

TITLE

**Comparative Analysis of Patients' and Nurses' Perceptions of Nurse
Caring Behaviours in Two Tertiary Hospitals in Jos**

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APPROVAL

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CERTIFICATION

This is to certify that this dissertation is the original work of Daniel Cletus Okpe Registration Number PG/M.Sc./07/46888 certify that the original work is mine except as specified in acknowledgment and references and that neither, the dissertation nor the original work contained therein has been submitted to the University or any other Institution for the award of Degree.

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DEDICATION

This work is dedicated to God Almighty and the members of my family for their understanding and co-operation.

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ABSTRACT

The purpose of this study was to comparatively assess patients' and nurses' perceptions of nurse caring behaviours in Jos University Teaching hospital (JUTH) and Plateau State Specialist Hospital (PSSH) Jos. A cross-sectional descriptive survey design was employed to study 332 patients and nurses. No sampling was done as all the subjects who met the inclusion criteria were included in the study. Data were collected using a modified Caring Behavior Assessment questionnaire (CBA-Q) (37 items), a 5-point likert-type scale and arranged in 7-subscales. Data were analyzed using descriptive and inferential statistics. The result indicated that all the caring behaviours statements except item 17 (visiting patient if patient moves to another hospital units) with item mean of 2.63; SD = 1.33 and t-value of 1.24 which is below the mean criterion value of 2.50) were accepted as indicators of care by patients. The findings that using soft gentle voice with patients, being kind and considerate to patients, answering patients' questions clearly, and giving patients' treatments and medications on time were the four highest (most important) scored items by patients. The findings that visiting patient if patient moves to another hospital unit, preparing patient for death when it is inevitable, Praying with and or for patient and checks his or her perception of the patient with the patient before initiating any action were the four lowest (least important) scored items by patients. The result is indicative that all the caring behaviour statements except item 17 (visiting patient if patient moves to another hospital unit, with item mean of 2.62, SD = 0.90, and t-observed value of 1.69 which is below the mean criterion of 2.50) were accepted as indicators of care by nurses. The findings that giving patients treatments and medications on time, treating patients information confidentially, using soft gentle voice with patient and showing patient love, were the four highest (most important) scored items by nurses. The findings that visiting patient if patient moves to another hospital unit, is calm and preparing patient for death when it is inevitable were the three lowest (least important) scored items by nurses. Comparison of mean scores and standard deviation of patients and nurses on CBAQ subscale showed that patients and nurses perceived humanism/faith hope sensitivity, helping/trusting and human needs assistant as the most important and existential phenomenological/spiritual forces as the least important subscale. The mean scores showed that nurses gave higher mean values than did patients to all the seven subscales. A comparison of the top 10 CBAQ items between patients' and nurses' perception revealed similarities as well as differences. Patients and nurses agreed on 6 out of the 10 most important items and do not agree on the remaining 4 top 10 caring behaviour statements. The result also indicated that nurses more than patients value the subscale humanism faith hope sensitivity while patients valued the subscale; human needs assistant more than nurses. In total, nurses scored higher in 31(83.7%) items than patients who scored higher than nurses in only 5 (13.5%) items. A comparison of the 10 least important CBAQ items showed that patients and nurses agree on 5 out of 10 of the 10 least important items. Items 17 and 23 on the CBAQ (visiting patients when patient moves to another hospital unit, and check his or her perception of the patient with the patient before initiating any action) were ranked same by both patients and nurses. There is a significant difference in the perceptions of CBAQ statements as indicators of care between patients and nurses ($F=7.456$, $P \leq 0.05$) $P = 0.007$. It was recommended that the result of the study be communicated to nursing staff of the two hospitals. In order to help nurses meet caring expectations of clients and enhance patients' positive health outcomes. The result from this study therefore provide improvement implications for the care of patients, like concrete information on what behaviours the patient would like to experience.

CHAPTER ONE

INTRODUCTION

Background of the Study

Caring is when a loving and kind gesture is demonstrated by a person as he or she functions to promote wellness, well being, maintain health, alleviate sufferings, rehabilitate the disabled individuals, family, group, community, or population. Nurse caring is the process by which the nurse becomes responsive to another person as a unique individual, perceives the other's feelings, and sets that person apart from the ordinary (Watson 1998 in Batsdusdottir and Jonsdettir, 2002). Nurse caring behaviour on the other hand, refers to those things that a nurse says or does that communicate caring to the patients (Batsdusdottir and Jorsdottir, 2002). Caring is the service the nurse renders while caring behaviours are those attitude, competencies and skills the nurse exhibits while rendering the services (Ehiemere, 2011).

Caring which has been identified as the essence of nursing, the dominant, distinctive and underlying feature of nursing practice (Leininger, 1979 in Erb and Kozier, 2008), has traditionally been at the core of nursing (Larrabee, Putman and Wu, 2006). Nursing as a profession places the greatest demands specific to the development and refinement of the caring component of nursing (Azimzadeh, Rahmani, Valizadeh and Zamanzadeh, 2010). Thus, the study of human caring as an essential characteristic of nursing practice has gradually expanded from early definitional, philosophical and cultural writings on the meaning of caring to evidence-based care (Boykin and Schoenhofer, 2000). To be meaningful, Azimzadeh, Rahmani, Valinzaadeh and Zamanzadeh (2010), maintained that nurse caring must be based upon mutual agreement between nurses and patients as to what constitutes nurse caring behaviours.

