participant's comments demonstrate the relationship between the caring nurse's demonstration of confidence and ability and the confidence and trust evoked in the family member.

Cared For

The caring and attention shown to the families was "appreciated," made them "feel special," and made "the situation more tolerable." When asked how the demonstrations of caring made him feel, one participant said, "Well, you of course

feel a whole lot better about the whole experience of being here. It makes you feel much better . . . . 'Cause everybody likes attention." Others said, "It makes you feel comfortable" and "I was very comfortable."

One family member related the patient's well-being to the knowledge that family members were being and felt cared for.

> If the, if the family's at ease, that makes the patient feel better I think. 'Cause he's sittin' there, and he's watchin' what's goin' on, and if he sees that his family's takin' care of or she sees, then he's more at ease. It makes his stay and gettin' better, I think, faster because he's worried about his family as well as him bein' sick. So with them bein' takin' care of, I think it helps him or her.

Connected to the Nurses

Family members described a special connection with caring nurses. It was as if family relationships were expanded to include the nurse. One participant expressed the connection by saying, "We almost feel like they were part of the family in this length of time." Another participant described a similar experience, but in this instance the nurses seemed to expand the "family of caregivers" to include patients' family members.

> Well, it makes me feel like I'm part of the family. I'm not an outsider anymore. I feel like I'm part of things rather than, you know, just his wife . . . . It makes me feel like, you know, I am part of this thing to get him well.

Frequently, when asked to describe a caring nurse, participants were able to give the name of a particular nurse or a group of nurses. One said, "I'd probably describe a person by the name of _____." Another said, "The nurse's name was _____." Likewise, caring nurses knew family members by name. One of the participants described some of her feelings about caring:

> I guess I been here so long, they all know me by name, you know, and I bring little things to 'em every once in a while. I did bring a cake the other day and you know, they, they really seemed like they appreciate me caring for them.

This participant hinted at a reciprocal caring relationship. Each party in the caring interaction knew the other by name, and each demonstrated caring behaviors toward the other. One participant admitted, however, that the attachment or

connection between the nurses, the patients, and the families may lead to "burnout from the nurses."

Perhaps the relationship families have with caring nurses and the understanding they have of the nurses' role in promoting the welfare of their loved ones can be summed up best by this comment:

> I have a wonderful respect for all of nursing and somebody'd say, well they call me, "How'd it be if we call you doctor?" 'cause I had my stethoscope and everything else . . . I wanted to listen . . . all of those kinds of things, and I said, "No, just call me a nurse." They're the ones, they didn't prescribe it and so forth, but they're the ones that we credit an awful lot with _____.

Uneasiness with the Situation

Not all experiences were perceived as caring. When nurses were not viewed to be meeting needs or to otherwise demonstrate caring, family members expressed an overall feeling of uneasiness with the situation. They described feeling "uneasy," "confused," and "frustrated." One participant, when speaking about her feelings of frustration, acknowledged that the nature of the crisis situation influenced her tolerance. She said, "We just don't have the same level of composure that we would have if this was just a one day situation." In a sense, it was as if she was apologizing for or explaining her reaction to what she perceived as uncaring behaviors on the part of the nurses. Another participant appeared to excuse what might be perceived as noncaring behaviors, because he didn't expect nurses to care or to be caring. The individual said, "They can't care for my wife as I'd care for her, or anyone that I'm related to, and I don't even expect them to."

Other behaviors of family members were affected by the noncaring experience. One participant was aware that she had felt withdrawn until she became assertive enough to speak with the head nurse about what she was experiencing. After that "things were totally different" because she and her family "had a chance to feel them out" and the nurses "had a chance to feel us out, so we're not facing the same introductory situation every time we come in here." The length of the relationship

between the nurses and the family and the continuity of the relationships appear to have influenced the caring behaviors and the perceptions of those behaviors.

Fearful of Sanctions

Fear of sanctions from nurses was described by more than one participant. The sanctions most often described and feared by the families were those of loss of access to the patient and verbal reprimands from the nurses. One said:

> What we don't want, is we don't want to, to come across as being a nuisance and have them feel that it's better for him not to have us in there, because obviously we think . . . he really needs that link with the real world, and we're his real world. So, you know, I didn't like being put in that position, which could have, it didn't, but it could have jeopardized our visiting privileges.

Another participant described an encounter with a nurse who was upset because the family member had violated the established visiting hours. The family member explained that her husband had just been admitted to the critical care unit and that no one from the hospital staff had given her information about visitation; she had obtained incorrect information from another visitor. She said:

> Well, I felt like she was annoyed with me and I didn't do it on purpose, you know . . . . It makes me feel uneasy when I go up to see 'im now. If I don't git out on the certain time, they're gonna come back in and say somethin' else to me . . . . The whole time I'm in there, I'm watchin' it [the clock] to make sure I don't go over my time. Which I'm kinda tense and I don't say much, you know, 'cause I'm scared to go over time, scared they're gonna say somethin' else to me . . . I don't want 'em mad at me . . . . But you know, there's a lot you wanna see 'im, and you don't wanna spend more time than you have to up there 'cause you know you're not s'pose to, but that did, did make me feel uneasy. It does spoil your visits with 'im 'cause I'm not relaxed, 'cause I'm sittin' there talkin' to him, and I got one [hand], holdin' his hand and one eye on the clock makin' sure that I don't run over.

Summary

Family members of critically ill patients have many feelings and emotions associated with the critical care experience. Coping with the critical illness of their loved one is made easier when nurses demonstrates caring. Family members describe feeling relieved of stressors, secure in knowing the patient will be safe in their absence, cared for, and connected to the nurses. They also describe an uneasiness

with the noncaring situation and feared being negatively sanctioned if they violated formal or informal rules of the unit.

Additional Findings

As the family members shared their experiences, they frequently offered other information that was not directly asked for nor directly related to the research question of this dissertation. However, the frequency and potential meaning of their descriptions is believed to be great enough to warrant interpretation and presentation. The themes identified in the descriptions have been grouped within the two categories of "physician caring in the critical care environment" and "suggestions for making the critical care experience more caring." It is important, however, to note that because no specific data were sought in these areas, it is probable that the perspective presented is limited, therefore the interpretation should not be judged to imply anything other than what is presented.

Physician Caring in the Critical Care Environment

Frequently, when asked to describe their experiences of professional nurse caring, participants offered information about their perceptions of caring as demonstrated by physicians. In some instances the experience was described as caring, and in other instances demonstrations of caring were perceived to be lacking. Two themes emerged with respect to interactions between family members and physicians, availability of physicians to the family and acknowledgement of the family's knowledge of and experience with the critically ill patient.