Nurses cannot be certain that their behaviour is consistent with patients' perception and expectations of their care. Nurses cannot therefore assume that patients perceive their caring efforts as they are intended. To avoid this problem, it is imperative that nurses validate with the patients that their care needs are being met (Azimzadeh, Rahmani, Valizadeh and Zamanzadeh, 2010).

There is currently considerable emphasis on the provision of patient-centred care in all aspects of health care (Greenhalgh, 1998 in Azimzadeh, Rahmani, Valizadeh and Zamanzadeh, 2010). What is most important here is to make clear or ascertain factors that influence patients' satisfaction to enable nurses improve quality of nursing care. Kimble (2003) observed that the degree of congruence between patients' expectations of nurse caring behaviour and their perception of the care they really get forms their satisfaction with nursing care. Hence, Azimzadeh, Rahmani, Valizadeh and Zamanzadeh, (2010) concluded that there could be a relationship between nurses' caring behaviours and patients' satisfaction.

Previous studies on caring (David, Ozawa, Puangrat and Takeo, 2002; Watson, 2002) focused on nurses' perceptions of what constitutes caring for the patient, patients' perception of what is important in making them feel cared for, and comparisons of patients' and nurses' perceptions of what constitutes important nurse caring behaviours (Azimzadeh, Rahmani, Valizadeh and Zamanzadeh, 2010). Many of these studies have generally demonstrated significant discrepancies (differences) in patients' and nurses' perceptions of nurse caring behaviours, (Chang, 2005). This discrepancies may result in patients' needs being unmet and patients' dissatisfaction with the care received.

Kimble (2003) opined that the perception of an uncaring nurses' behaviours can lead to increased anxiety and diminished coping abilities for patients and litigation for nurses and health institutions. Although human caring has been perceived as a universal phenomenon, the expressions, processes and patterns vary among cultures (Leininger, 1998 in Azimzadeh, Rahmani, Valizadeh and Zamanzadeh, 2010). This means that culture and values affect our understanding of the concept of caring (Evans, Mizuno, Okada, Ozawa and Taked, 2005). Since nurse caring behaviour is central and crucial in hospital for achieving, effective, efficient, minimal risk to patients, satisfaction of patients, and overall physical, psychological and sociological patients' positive health outcomes, there is therefore a need to ascertain nurses' and patients' perceptions of nurse caring behaviours in different settings. This is a practical approach to the caring concept and the basis for this study in a Nigerian setting where there is a dearth of literature on comparative analysis of patients' and nurses' perceptions to nurse caring behaviour.

Statement of Problem

Although the concept of nurse caring behaviour is central to the practice of nursing, there is, discrepancies as to a single definition of nurse caring behaviour. Patients and nurses differ in their perceptions of what they consider to be caring behaviour (Patistea, Siamanta, 1999). Major sources of information regarding patients' perception of nurse caring behaviour are hospital satisfaction surveys conducted in United States of America. However, there may be some relationship between patients' satisfaction and a patients' perception of 'very good care', but they do not necessarily mean the same thing (Sossony and Poirier, 2007). Also surveying nurses' satisfaction equally does not address nurses' perceptions of what constitutes caring behaviour.

Further comparison of what constitutes caring from both the patients' and nurses' perspectives will help patients, nurses and organizations as they continually seek to improve patient care.

In Nigeria care of patients has encountered several serious challenges that suggest a large disparity with international standards which must be filled. The perception of nurses' caring behaviours varies from culture to culture as well as the setting of their practice. Complaints of poor attitude of nurses towards patients are rife and appear to be increasing. In Jos such complaints were observed on daily basis but escalated since the incessant civil unrest, emanating from the Boko Haram mayhem, with unprecedented casualties and subsequent increase in hospital admissions. This has led to the perception that nurses are increasingly distancing themselves from patients, and giving care that is not meeting patients' expectations.

The researcher having stayed in the wards for not less than fifteen years of his clinical practice been in frequent contact with professional nurses and patients have observed that there are discrepancies in nurses' and patients' perception of the nurse caring behaviours from certain incidents. The nurse intends communicating caring, but the patients views the nurses action as uncaring (not indicative of caring). For instance, increase in workload which makes nurses prioritize care to the most seriously ill-patients with the tendency of leaving some patients unattended to is regarded as neglect by patients. Inattention or neglect however is unacceptable to both nurses and patients (Baldusdotti and Jonsdottier, 2002). A night nurse may order all patients to go to bed and sleep and consequently put off the bright light. The patients and her

relatives may view the nurse's action as doing that to pave way for her to go and sleep herself, and not purely having the interest of patients at heart etc.