Availability of Physicians to Family Members

Availability of the physicians to the family members was expressed as an element of physician caring. One participant, whose husband had transferred from one critical care unit to another, described her experience in the second unit:

> I'd be safe to say there's not a day goes by that when I'm visitin', one of the doctors'll stop by. I mean it doesn't matter, it's one of the doctors. And, and it makes you have a feeling like, "Hey they care, and they're doin' their job and they want me to know what they're doin'.".

She contrasted this experience with her experience in the unit from which her husband had been transferred. She described a lack of availability of physicians to family members in saying, "We would go almost a week and not even see a doctor."

Others had similar experiences. One commented: "They only come when the family's not there and when a patient is sick he can't remember what the doctor said." This same participant, who accompanied her husband to the critical care unit three days before the interview, went on to say, "I haven't seen him [the physician] at all since I been here . . . . I haven't seen his intern or anybody. He comes when we're not there." Another offered, "If I see anyone, it's the attending surgeon or the cardiologist. That's if I see anybody." She went on to relate her perception of physicians' attitudes toward the family. "They act like you don't, like you, your time is not valuable at all. Theirs is the only time that is valuable."

Acknowledgement of the Family's Knowledge of and Experience with the Patient

Family members need to be included in the treatment process and to be acknowledged as individuals with a valuable knowledge and insight into the critically ill patients. Having this need met by physicians was described as an element of physician caring. One participant expressed frustration in not having her knowledge of her husband and his wishes acknowledged by the physician. She related:

> I don't know what my husband has told 'em. I tried to talk to the doctor last night and he kept, he started out with, "You know Mrs. _____, I've been talkin' to y'all about this [procedure] for 5 years." I said, "No sir, you haven't been talkin' to me. You've been talkin' to my husband. And my husband has never, never told me you were considerin' [the procedure] until June when I had to bring him in here." I said, "That's the first time I ever laid eyes on you." He was very indignant with me and I don't appreciate that.

Wiping tears from her eyes she went on:

> He said, "I know your husband" and I wanted to say, "No you don't know my husband; you think you do, but my husband is a very private man." . . . . He's kept very much to himself, and then the doctors don't know he's kept it to himself, but then they treat me, in my opinion, like a stepchild.

Again her eyes filled with tears; later in the interview she said:

> You're at their mercy, let's put it that way. You're at their mercy, 'cause you are not a doctor, and you have no control. And I don't like being totally ignored and out of, well totally ignored, is what the whole deal is, and your wishes don't mean nothin'.

Another participant offered similar observations regarding his views of this element of physician caring:

> A physician in most cases, not so much today as it was at one time, but they're put up on a pedestal. They don't have to answer any questions; they don't have to respond to anybody; they're gods in their own right.

Suggestions for Making the Critical Care Experience More Caring

Three participants expressed thoughts about what the institution could do to make the critical care experience more caring for family members of critically ill patients. These suggestions included the following:

1. Provide daily updates of the patient's condition.
2. Provide an information booklet/package for the patient and the family.
3. Improve visitation services, policies, and procedures.
4. Offer telephone services at the patient's bedside.
5. Improve physician and family communication.

Provide Daily Updates of the Patient's Condition

As indicated earlier in this chapter, one of the greatest needs of family members is honest and complete information about the critically ill patient. Obtaining this information, whether from nurses or physicians, in a consistent and organized manner would be extremely helpful and meaningful in a caring experience. One family member offered this thought:

> I think when the family comes in they should have one person to come in and say "Let me tell ya what's going on with him." . . . . They should come in once a day and tell you what, maybe in the evening, the last visit, or the second to the last visit, what is goin' on with him.

Another suggested the following:

> I think maybe if there was a little, maybe just a very brief written synopsis at the end of the day or the beginning of the next day of what was performed during the previous day . . . . without it becoming an obnoxious intrusion on, a lot of time, but you know some brief things to make [it] easy. Because one of the things that's really impossible when you're not associated with the

> medical profession, is even to try and take notes. You can't understand what in the world the phrase was, much less try and write it in a manner where you could ever go back and identify it and make accurate pronunciations of it.

The participant pointed out the need to provide families with information in lay language rather than in the language of the health professions. This notion is also important with regard to the next suggestion.

Provide an Information Booklet/Package

Two participants spoke of giving patients and family members a booklet or package that contained information about the institution and the surrounding area. One suggested:

> If they'd a had a package for the family tellin' 'em about the escort service, places to stay, then it would, after it got so expensive and you've been here so long and you're low on funds of money, then you'd know where to go and what to do. They need to fix a package where people can go to eat, and like this escort service, so we would know when we come in. Just give it to the family and they'd know what to do . . . . But if they could do that with the packets with the families when they come in it would really help them, you know. Because like I said, when you come in you don't know. You're in a big town, 'cause _____ [home town] is small, and you don't know where to go.

Another participant expanded on this notion by suggesting other content areas for an orientation booklet and ways to present that information.

> Try and simplify it as much as possible and maybe break the booklet down into what the patient needs and then what the family needs. The operational procedures are a lot different depending on which side of the bed you're on . . . . The thing that's important with the way that I do things is that I like visuals. You know, say for example the thing that they do the day before surgery is, you know, they go through what the procedure's gonna be and they tell you where to go wait. But if you've never been to [the institution], you don't know one floor from the next or one building from the next. And there's a parking directory map is about as close as it comes to what's where. If that was concise, that after the patient leaves their room to go to the operating room, you take the elevator to X floor and go here, and just to make it as simple as possible.

This participant also suggested the following:

> Maybe even if there could be a volunteer staff who could help escort the family around and kind of, you know, so that it wouldn't be part of the burden on the nursing community but, you know, just somebody to help orient the family to the surroundings.

Included in the information or orientation booklet should be information about the waiting areas and housing facilities for families and the telephone numbers specific to those areas.

> I think if they had somethin' fixed up for the family, it would really help the families out. When we walked in with no where to go, and you wouldn't have to spend the time worrying about where you were gonna stay. 'Cause I had, the last time I stayed here I didn't, I just stayed in the waitin' room most of the time.
>
> Another thing that would have been easier in advance is the whole orientation about the waiting room downstairs, if people wanted to call, you know. You get a lot of people in this hospital who are from out of town so they don't have the advantage of looking at the phone directory and even knowing that there are numbers, and yet they're spending money long distance to go though 17 different people, and some operators are better than others at trying to direct calls.