In these instances, the nurse caring behaviours that the nurse perceived as indicative of caring is not perceived as such by the patient. These discrepancies may result in patients' needs not being met leading to patients' dissatisfaction with the care being rendered by the nurses. In the midst of these discrepancies, one therefore wonders whether there are congruencies in the nurses' and patients' perception of nurse caring behaviours as much as there are differences. The understanding is that emphasizing on nurse caring behaviours identified by both patients and nurses, may enhance patients' positive response to care and hence win their cooperation in ensuring compliance to prescribed regimen or procedures of management. Based on the foregoing, the present study is designed to have a comparative analysis of patients' and nurses' perceptions of nurse caring behaviours in two tertiary hospitals in Jos.

Purpose of the Study

The purpose of the study was to have comparative analysis of patients and nurses' perceptions of nurse caring behaviours in two tertiary hospitals in Jos, North-central Nigeria.

The following specific objectives were set for the study.

1. To determine nurse caring behaviour statements that patients perceived as indicators of care.
2. To determine the most and least important nurse caring behaviours as perceived by patients.
3. To determine nurse caring behaviour statements that nurses perceive as indicators of care.

4. To determine the most and least important nurse caring behaviours as perceived by nurses.
5. To determine if differences exist in the nurse caring behaviours statements that patients and nurses perceived as indicators of care.

Research Questions

The followings are the questions this research study addressed:

1. Which of the nurse caring behaviour statements are perceived by patients as indicators of care?
2. Which of the nurse caring behaviour indicators are perceived as most and least important by patients?
3. Which of the nurse caring behaviour statements are perceived by nurses as indicators of care?
4. Which of the nurse caring behaviour indicators are perceived as most and least important by nurses?
5. Do differences exist in the nurse caring behaviours that patients and nurses perceived as indicators of care?

Research Hypothesis

1. There will be no significant difference in the perceptions of nurse caring behaviours of patients and nurses.

Significance of the Study

The findings of the present study revealed what patients and nurses perceived as indicators of care. Based on the findings, health institutions and nursing services may utilize the corresponding suggestions to map out strategies to improve nursing care. It

could contribute to benchmark to measure the nurses performance and as foundation for development of guideline for practice. The findings of this study might allow nurse clinicians to be sensitive to their caring behaviours by increasing their realization of how behaviours are perceived by patients. Could provides information to new nurses thereby leading to improve performance and better meet patients needs. The result could enhance research in the concept of caring as well as the patients expectations of the nursing staff. It could also harmonise the nurses behaviours/cares in line with expectations of patients leading to satisfactions of patients. It could help to evaluate, define and set up standards of nursing care.

Patients care needs being met as a result of knowledge gained from this study would lead to decrease in patients anxiety that usually lead to diminished coping abilities, litigation and financial loss on the part of the nurse and institution. It will also increase patients patronage of the institution, because nursing care is the single most significant factor in the patient's perception of high quality hospital care. (Buldursdottir, Jonsdottir, 2002). It could go a long way in improving the public image of nurses and nursing that creates a framework by which others approach nursing as a profession, as well as each nurse, individually. It has been proven that image influences patients safety, resource allocation, public policy, recruitment into the profession and other issues that have far reaching consequences (Kearns, 2009). It could assist the nurse to achieve a better pedestal in their relationship with the patients and appropriate job satisfaction and by extension establish the reputation of the health institutions as valuable healthcare providers in the ambience of competitive standing. The result of this study and corresponding suggestions if implemented could reveal the contribution of nursing to patients recovery which might contribute to appropriate budget for nursing.

Scope of the Study

The study was delimited to the comparative analysis of patients and nurses perceptions of nurse caring behaviours in two tertiary hospitals in Jos. It looked at nurse caring behaviours that are indicators of caring, most and least important nurse caring behaviour indicators, and then compared patients and nurses indicators of caring. The two hospitals were chosen, because of the large patient population and various cadres of nurses.

Operational Definitions

Caring Behaviour: Nurse caring behaviour refers to action by nurses taken towards their patients to show empathy and this entails things they do or say to patients, or how they do or say them to positively influence their patient's faith, trust, feelings, learning, needs, support and spirit as measured by the Caring Behaviour Assessment Questionnaire (CBAQ) designed by Cronin and Harrison.

Perceptions of Nurse Caring Behaviour: Refers to patients' and nurses' responses or reactions to selected caring behaviour statements in the CBA measuring instrument for this study. In other words, perceptions of nurse caring behaviour refers to patients' or nurses' feeling towards caring behaviour statements in CBA and was measured by numerical quantification of the magnitude of that feeling such that the strongest positive perceptions as of a nurse caring behaviour are truly reflective perceptions of care by the patients or nurses is rated 4 suggesting a strongly agreed by the respondent to that effect. Similarly, the next is 3 suggesting agreed, 2 suggesting disagreed, 1 suggesting strongly disagree and 0 suggesting undecided.

Patient: Male or female, aged 18 years and above, sick, admitted for not less than five (5) days of date of data collection in either Jos University Teaching Hospital or Plateau State Specialist Hospital Medical or Surgical Unit.

Tertiary Hospitals in Jos: These are Jos University Teaching Hospital and Plateau State Specialist Hospital.