Improve Visitation Services, Policies, and Procedures

Space for family members to stay between visitation periods is often at a premium and frequently lacks adequate comfort measures. One participant expressed this wish: "I wish every intensive care unit had a place for the family, but I guess that just isn't possible. You know, it's not cost effective or whatever."

Aspects of family visitation with critically ill patients were described in a variety of ways as the participants spoke about their experiences with professional nurse caring. Frequency of visits was a concern; one participant expressed this: "If they could just change the visiting hours just a little bit. Maybe three hours instead of four, because four is a long time to wait." Preparing the family for the visit was a request of two participants. One suggested: "They should designate one [nurse] to tell the family what is goin' on. Because we're really in the dark when we go in there." The other commented:

> If they could almost shift it so that the nurse has the opportunity to talk with the family just prior to the family going in, while maybe somebody else is relieving her and can be directing their attention toward the patient, so that she's not, you know, trying to think about taking care of this over here and still talking to you at the same time.

Delays in allowing families into the critical care unit for the visit was also a frustration as indicated by the participant who suggested the following:

> Maybe there can be some communication thru the individual patient's nurse as to, you know, why things are being delayed. Is it something with our particular patient, or is it, you know, just something that's happening on the floor and even so is there an alternate, you know, approach that can be used because the waiting is a huge stress factor for all of us.

Offer Telephone Services at the Patient's Bedside

As noted by one participant, telephone services at the bedside are not usually available.

> For the most part the general protocol in an intensive care unit is not to have any phone contact, and you know, thinking of our current situation it might be good if at least from time to time, not to the point that it would become a nuisance, but that say for example, if our daughter wanted to talk to her dad, and we know he's not going to be able to respond, but maybe just while one of the family members were in there, just so that she knows he's hearing her voice, that would certainly be a demonstration of caring.

Improve Physician and Family Communication

As noted earlier, the role of the nurse in facilitating communication between physicians and families is an important element of professional nurse caring and availability of a physician to the family is described as an element of physician caring. One family member offered a suggestion as to how the physician-family interaction could become more of the routine for patient/family care. "I think they [the nursing unit] should have it fixed [so] the physician knows when the family's gonna be there . . . [and] he could come sometimes when the family's . . . there."

One family member offered a suggestion that would make the critical care environment more caring for the critical care nurse as well as for the patient and the family. She offered:

> I know you can't just add on for them [nurses], but they do need a little more work space sometimes. They could use a desk other than just the little patient table that's in the room; they have a lot of things to keep up with. Maybe there could be something devised to help them, you know, because they have so much to do . . . . They could use more space between the beds; they could use more private rooms.

Her concern for the working environment of the nurse is evidence that families identify closely with the critical care nurse and demonstrate caring behaviors toward them.

The Meaning of Professional Nurse Caring in the Critical Care Setting

Professional nurse caring as experienced by family members of critically ill patients is multidimensional and adaptive to the situation of the moment. The experience of caring is influenced by the nature of the critical care environment, the patient's condition, the length of the patient's stay, and the preconceived expectations of the family members.

The experience of caring begins with what family members perceive as caring nurses. Without a caring nurse, professional nurse caring cannot be experienced. Caring nurses possess personality characteristics that are expressed to family members and patients through the touch of a hand, a softness and calmness of the voice, a warm and open smile, and other verbal and non-verbal expressions. The personality characteristics of the caring nurse must be integrated with the professional attributes of confidence, knowledge, and technical skill. Nurses who have and express a caring personality but who are not confident, knowing, and skillful are not perceived as truly caring. The reverse is also true: confident, knowing, and technically skilled nurses who do not express a caring attitude through their behaviors or who do only the prescribed essentials of their job and no more, are not perceived as caring. Caring nurses are committed to the patient and the family and are physically and emotionally present for them rather than being physically present to get a paycheck. They express empathy for what the patients and family members are experiencing.

The "job to be done" in critical care is meeting needs, first of the patients and then of the patients' families. Caring for patients is providing continuous and vigilant monitoring, communicating emotional care and encouragement, giving physical care and comfort, and providing an opportunity for and assisting with healing, while maintaining the patient's dignity and providing for privacy. Patients are the first priority of the caring nurse who is ever present for the patient whether the vigil is

maintained directly from the bedside or indirectly from across the room or unit. Techniques used to communicate care and encouragement include joking and teasing, touching, connecting the past to the present, praising, explaining, reassuring, and coaching. Caring is preparing patients, whether alert or unconscious, for what is being or will be done to and for them. Comfort of the patient, whenever possible, is placed before the comfort of the nurse, the physician, or the family. Caring is being the caretaker and advocating for the patient in all situations. Through the provision of caring the patient has the opportunity to heal or to progress to a comfortable and peaceful death.

Caring for families is assuring that the critically ill patients are taken care of; offering honest and consistent information without being asked for it; facilitating access to the physician; providing access to the patient; allowing family members to participate in the care of their loved one(s); providing physical, emotional, and spiritual support or comfort; and recognizing and acknowledging the family both inside and outside of the critical care environment. Family members are informed and educated about the illness or trauma, the diagnostic and therapeutic interventions being implemented or planned, and about the expected or realized outcomes of those interventions. Measures are taken to assure that families receive proper nourishment and rest, to provide for their physical comfort, to assist with activities of daily living, and to attend to their spiritual needs. Families are consoled in times of stated or unstated need. This consolation is sometimes conveyed by touching or hugging.

The feelings of relief, security, comfort, and connectedness that families experience, either mentally or physically, are the direct result of having their needs recognized and responded to by the nurses. Uneasiness with the critical care environment and fear of being sanctioned result when patients' or family members' needs are not met and they experience noncaring.

Summary

Presented in this chapter has been the analysis and interpretation of the data as shared by nine family members of critically ill patients. Four theme categories which capture the meaning of professional nurse caring were presented. Additional findings associated with physician caring in critical care and with suggestions for making the total critical care experience more caring were also presented. The themes and categories were summarized into a language appropriate for the communication, confirmation, and critique by others in the discipline of nursing.

CHAPTER V

DISCUSSION, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to identify, analyze, and describe the meaning of professional nurse caring as experienced by family members of critically ill patients. The data analysis and interpretation were guided by the philosophy, approach, and methodological procedures of phenomenology. Presented in this chapter is a discussion of the findings; conclusions drawn from the study; implications for practice, research, and education; and recommendations for further research.

Discussion

The participants in this study described caring in terms of the way the nurse is, meeting the needs first of critically ill patients and their family members, and feelings or responses of family members to demonstrations of caring and noncaring (Appendix E). Each of these theme categories will be discussed and related to each other and to relevant research and theoretical literature.