CHAPTER TWO

LITERATURE

This chapter presented a review of the available and existing works on nurse caring behaviour particularly nurse caring behaviours that are indicators of caring under the following sub-headings:

1. CONCEPTUAL REVIEW

Concept of caring: Concept of nurse caring behaviours , Caring as human trait, Caring as moral imperativeness, Caring as an affect, Caring as a nurse ï patient interpersonal relationship, Caring as a therapeutic intervention .

Concept of perceptions: Definitions and process of perception, Factors influencing or affecting perceptions of care,

a. In the patients

b. In nurses

2. THEORIES UNDERLYING THE STUDY

Theory of human caring by Jean Watson theoretical sources assumptions of the theory, theoretical assertions and philosophical underpinning.

Leininger's Cultural Care Diversity and Universality: Theoretical sources for theory development, major concepts and definitions, major assumptions, theoretical assertions.

3. Empirical Review

Empirical review on patient's perception of nurse caring behaviours.

Practicing Nurses's Perceptions of Caring.

4. Conceptual/theoretical Model for the study

The Concept of Caring

The concept of caring is one of the least understood ideas, a poorly defined concept, viewed as an extremely complex phenomena and an ontological state of being. It is considered an elusive and imprecise concept, thus the following are attempts by scholars at its definitions and characteristics. Although Sossong (2007) asserted that there is no single definition of what it means to care, nurse researchers have conceptualized caring within the context of nursing from a variety of perspectives.

In considering the concept of caring some attributes immediately come to mind which comprises of, but are not restricted to being: a kind, thoughtful, gentle, helpful, compassionate, considerate, loving, sensitivity, concerned, caregiver. Together these words fit into the philosophies of nursing and the provision of care to individuals which provide the marked distinction between the profession of nursing and just another job carrying out assignment, duties or providing service for a paycheck.

Random House Webster's unabridged dictionary (1999) defines caring as being under one's protection or charge like a doctor or caregiver. Care ethicists emphasize the importance of caring as maintaining a relationship no matter the consequences for the caretaker and others; it is choosing an option but acting so as not to violate relationships or hurt others with whom one is in relationship (Parks and Wike, 2010). Care is expressed as concern for others, their rights and treating every individual equally (Edeliman and Mande, 2010). Davison and Williams (2009) states that, "compassion or caring can be viewed as "nursing's most precious asset" (Schantz, 2007), a fundamental element of nursing care (Dietze and Orb, 2000) and as one of the strengths of the profession. According to Torjuul et al (2007), it involves being close to patients and seeing their situation as more than a medical scenario and routine

procedures A nurse is required to exercise sensitivity in different situations and to different individuals, especially, when dealing with different cultures. Recognizing cultural diversity, integrating cultural knowledge, and acting, when possible in actual appropriate manner enables nurses to be more effective in initiating nursing assessments and serving as client advocates (ANA; 1991) all in Randon House Webster's Dictionary (1999).

The concept of caring in nursing profession as explained by Gwenda (2003), aims to serve society by contributing to a therapeutic, curative, educative and preventive role in health care. The concept involves aiding the individual in every type of medical difficulties or emergency and providing practical assistance and psychological and emotional support when they are prevented from carrying out essential tasks of everyday living through mental or physical illness, handicap, incapacity or injury. It involves the following important factors:

1. Respect for fundamental human rights in the delivery of health care and in the participation in investigations and treatments provided to patients in my care without prejudice, regardless of their psychological and physical condition, their age, gender, race, belief, position in society.
2. Rapid establishment of a helping relationship in order to provide reassurance to a patient and their families, while identifying their medical needs in relationship to their pathology, biography, psychological state and in their social and cultural context, in order to establish an adapted and holistic plan of care.

3. To ensure that the patient remains the centre focus of the multidisciplinary team and by the medical establishment in which they have placed their confidence.
4. The delivering of care with respect for the dignity and individuality of each and every patient while considering the balance between the degree of dependency and their need for personal autonomy.
5. Respect for the right to accept or refuse care or in the case of incapacity to make an informed decision, to act in their best interest with the agreement of the multidisciplinary team and where relevant, the patients's closed family.
6. The sacrosanct duty of professional confidence, respect for patient confidentiality and protection of their data.
7. The ability to work independently and also in collaboration with the multidisciplinary team in order to share skills, competences and professional knowledge with patient as well as their entourage.
8. The ability to use the professional capabilities of each team member in order to deliver optimal care while acknowledging the limitations and also the restrictions of resources such as budgetary, material and human resources.
9. Awareness and implementation of local and regional health care policies and laws that govern professional practice.
10. Respect for the philosophy of care of the healthcare organization and working within the chosen framework of the nursing process.
11. Identification of physical and psychological risk at all levels to patients and defence of their rights and their interest, ensuring safe working practices.
12. Offering patients/clients adequate information appropriate to their level of understanding and language concerning their state of health or their illness, the

investigations, prescribed curative or palliative treatments, expected outcomes and significant side effects that may affect the patient.