The Way the Nurse Is

Family members began their description of caring by discussing the caring nurse in terms of the way caring nurses are as individuals. Nurses perceived to be caring were physically and emotionally present for and available to the patient and family members. As professionals with special personality characteristics, confidence, knowledge, and technical skill, caring nurses expressed a variety of behaviors designed to meet the needs of patients and, in one study, their family members. These findings support studies of critically ill patients' and their families' perspectives about caring; personal and professional characteristics of the nurse were

reported to be important to the meaning of caring (Cronin & Harrison, 1988; Devries, 1991; Greiner & Harris, 1992; Henry, 1991; Huggins et al., 1993; Miers et al., 1991; Semonin-Holleran, 1991).

Some family members offered that professional nurse caring is related to the professional experience of the nurse. Mayeroff (1990) wrote about caring in terms of knowing the one being cared for and knowing the self.

> We sometimes speak as if caring did not require knowledge, as if caring for someone, for example, were simply a matter of good intentions or warm regard. But in order to care I must understand the other's needs and I must be able to respond properly to them, and clearly good intentions do not guarantee this. To care for someone, I must *know* many things. I must know, for example, who the other is, what his powers and limitations are, what his needs are, and what is conducive to his growth; I must know how to respond to his needs, and what my own powers and limitations are. (Mayeroff, 1990, p. 19)

Considering Mayeroff's view that caring individuals must know how to respond to another's needs and what their own powers and limitations are, it is not surprising that family members would perceive nurses with limited experience, knowledge, and competence as less caring. This perception appears to support the findings of others who studied caring from the perspective of patients and nurses (Brown, 1981/1982; Cronin & Harrison, 1988; Green-Hernandez, 1991; Luegenbiehl, 1986; Ray, 1987; Weaver, 1991). With experience comes knowing and with knowing comes competence and confidence in one's ability (Beckham, 1993). These together with compassion are perceived as caring. Beckham shared the perceptions of family members of critically ill patients, that is, compassion without competence does not "count for much" (p. 90).

Nurses interviewed by Barr (1985/1986) described self-confidence in the work situation and adequate level of clinical knowledge and expertise as factors which promoted caring. Nurses who are not confident about their knowledge and skill do not always instill confidence in patients or family members. They focus more of their attention on themselves and their own physiological and safety needs than on the needs of patients and families. Mayeroff (1990) indicates that in caring,

the other must be primary. Attention to self rather than to the patient and family inhibits the development of a connection with care recipients that is caring.

Clayton, Murray, Horner, and Greene (1991) described findings from their study, which was designed to identify how the bonds of a caring relationship are established. Categorical codes which emerged from their data included personal being, "those personality characteristics of the nurse which lead others to view the nurse as special or unique"; professional/expert knowing, "the knowledge, skills, professional activities, 'ways of knowing and being' that characterize the expert clinician"; and connecting, "the transpersonal experiences and feelings that lead to the sense of connection, attachment, or bonding between a nurse and a patient/family" (p. 158). Connecting was viewed as the precursor to caring. The first stage in the process of connecting was presencing, which occurred when the nurse encountered the patient/family. The description of presencing offered by Clayton et al. mirrors the description of the way caring nurses were known to family members in this study.

Riemen (1983) described a caring interaction as the nurse's existential presence, which patients in her study perceived to be more than just a physical presence. She noted that the nurses gave themselves to patients, sometimes in response to a request from the patient/family, but more often voluntarily and without solicitation. Nurses expressed an attitude and behavior that allowed them to respond to the unique concerns of the patient as a person of value. This presence described by Riemen is not unlike what family members of critically ill patients described when speaking about the way the nurse is. Caring nurses were present for the family members and anticipated what they needed to know or to do.

Marsden (1990) wrote about real presence and described it as "a demonstration of our commitment to that individual as someone valuable, unique, and worthy of respect" (p. 540). Real presence conveys empathy and promotes the autonomy of the individual. Marsden believes that real presence can be an antidote to the

dehumanizing effects of technology. The description of caring behaviors offered by family members support Marsden's descriptions of the attributes of real presence, which Marsden presented in this way:

> Most of what we will notice about those with real presence is nonverbal: that they are comfortable with silence, make eye contact with the person speaking, are sensitive to the body language of others, and use touch in a judicious way to comfort or express concern. In their verbal interactions those who practice real presence call others by name, speak quietly and respectfully, and do not interrupt. (1990, p. 541)

Consistent with Marsden's description, participants in this study had difficulty articulating how they knew whether a nurse was caring or not. Family members indicated there was usually something visible in the faces of caring nurses that allowed them to know the nurses were there for them and that they cared. This description parallels Marcel's (1971) theme of availability. Marcel wrote:

> It is an undeniable fact, though hard to describe in intelligible terms, that there are some people who reveal themselves as present–that is to say, at our disposal–when we are in pain or in need to confide in someone, while there are other people who do not give us this feeling, however great is their good will . . . . presence is something which reveals itself immediately and unmistakably in a look, a smile, an intonation, or a handshake. (p. 25)

Descriptions of the personal and professional qualities of the nurse reported by family members in this study were identified in reports of studies about the process, meaning, and ethics of caring in which patients and nurses were subjects. Henry (1975) reported nurse caring behaviors that she labeled as how the nurse does. Included in this category were terms such as gentle, careful, friendly, patient, interested, concerned, kind, considerate, pleasant, and nice. These descriptors are consistent with those expressed by family members of critically ill patients and with descriptors presented by Clayton et al. (1991). Family members described caring as going beyond and being more than just a job. This is similar to Henry's description of how much the nurse does, which included the notion of doing extras or more than the nursing role required. It is also consistent with findings reported by Clayton et al.; Miers et al. (1991), who identified the theme of going beyond in a study of the meaning of caring as perceived by critically ill patients; and Fosbinder (1991), who

studied nursing care through the eyes of the patient and described a characteristic identified in nurses that patients labeled "going the extra mile" (p. 124).

Patients in Brown's (1981/1982) study described personal and professional qualities of the nurse, which Brown characterized as what the nurse is like. These qualities were categorized as a component of the affective dimension of care as opposed to the task dimension of care. Brown reported that nursing behaviors perceived as indicators of care are a combination of what the nurse does and what the nurse is like as a person expressed in how the nurse does things. This finding is similar to the meaning of caring as experienced by family members of critically ill patients.

In a report of a study designed to describe what senior baccalaureate nursing students perceived as a commitment to professional ethics in nursing practice, B. O. Kelly (1988) found that subjects defined caring, in part, as all the little things, being cheerful and friendly, being empathetic, and being open and honest. Family members of critically ill patients expressed similar descriptions, which were combined in the theme category "the way the nurse is."

Drew (1986) reported a study in which distressing and nurturing encounters of patients with caregivers on one surgical and one obstetrical/gynecological unit were explored. Patients who experienced confirmation described a sense of energy being expended on their behalf. This energy was expressed by caregivers as "wanting to be there," "caring what happens," "liking their work," and "having personality." (p. 41). Other positive experiences of patients involved caregivers who smiled at the patients and their families and spoke to them with an emotionally warm voice. These confirming behaviors are similar to those described as expressive behaviors of caring by the family members of critically ill patients. Likewise, there are similarities between descriptions of noncaring and exclusion. For example, family members in this study described noncaring nurses as not wanting to be there with the patient or family and as not having a lot of personality. Patients in

Drew's study described experiences of exclusion in which the caregivers lacked emotional warmth; were starchy, cold, stiff, mechanical, indifferent, bored, impatient, and preoccupied; and had robot-like personalities.

Meeting Needs of Critically Ill Patients and Their Family Members

The focus of this study was on the meaning of caring and not the needs of family members of critically ill patients. However, as family members described their experiences with professional nurses and the meaning of caring to them in that context, they associated caring with first meeting the needs of the critically ill patients and then meeting the needs of the family members. This relationship of caring to meeting needs is not unexpected. Leininger (1980) reported that in her study of perceptions and knowledge about caring behaviors, processes, roles, and techniques in 30 different cultures, care-giving nurses helped or assisted others in need and anticipated the needs of the care recipients. Most care recipients in Leininger's study expected nurses to help them or anticipate their needs. Critically ill patients also rated meeting needs as a high priority when describing experiences of professional nurse caring (Cronin & Harrison, 1988; Devries, 1991; Semenza, 1991; Semonin-Holleran, 1991). Parents of critically ill children rated highly those caring behaviors that focused on the physical needs of the child (Henry, 1991). Critical care nurses spoke of caring in terms of meeting patients' needs (Barr, 1985/1986).

Helping family members participating in this study, or meeting their needs, involved helping and meeting the needs of their loved ones. Family members recognized that patients were admitted to critical care units because of threats to physiological functioning. This was evident from their descriptions of vigilant and continuous monitoring and the provision of physical care and comfort, which they experienced as caring. They observed nurses meeting physiological needs or assuring that those needs were met for the patients. Nurses who were perceived to be caring also attended to the patients' safety needs by offering emotional care and

encouragement. Family members observed the impact the nurses' caring actions had on the physical and emotional healing of patients. By meeting the physiologic and safety needs of patients, critical care nurses in turn met the safety needs of the patients' family members.

Numerous studies designed to explore the needs of family members of critically ill patients have been reported in the literature (Bouman, 1984; Daley, 1984; Koller, 1991; Leske, 1986; Lynn-McHale & Bellinger, 1988; Mathis, 1984; Molter, 1979; Norheim, 1989; Norris & Grove, 1986; Price, Forrester, Murphy, & Monaghan, 1991; Rodgers, 1983; Simpson, 1989; Spatt, Ganas, Hying, Kirsch, & Koch, 1986). Leske (1991) analyzed the raw data from 27 studies in which the Critical Care Family Needs Inventory (CCFNI) was used to identify and describe family needs over a 10-year period; she reported the 15 most commonly identified needs of 905 family members of critically ill patients. All of the needs met by nurses and described as aspects of caring by family members participating in this study were among the family needs reported by Leske (1991). Family members in Leske's review and in this study of the meaning of professional nurse caring needed to be assured the best care possible was being given to the patient, to have honest and consistent information, to see the physician daily, and to have access to the patient. When these needs were met, caring was experienced.

Allowing family members to participate in patient care was also experienced as caring by family members. This finding is relevant to the findings of Hickey and Lewandowski (1988) who asked 226 critical care nurses to agree or disagree with 22 statements describing patient care activities in which family members could participate. Although nurses agreed that family members should play a supporting, encouraging role and should participate in making decisions about the patient's care, they did not agree that families should provide physical care and emotional support to the patient during a crisis. In comparing the findings of these two studies, it appears there may be a nurse bias against the caring practice of allowing family

members to participate in patient care. If this is so, efforts to change the bias must be made if caring is to be experienced by family members.

Meeting the needs of family members included recognizing them as individuals apart from the critical care environment and as individuals with a unique and important perspective about the patient. In a sense, nurses confirmed their existence and their importance to the patients. Riemen (1983) noted that patients in her study appreciated being recognized as unique, thinking, and feeling human beings. Buber (1958) noted that "every human being needs confirmation because man as man needs it" (p. 71). Confirmation is associated with the feelings of connectedness that were described by family members in this study and with Drew's (1986) findings regarding feelings of exclusion and confirmation.

Feelings Evoked by Demonstrations of Caring and Noncaring

Family members of critically ill patients who were the recipients of professional nurse caring felt secure, comfortable, and relieved of some of the stress associated with having a loved one in a crisis situation. Having their needs met meant they could focus some of their attention on other concerns. They indicated they were better equipped and more willing to take care of themselves. Such a response is consistent with Roy's (Roy & Andrews, 1991) theory of person as an adaptive system, in which adaptation and coping are related to one's level of adaptation. The level of adaptation is influenced by the number and degree of internal and external stimuli influencing the person. The ability to adapt effectively is increased when there are fewer stimuli to which one must respond. The caring actions of nurses enable the family members to more effectively cope with the critical illness of their loved ones.

Family members described being connected to the nurses in the unit, and some expressed a reciprocal caring for those nurses. They confirmed the existence of the nurses by calling them by name, getting to know them as a "part of the

family," and by bringing them candy and cakes. Connecting and reciprocity are concepts found in the caring and critical care family literature. Clayton et al. (1991) wrote of connecting as a catalyst for caring. Caine (1991) indicated nurses should establish a connection with the family in which there is a reciprocal relationship or reciprocity. Reciprocity involves the establishment of a nurse-patient-family triad designed to maintain the unified family system that supports mutual caring (Caine, 1989, 1991).

Family members described a fear of being sanctioned if they violated explicit or implicit rules of the critical care unit. They indicated a fear of being too assertive in seeing that their needs for information or access were met and of being a nuisance to, and therefore, alienating the staff. The sanction most dreaded was having their visitation privileges restricted more severely or withheld altogether. Family members' reports of noncaring were consistent with Beckham's (1993) perception: "Patients and their family members are constantly torn between assertiveness and compliance, bargaining and demanding" (p. 94). When nurses are present for the family and when they empathize with the experience, caring exists and the fear of sanctioning is eliminated. Under such circumstances, families can feel comfortable and cared for. The care and compassion become "one of the few blessings" on which they can count (Jaret, 1984, p. 16).