13. The provision of an appropriate level support from the relevant area of professional expertise to assist patients/clients in making informed decisions about their care and the organization of or adjustments to their lives and those concerned such as their family or employer.
14. Effective teaching to encourage patients and their families, where relevant or desirable, to participate in their care as far as possible and prevent exacerbation or a relapse of their condition.
15. Accurate verbal communication with other members of the interdisciplinary team and meticulous record keeping.
16. Participation in continuous profession development and areas of specialization, making professional curiosity, identification of professional needs relevant to keeping knowledge and technical expertise up to date.
17. Use of care guidelines provided by the healthcare facility and evaluation of the research literature to provide evidence-based techniques.
18. Self-motivate and encouraging an atmosphere of collegiality where the multidisciplinary team, students and visiting staff enjoy exchanging ideas and striving for excellence.
19. Interpretation of and adhesion to the codes of professional conduct relevant to a work situation established by national and international regulatory nursing organizations.

Perspectives of Caring

In an attempt to synthesize the different perspectives into a coherent structure, Morse, Solberg, Neander, Bottorff and Johnson *et al* (1992/1991) analysed the content of 35 authors definitions of caring and the main characteristics of each perspectives are categorized into five. These are:

1. Caring as human trait
2. Caring as moral imperative or ideal
3. Caring as affect
4. Caring as an interpersonal relationship and
5. Caring as an intervention

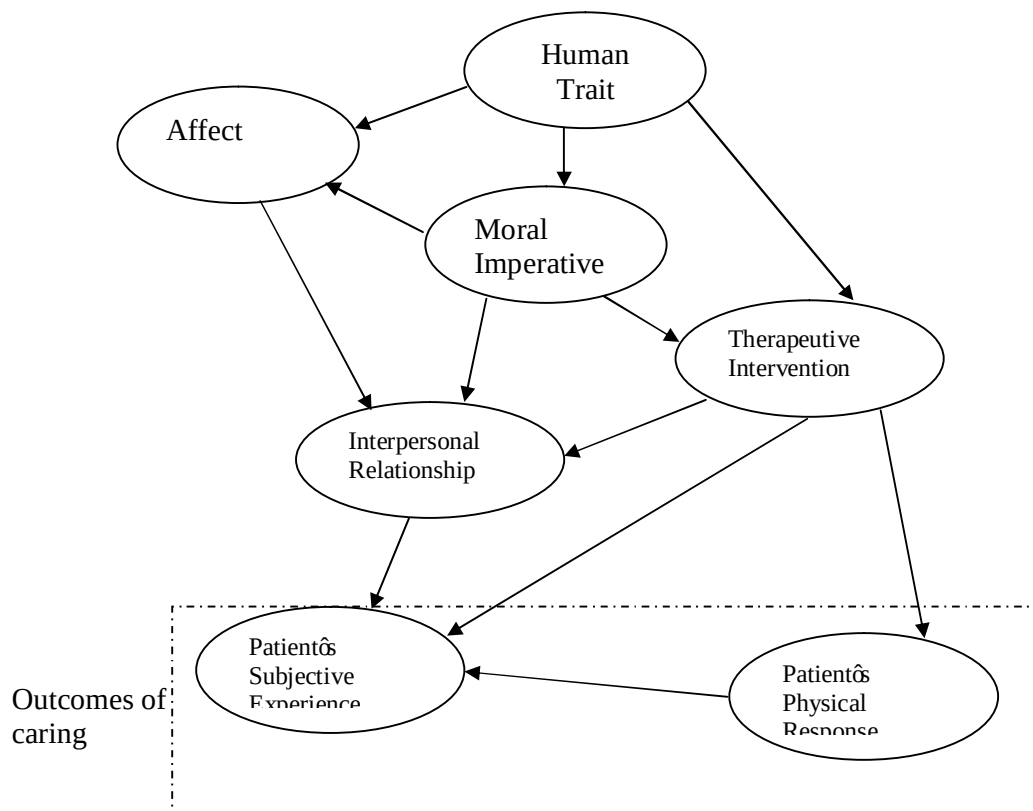


Fig 1: The interrelationship of five perspectives of caring

Source: Adv. Nurs. Sci. 1990; 13(1): 3 @ 1990 Aspen Publishers, INC

Explanation of the diagrammatic Schematic Interrelationship of the Five Perspectives of Caring

As a human trait caring is an in-born trait or potential in every human person not just in nurses. It is a part of human nature essential for human existence. Caring is in-built in human being. This potential is being developed in nurses through knowledge and skills and made them to have the perspective of caring as moral imperative or obligation which is sharing concern or looking after people's physical, medical and general welfare. The human trait and moral imperative perspective leads to caring as affect. This extends from emotion conveying love and kindness and it is this that makes the nurse to act selflessly without personal gratification. When the above three perspectives are directed toward the patient, it is viewed as 'caring as therapeutic intervention'. All nursing procedures or interventions to enable or assist patient when conditions of patient became necessary for caring actions are said to be therapeutics e.g. health education. Care therefore differs according to patient's condition, serving unit and competencies of the nurse. These lead to caring as interpersonal relationship; caring is interactive as humans are social being. It is a partnership approach hence the outcomes of caring are patient's subjective experience and patient's physical response. At the end the psychological needs of the patient is met and promotion of health and wellbeing, maintenance of health, alleviation of suffering, recovery and rehabilitation of patient is achieved. Now the detailed in-depth explanation of the five perspectives of the concept of care as put forward by Morse et al (1991/1992).

1. Caring as human trait

Caring is a part of human nature essential for human existence. It is an inborn trait or potential in every human person, not just in nurses. Individual's experience in being cared for and experiencing caring influences one's ability to care. The nurse's educational experience professionalizes this caring through the acquisition of knowledge and skills. Diverse expression, meanings, patterns and modalities of caring are culturally derived. The human trait of caring is the motivation of nursing actions. One's ability to care is enhanced by learning and that differences in nursing practice reflect different levels of expertise in understanding the meaning of patient's experiences of health and illness. Orem's believed that caring consist of actions by others that become necessary when self-care requirements cannot be met. Caring in the bureaucratic hospital organization encompasses political, economic, legal and technical aspects as well as humanistic dimension of care. Caring is in-built in human being. Caring as a nurturing behaviour e.g girls care for their dolls, parents their children, sons and daughters their elderly parents.

Models of nursing that reflect this school of thought are: Orem's self care theory, Nightingale environmental theory and Levine four conservation principle.

2. Caring as moral imperative or ideal (obligation)

Caring involves showing concern. Being compassionate or looking after people's physical, medical and general welfare. It is part of our ethical and legal obligation to recipient of nursing services. Caring as a moral ideal (obligation), it entails a commitment to a particular end. Watson (1999) in Kozier, Berman (2008) noted caring as a moral ideal in nursing whereby the

end is protection, enhancement and preservation of human dignity. As a moral imperative, human caring involve value, a will and a commitment to care, it also involves knowledge, caring actions and consequences. It is a fundamental value. Caring is the adherence to the commitment of maintaining the individual's dignity and integrity. Caring provides the basis for all nursing actions. The environment in which nurses work must facilitate and support caring.

Models of nursing that reflect this school of thought are: Roy's adaptation model, Neuman system model, Faye Clerin Asdellah 21 Nursing problems and Hydin Hall's core care cure model.

3. Caring as an affect

From the perspective of caring as an affect, the nurse is made to act selflessly without immediate gratification or expectation of material reward.

The nature of caring extends from emotional involvement with or an empathetic feeling for the patient experience. The term love is not commonly associated with professional care and yet, according to McMahon and Pearson, (1991) when love is used within the caring relationship, it has a therapeutic effect on the provider and receiver of care.

It is a response that is primarily focused on increasing intimacy between the nurse and the patient, which in turn enhances mutual self-actualization and consist of four developmental stages: attachment, assiduity, intimacy and confirmation. Affect reflect nursing as a female profession with historical root in religion.

One of the ten caritas process of Watson (2003) described caring as a practice of loving and kindness. Without affection (love) one cannot adequately be concerned with the affairs of another person.

Caring in nursing is an altruistic active expression of love. It is also the intentional and embodied recognition of value and connectedness. Unfortunately, the effectual nature of caring may be jeopardized or devalued in some situations. Constraint on nursing time, technological demands and unattractive patient characteristics may inhibit the development of a caring feeling toward the patient.

Models of nursing that reflect this school of thought are: Jean Watson human caring, M. Rogers theory of unity human beings and Dorothy Johnson behavioural system model.

4. Caring as a nurse – patient interpersonal relationship

Human beings are social beings and can not live in isolation. Caring is interactive, in that the strengths, abilities of the person who is cared for are as important as the skills of the person caring for him. Openness and capacity to respond to care on the part of the client is required. Caring is an interpersonal inter-subjective human experience of connection with a caregiver and client, a relationship that makes it safe for sharing oneself with another.

Caring encompass both feeling and the behaviour occurring within the relationship: - (i.e feeling) and content (behaviour) of caring include aspect as showing concern and health teaching. Caring requires attending to a particular client over time, determining what matters to the person. In caring practice, being with someone may be just as important as doing something for the person.

It is therefore necessary for the professional carer to develop a strong partnership approach with the patient and the patient's family so as to enhance the self-healing process that Watson (1985, p.44) contends increases self-knowledge, self-reference, self-healing, and self-care process while allowing increasing diversity. Humanistic approach to care perceives that interpersonal skills are more central to the caring concept than the physical or technical elements of care.

Models of nursing that reflect this school of thought are: Peplea interpersonal model, King's goal attainment theory and Roger's science of unitary human being and Jean Watson's theory of human caring.

5. Caring as a therapeutic intervention

By defining specific nursing interventions or therapeutics as caring, or by describing conditions as necessary for caring actions, these theorists have linked caring more directly than others to the work of nurses. Caring action may be specific e.g. listening, patient teaching, being there, and technical competencies or caring may include all nursing actions (i.e. all nursing procedures or interventions) that enables or assist patient. Adequate knowledge and skill as a basis for the caring is important. Patients determine what caring actions are, e.g. patient feel cared for when nurses treat them as individual, anticipate their needs, believe that nurses are available and confident.