Family members of critically ill patients who had been admitted to more than one intensive care unit indicated there was a difference in caring as experienced in the various units. They did not judge the differences as better or worse, more caring or less caring, but just different. In some instances they attributed the differences to the environment (open ward vs private rooms) and in other instances they attributed the differences to the nature of the patient's illness and the length of the patient's stay. It is probable that the environment and the nature of the illness influence the nurse's ability to know the patient. When patients have a short length of stay in the critical care unit, nurses have fewer opportunities within which they

can come to know patients in the way Mayeroff (1990) indicated was necessary for caring to occur. Conversely, when patients have a prolonged stay in the critical care unit, nurses have many more opportunities to know patients and their families. The experience of caring and being cared for is likely to be different under these different circumstances.

Conclusions

The following conclusions were drawn from the findings of this study:

1. Family members of critically ill patients are vulnerable and in tremendous need of professional nurse caring.

2. Professional nurse caring is a complex, multidimensional phenomenon that is valued by family members of critically ill patients.

3. The experience of professional nurse caring is influenced by the nature of the critical care environment, the condition of the critically ill patient, the length of the patient's critical care stay, and the preconceived expectations of the family members.

4. The experience of professional nurse caring begins with nurses who have innate caring personalities and the professional attributes of confidence, knowledge, and technical skill.

5. Professional nurse caring is experienced when nurses combine or integrate their personality and professional attributes and express them through verbal and non-verbal behaviors.

6. Professional nurse caring is doing more than the prescribed essentials of the job and involves the nurse being physically and emotionally present with and available to the patient and the family.

7. The process of caring involves meeting the needs first of the patients and then of the patients' family members.

8. Caring for patients means meeting their needs for continuous and vigilant monitoring, emotional care and encouragement, physical care and comfort, dignity and privacy, and healing.

9. The first priority of the caring nurse is the patient for whom a watchful vigilance is continuously maintained.

10. Techniques used to express caring include joking, teasing, touching, praising, explaining, reassuring, coaching, connecting the past to the present, and preparing the patient for what is being or will be done.

11. Caring nurses place the comfort of the patient before their own comfort or that of other caregivers.

12. Professional nurse caring involves the nurse advocating for the patient.

13. Professional nurse caring is comforting to patients and assists them to reach a level of healing or to have a comfortable and peaceful death.

14. Caring for family members of critically ill patients involves assuring them that their loved ones are being well and effectively cared for; offering them honest and consistent information; facilitating their access to the physician; providing them with access to the patient; allowing them to participate in the care of their loved ones; providing them with physical, emotional, and spiritual support or comfort; and acknowledging them inside and away from the critical care environment.

15. Caring nurses inform and educate family members, inquire about and assist with meeting family members' needs for nourishment and rest, assist family members with activities of daily living, and attend to the spiritual needs of family members.

16. Caring nurses use touching or hugging to console family members in times of stated or unstated need.

17. The consequences or results of professional nurse caring for family members include feelings of relief from some of their stressors, security in knowing

their loved ones are in "good hands," comfort with the critical care environment, and being connected to the caring nurses.

18. Professional nurse caring affects the ability of family members to cope with the crisis of the patient's illness.

19. Professional nurse caring is not always experienced by family members of critically ill patients; some comments from and actions by professional nurses and others are experienced as noncaring.

20. The experience of noncaring results in feelings of uneasiness, discomfort, confusion, and frustration.

21. When caring is not experienced, family members fear losing or having severe restrictions placed on their visitation privileges.

22. The meaning of caring as experienced by family members of critically ill patients is similar to the meaning of caring described by other population groups, specifically, nurses and patients. However, family members bring a different perspective to the understanding of the phenomenon.

23. Family members of critically ill patients are able and willing to describe experiences of physician caring.

24. Given the opportunity, family members of critically ill patients will express their ideas and suggestions for making the critical care experience more caring.

Implications for Practice

The critical care environment, although familiar to the nurses and physicians, is a threatening environment to family members of critically ill patients. It is a place where their loved ones are poked, prodded, attached to, and in some instances maintained by a variety of technologic devices. It is a place where loved ones may or may not recover from life-threatening illness. Regardless of the outcome, the experience of critical care is a threat to the safety, security, and structure of family members' lives. Nurses, and others, in the critical care setting must remember this

and do what they can to minimize the threat and promote the safety needs of family members.

Much has been said recently about patient-centered care. This notion, though, needs to be expanded to become family-centered care. Patients have families! Patients come from, and hopefully, will return to a family unit. No longer should it be acceptable to treat patients as if they are separate from their families. Patients and family members believe, and research has documented (Simpson, 1991), that family members can be a positive influence on the patient's recovery from illness. Nurses must develop better family assessment skills so that they can come to know the needs of family members and their coping abilities. To be perceived as caring, family-centered care will involve open communication with family members; open or, at the very least, individually contracted, visitation privileges; improved access to physicians; increased family involvement in patient care; and humane treatment that includes confirmation of the family through the real and empathetic presence of the nurse. When families are acknowledged, plans can be made for their presence in the unit; written orientation and other educational materials can be prepared and distributed prior to or at the time of the patients' admission to the unit.

It appears that caring behaviors may be equated with behaviors that confirm the patient and/or the family and noncaring behaviors may be equated with those that exclude or depersonalize the patient and/or the family. Because the technology in the critical care environment and the fast paced, high tech care delivered in critical care units have the potential for dehumanizing patients and families (Marsden, 1990, 1992), it is extremely important for nurses to demonstrate caring behaviors to patients and families so that the dehumanization and depersonalization associated with the environment can be minimized. Relationships between caring behaviors and confirmation and between noncaring behaviors and exclusion in

critical care require further study as do the outcomes of caring behaviors on feelings of dehumanization and depersonalization.

Joking, teasing, touching, and hugging are important caring behaviors that promote confirmation and humanization of patients and families. The nature of the critical care environment, the technology required for crisis care, and the critical status of the patient can not be allowed to overshadow the humanity of the patients, families, and staff. The universal precautions being used today to ensure safe and protective care must not become universal barriers to human kindness and humane care.