Care differs according to different units: - Whereby different aspect of caring is being performed. The degree of caring given depends on units and needs of clients involved. Professional caring embodies cognitive deliberate goal, processes and acts, providing

assistance to others, expressing attitude and actions of concern for them in order to support their wellbeing, alleviate discomforts and meets obvious or anticipated needs. Models of nursing that reflect this school of thought are: Hinderson's definition of nursing, Orem's self care theory, Nightingale's environmental theory, Bethy Neuman system model, Leininger's theory of cultural care and Jean Watson's theory of human care.

Perception

Concept of perception

Perception (from the Latin perceptio, percipio) is the organization, identification, and interpretation of sensory information in order to represent and understand the environment. Perception is our sensory experience of the world around us and involves both the recognition of environmental stimuli and action. All perception involves signals in the nervous system, which in turn result from physical stimulation of the sense organs. For example, vision involves light striking the retinas of the eyes, smell is mediated by odor molecules and hearing involves pressure waves. Perception is not the passive receipt of these signals, but can be shaped by learning, and expectation. Perception depends on complex functions of the nervous system, but subjectively seems mostly effortless because this processing happens outside conscious awareness (wikipedia, the free encyclopedia).

The process of perception begins with an object in the real world, termed the distal stimulus or distal object. By means of light sound or another physical process, the object stimulates the body's sensory organs. These sensory organs transform the input energy into neural activity-a process called transduction. This new pattern of

neural activity is called the proximal stimulus. These neural signals are transmitted to the brain and processed. The resulting mental re-creation of the distal stimulus is the percept. Perception is sometimes described as the process of constructing mental representations of distal stimuli using the information available in proximal stimuli.

People go through the following process to form opinions:

1. When a perceiver encounters an unfamiliar target we are opened to different informational cues and want to learn more about the target (Free Merriam webster and free online Dictionary).
2. In the second step we try to collect more information about the target. Gradually, the encounter some familiar cues which helps us categorize the target.
3. At this stage the cues become less open and selective. We try to search for more cues that confirm the categorization of the target. At this stage we also actively ignore and even distort cues that violate our initial perceptions. Our perception becomes more selective and we finally paint a consistent picture of the target.

There are three components to perception:

1. The perceiver: the person who becomes aware about something and comes to a final understanding. There are three factors that can influence his or her perceptions: experience, motivational state and finally emotional state. In different motivational and emotional states, the perceiver will react to or perceive something in different ways. Also in different situations he or she might employ a "perpetual defence" where they tend to "use what they want to see".

2. The target: This is the person who is being perceived or judged. Ambiguity or lack of information about a target leads to a greater need for interpretation and addition.
3. The situation also greatly influences perceptions because different situations may call for additional information about the target.

Features of perception

Constancy: perceptual constancy is the ability of perceptual systems to recognize the same object from widely varying sensory inputs. Some kind of perceptual constancy is colour constancy, roughness constancy, melody, odor, brightness and words constancies. These constancies are not always total, but the variation in the percept is much less than the variation in the physical stimulus. The perceptual systems of the brain achieve perceptual constancy in a variety of ways, each specialized for the kind of information being processed.

Grouping: first proposed by Gestalt psychologist to explain how humans naturally perceive objects as organized patterns and objects. The principle of proximity states that, all else being equal, perception tends to group stimuli that are close together as part of the same object, and stimuli that are far apart as two separate objects. The principle of similarity states that, all else being equal, perception tends to seeing stimuli that physically resemble each other as part of the same object, and stimuli that are different as part of a different object.

The principle of **closure** refers to the mind's tendency to see complete figures or forms even if a picture is in complete overlap: when there is an intersection between two or more objects, people tend to perceive each as a single uninterrupted object. The principle of **common fate** groups stimuli together on the basis of their movement. The

principle of **good form** refers to the tendency to group together form of similar shape, pattern, colour etc. **contrast effects**. An object can be affected by qualities of context. Whether a piece of music is perceived as good or bad can depend on whether the music heard before it was unpleasant or pleasant. The contrast effect, John Locke, observed that lukewarm water can feel hot/cold, depending on whether the hand touching it was previously in hot or cold water. **Effect of experience**: with experiences, organisms can learn to make finer perceptual distinctions, and learn new kind of categorization. Wine-testing, the reading of x-ray images and music appreciation are applications of this process in the human sphere. **Effect of motivation and expectation**. A perceptual set, also called perceptual expecting or just is a predisposition to perceive things in a certain way. Perceptual sets occur in all the different senses. Set can be created by motivation and so can result in people interpreting ambiguous figures so that they see what they want to see. For instance, how someone perceived what unfolds during a sports game can be biased if they strongly support one of the teams. When someone has a reputation for being funny, an audience are more likely to find them amusing. The individual set reflect their own personality traits. For example, people with an aggressive personality are quicker to correctly identify aggressive words or situations. There is a great deal of feedback between perceptions and expectation (perceptual experiences often shape our beliefs, but those perceptions were based on existing beliefs).

Physiology of Sensory System

A sensory system is a part of the nervous system responsible for processing sensory information. A sensory system consist of sensory receptors, neural pathways, and part of the brain involved in sensory perceptions. Commonly recognized sensory systems are those for vision, hearing, somatic sensation (touch), taste and olfaction (smell).