Leininger (1984) has differentiated between scientific caring and humanistic caring. Scientific caring is associated with those judgments and acts of helping others based upon tested or verified knowledge. Humanistic caring is identified as the creative, intuitive, or cognitive helping process for individuals/groups based on philosophic, phenomenologic, and experiential feelings and acts of assisting other (Leininger). Critical care units have long been known for the scientific caring that takes place there; they now must become known for the humanistic caring that can take place. Orientation and staff development programs that promote the scientific basis of critical care nursing must be supplemented with programming that highlights and promotes the humanistic basis of critical care.

Demonstrating professional nurse caring can be an emotional burden to nurses if they do not receive adequate social support at work and at home. The stress of working in the highly charged critical care environment can drain the nurse of the emotional energy needed to be caring toward patients and their families. Nurse administrators in critical care need to be aware of and attend to the emotional needs of nurses so that they in turn will have the emotional energy with which to demonstrate caring to patients and families. Inexperienced nurses must be provided with caring mentors so that they can learn to integrate compassion with

knowledge and technical skill, and they must be provided the time and opportunities to practice that integrated behavior.

Family members have a unique perspective to share with the nursing staff. Opportunities should be made for including former family members as participants on task forces established for the purpose of developing family-centered educational materials, reviewing and revising family visitation policies, and creating a more family-centered critical care environment. Suggestions offered by the participants in this study should be reviewed and where appropriate implemented or refined for future implementation.

Implications for Education

Family members seem to believe that caring nurses are made to be the way they are. If personality traits experienced as caring are inherent, then individuals with those traits need to be identified and recruited into the profession. If they are learned behaviors, then educational institutions must place emphasis on developing the caring expressions of the personality as they develop the knowledge and technical skill required to become capable, competent, and caring nurses. Teaching methods designed to foster empathy and confirmation must be developed, tested, and implemented in the classroom and clinical settings.

Educational programs need to focus more attention on the provision of family-centered care. It is not unusual to emphasize family care when teaching obstetrical, pediatric, or community health nursing content in schools of nursing. Less commonly is family care emphasized in the traditional medical or surgical nursing or adult health content. This practice needs to change, and students must develop skills in family needs assessment. Nursing models that foster the assessment and meeting of family needs as an aspect of holistic care should be used to guide the students' learning and nursing practice. Students must have maximum opportunity to practice family-centered care in the controlled educational environment. Role-playing may be one very good technique for allowing the student to see and feel

what family members see and feel. Family members as guest speakers might share their experiences with students and participate in discussions about what nursing interventions would be perceived as caring.

Recommendations for Research

The following recommendations are made as a result of this study:

1. Repeat this phenomenologic study with other populations of family members of patients. Compare the meaning of caring from the perspectives of family members of home health care patients, family members of patients with cancer, family members of patients admitted to acute care medical/surgical units, and family members of patients admitted for obstetrical or gynecologic care.

2. Conduct a study to investigate the effect of specific caring behaviors or interventions on the reduction of stressors influencing critically ill patients and their family members.

3. Conduct a phenomenologic study to simultaneously investigate the meaning of professional nurse caring from the perspective of nurses, patients, and family members.

4. Conduct a study to investigate whether the expression or demonstration of caring is influenced by the years of experience as a critical care nurse.

5. Conduct a study to investigate whether the expression or demonstration of caring is influenced by the educational preparation of the nurse.

Summary

The meaning of professional nurse caring for family members of critically ill patients was examined by interviewing nine individuals who were related to a critically ill patient by marriage or blood. The data were analyzed using the phenomenological methodology described by Spiegelberg (1976). The meaning of professional nurse caring encompassed 21 themes which were clustered into four theme categories: the way the nurse is, meeting patients' needs first, meeting family members' needs, and feelings evoked by the demonstrations of caring and noncaring.

These theme categories were discussed and related to relevant research and theoretical literature and to each other. Conclusions of the study were presented along with implications for practice and education. Recommendations for further research were offered.

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APPENDIX A

Human Use Approvals

The University of Alabama at Birmingham
Institutional Review Board for Human Use
205/934-3789
Telex 888826 UAB BHM

FORM 4: IDENTIFICATION AND CERTIFICATION OF RESEARCH PROJECTS INVOLVING HUMAN SUBJECTS

THE INSTITUTIONAL REVIEW BOARD (IRB) MUST COMPLETE THIS FORM FOR ALL APPLICATIONS FOR RESEARCH AND TRAINING GRANTS, PROGRAM PROJECT AND CENTER GRANTS, DEMONSTRATION GRANTS, FELLOWSHIPS, TRAINEESHIPS, AWARDS, AND OTHER PROPOSALS WHICH MIGHT INVOLVE THE USE OF HUMAN RESEARCH SUBJECTS INDEPENDENT OF SOURCE OF FUNDING.

THIS FORM DOES NOT APPLY TO APPLICATIONS FOR GRANTS LIMITED TO THE SUPPORT OF CONSTRUCTION, ALTERATIONS AND RENOVATIONS, OR RESEARCH RESOURCES.

PRINCIPAL INVESTIGATOR: LINDA J. MIERS, RN, DSN

PROJECT TITLE: THE MEANING OF PROFESSIONAL NURSE CARING: THE EXPERIENCE OF FAMILY MEMBERS OF CRITICALLY ILL PATIENTS

_____1. THIS IS A TRAINING GRANT. EACH RESEARCH PROJECT INVOLVING HUMAN SUBJECTS PROPOSED BY TRAINEES MUST BE REVIEWED SEPARATELY BY THE INSTITUTIONAL REVIEW BOARD (IRB).

__X__2. THIS APPLICATION INCLUDES RESEARCH INVOLVING HUMAN SUBJECTS. THE IRB HAS REVIEWED AND APPROVED THIS APPLICATION ON SEP 2 - 1992 IN ACCORDANCE WITH UAB'S ASSURANCE APPROVED BY THE UNITED STATES PUBLIC HEALTH SERVICE. THE PROJECT WILL BE SUBJECT TO ANNUAL CONTINUING REVIEW AS PROVIDED IN THAT ASSURANCE.

__X__ THIS PROJECT RECEIVED EXPEDITED REVIEW.

_____ THIS PROJECT RECEIVED FULL BOARD REVIEW.

_____3. THIS APPLICATION MAY INCLUDE RESEARCH INVOLVING HUMAN SUBJECTS REVIEW IS PENDING BY THE IRB AS PROVIDED BY UAB'S ASSURANCE. COMPLETION OF REVIEW WILL BE CERTIFIED BY ISSUANCE OF ANOTHER FORM 4 AS SOON AS POSSIBLE.

_____4. EXEMPTION IS APPROVED BASED ON EXEMPTION CATEGORY NUMBER(S)_

DATE: SEP 2 - 1992

RUSSELL CUNNI
INTERIM CHAI
INSTITUTIONA

UAB SCHOOL OF MEDICINE

Department of Surgery
Division of General Surgery

August 28, 1992

M E M O R A N D U M

TO: Linda Miers
School of Nursing/NB 222

FROM: Beverly A. Bowens, RN, MN
Chairperson, Nursing Research Committee

RE: Study entitled "The Meaning of Professional Nurse Caring: The Experience of Family Members of Critically Ill Patients"

The above referenced study has been approved by the Department of Nursing. When your study is completed, we ask that you share the results with the nursing staff as seems appropriate.

Good luck with this very interesting study! If I can be of any further assistance, please call me at 934-7373.

The University of Alabama at Birmingham
112 Lyons-Harrison Research Building • 701 South 19th Street
Birmingham, Alabama 35294-0016 • (205) 934-4903 • FAX (205) 975-7294

APPENDIX B

Subject Consent Form

Subject Consent Form

A study of the meaning of professional nurse caring is being conducted by Linda Miers, a doctoral student at the University of Alabama School of Nursing, The University of Alabama at Birmingham. The study is being conducted to learn more about the phenomenon of caring.

Participation in the study involves completion of a short demographic data collection sheet and an interview with the researcher that will last up to approximately 1 hour. The interview will be audiotaped by the researcher and later transcribed. There will not be any identifying names on the tapes, and your name will not be available to anyone. The tapes will be destroyed after the completion of the study. You may be asked at a later date to discuss with Linda Miers the patterns, themes, and categories of the experience of professional nurse caring. This follow-up discussion may be by telephone or at a face-to-face meeting.

The information gathered will be used to write the research report and may be published and presented at professional meetings. The information shared by you will in no way identify you or enable anyone else to identify you. The information will help professional nurses and others to better understand the concept of professional nurse caring as demonstrated in critical care.

Participation is voluntary. You have the right to refuse to participate in and to withdraw at any time from the study. Your decision whether or not to participate will not influence in any way the care you, or your family member in the critical care unit, will receive.

If you have any questions, feel free to contact the researcher at the number below.

_____ _____

Signature Date

Researcher: Linda Miers
205-934-6849

APPENDIX C

Demographic Data

Demographic Data

Participant Name:_____

Participant Address:_____

_____

Participant Telephone Number: (____)_____

Participant ID #:_____

Date: _____ _____ _____

Age: _____ _____

Sex: _____1. Female

_____2. Male

Cultural Background:

_____1. White

_____2. African American

_____3. Oriental

_____4. Spanish American

_____5. Native American

_____6. Other

Relationship to Patient:

_____1. Wife

_____2. Husband

_____3. Mother

_____4. Father

_____5. Daughter

_____6. Son

_____7. Sister

_____8. Brother

_____9. Other

Length of Patient's Stay in Critical Care Unit:

_____1. Less than 24 hours _____hours

_____2. 24 hours or greater _____days

APPENDIX D

Interview Guide

Interview Guide

1. Think about your interactions with the nurses since your family member has been in the critical care unit. Tell me about your experiences with the nurses.
2. Did you find the nurses to be caring in their interactions with you?
3. What does caring mean to you?
4. Can you tell me what the nurses did with or for you that let you know they were caring?
5. How did the nurses' caring affect you?
6. Did you find any nurses to not be caring in their interactions with you?
7. What did those nurses do for or with you that let you know they were not caring?
8. How did it affect you when the nurses were not caring?

APPENDIX E

The Meaning of Professional Nurse Caring in the Critical Care Setting

The Meaning of Professional Nurse Caring in the Critical Care Setting

Professional nurse caring as experienced by family members of critically ill patients is multidimensional and adaptive to the situation of the moment. The experience of caring is influenced by the nature of the critical care environment, the patient's condition, the length of the patient's stay, and the preconceived expectations of the family members.

The experience of caring begins with what family members perceive as caring nurses. Without a caring nurse, professional nurse caring cannot be experienced. Caring nurses possess personality characteristics that are expressed to family members and patients through the touch of a hand, a softness and calmness of the voice, a warm and open smile, and other verbal and non-verbal expressions. The personality characteristics of the caring nurse must be integrated with the professional attributes of confidence, knowledge, and technical skill. Nurses who have and express a caring personality but who are not confident, knowing, and skillful are not perceived as truly caring. The reverse is also true: confident, knowing, and technically skilled nurses who do not express a caring attitude through their behaviors or who do only the prescribed essentials of their job and no more, are not perceived as caring. Caring nurses are committed to the patient and the family and are physically and emotionally present for them rather than being physically present to get a paycheck. They express empathy for what the patients and family members are experiencing.

The "job to be done" in critical care is meeting needs, first of the patients and then of the patients' families. Caring for patients is providing continuous and vigilant monitoring, communicating emotional care and encouragement, giving physical care and comfort, and providing an opportunity for and assisting with healing, while maintaining the patient's dignity and providing for privacy. Patients are the first priority of the caring nurse who is ever present for the patient whether the vigil is maintained directly from the bedside or indirectly from across the room or unit. Techniques used to communicate care and encouragement include joking and teasing, touching, connecting the past to the present, praising, explaining, reassuring, and coaching. Caring is preparing patients, whether alert or unconscious, for what is being or will be done to and for them. Comfort of the patient, whenever possible, is placed before the comfort of the nurse, the physician, or the family. Caring is being the caretaker and advocating for the patient in all situations. Through the provision of caring the patient has the opportunity to heal or to progress to a comfortable and peaceful death.

Caring for families is assuring that the critically ill patients are taken care of; offering honest and consistent information without being asked for it; facilitating access to the physician; providing access to the patient; allowing family members to participate in the care of their loved one(s); providing physical, emotional, and spiritual support or comfort; and recognizing and acknowledging the family both inside and outside of the critical care environment. Family members are informed and educated about the illness or trauma, the diagnostic and therapeutic interventions being implemented or planned, and about the expected or realized outcomes of those interventions. Measures are taken to assure that families receive proper nourishment and rest, to provide for their physical comfort, to assist with activities of daily living, and to attend to their spiritual needs. Families are consoled in times of stated or unstated need. This consolation is sometimes conveyed by touching or hugging.

The feelings of relief, security, comfort, and connectedness that families experience, either mentally or physically, are the direct result of having their needs recognized and responded to by the nurses. Uneasiness with the critical care environment and fear of being sanctioned result when patients' or family members' needs are not met and they experience noncaring.

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Major Subject Adult Health Nursing

Title of Dissertation The Meaning of Professional Nurse Caring: The Experience of Family Members of Critically Ill Patients

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Date 12/13/93

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