Types are of sound, of speech, touch, taste other senses enable perception of body balance, acceleration, gravity, position of body parts, temperature, pain, time and perception of internal senses such as suffocation, gag reflex, intestinal distension, fullness of reaction and urinary bladder and sensations felt in the throat and lungs.

Social perception is part of perception that allows people to understand the individuals and groups of their social world, and thus an element of social cognition.

A number of factors operate to shape and sometimes distort perception. These can reside:

1. In the perceiver
2. In the object or target being perceived or
3. In the context of the situation in which the perception is made.

Characteristics of the perceiver: Several characteristics of the perceiver can affect perception. When an individual looks at a target and attempt to interpret what he or she stands for, that interpretation is heavily influenced by personal characteristic of the individual perceiver. The major characteristics of the perceiver influencing perception are: attitude, moods, motives, self-concept, cognition, expectations. Some specific characteristic of perceiver are: knowing oneself makes it easier to see others accurately, one's own characteristics affect the characteristics one is likely to see in others, people who accept themselves are more likely to be able to see favourable aspects of people, accuracy in perceiving others is not a single skill. These characteristics greatly influence how a person perceives others in his or her environmental situation.

Characteristics of the target: Characteristics of the target that is being observed can affect what is perceived. Physical appearance play a big role in our perception of others, motions, sound, size and other attributes, verbal communication from target also affects our perception of people. Non verbal conveys a great deal of information

about the target. The perceiver deceiver eye contact, facial expression, body movement and posture all in an attempt to form an impression of the target.

Characteristics of the situation: The situation in which the interaction between the perceived and the target take place has an influence on the perceiver's impression of the target. The strength of the situation cues also affects social perception. Some situation provide strong cues as to appropriate behaviour. In this situation, we assume that interval's behaviours can be accounted for the situation, and that it may not reflect the individual's disposition.

Factors affecting patient's perceptions

90% to 95% of factors affecting patient's perceptions is their demographics.

1. **Age:** The most consistent findings is that perception has been related to age. Older Patients seems to have higher perception.
2. **Ethnicity:** Studies that had looked at ethnicity have generally held that being a member of minority group is associated with lower rate of satisfaction. In a ranking of degree of satisfaction, non Hispanic white had the highest satisfaction, followed by African Americans. The lowest degree of satisfaction was found in Indians/Alaskan natives.
3. **Gender:** Studies on the effect of gender are contradictory with some studies showing that women tends to be less satisfied and others showing the opposite.
4. **Socio-economic status:** Most studies found that individuals with low socio-economic status and less education tend to be less satisfied with their health care. However, one study find that frequent visitors to a family practice had lower educational status, lower perceived quality of life, and higher anxiety

and depressing scores, and were more satisfied with their family nurse/physician. Other studies has shown low satisfaction with experiencing worry, depression, fear, or hopelessness, as in having psychiatric diagnosis like schizophrenia or depression.

5. **Health status:** Patients with chronic diseases such as diabetes and migraine have shown less satisfaction with their care especially when the situation is poorly controlled.

Patients with two or more chronic illness reported more hassles with the health care system than those with single chronic illness. In this study, when communication and coordination of care increased, the patient's perception of his/her illness decreased and satisfaction improved:

Nurses related features by improving the way nurses interact with patients the following features in the nurses affects perceptions in the patients:

1. Expectations: Nurses should take time and effort to elicit patient's expectation
2. Communication: The manner in which the nurse communicates with the patients verbal or none verbally influences patients's perceptions.
3. Control: Patient should be allowed to explain their ideas and not that nurses. should dominate. Encourage patients to express ideas, concern and expectations.
4. Decision making: Patients expressed a preference to nurses who recognized the importance of their social and mental functioning as much as their physical functioning.
5. Time spent: Time spent chatting. Nurses with high value practices were more efficient with their time but lower rates of patient's satisfaction, offered fewer preventive services and were as less sensitive in the nurse patient relationship.

6. Technical skills: several studies have looked at patients' assessment of their nurses' technical skill and the effect on satisfaction but the findings are contradictory communication skill were linked to higher satisfaction but technical expertise was not. However, another study found that when forced to make a trade-off, participants expressed a strong preference for nurses who have high technical skills. Patients also indicated that nurses' ability to make correct diagnosis and craft an effective treatment plan were more important than his or her bedside manner.
7. Appearance: Patients also appear to respond to a nurses' appearance. In addition, most patient wanted to be called by their first name, be introduced to the nurse by his full name and title, and see a name badge.
8. Experience (Previous experience): According to Venholt, Bragesto, Clinton and Sandell (2007), play a key role in object recognition and visual perception. Object visual perception is one sense of an individual's body that allows his or her brain to interpret what is seen. Object recognition is an individual's ability to recognize object and its physical properties. Experience shapes the object recognition and visual perception. An individual's brain guesses at what that individual sees based on his or her past experiences. Visual perceptions are hypotheses based on an individual's stored information and past experiences. Through experiences an individual can determine and understand what an object actual is, how it relate to him or her as far as its purpose, and determine how it relates to the world instead of perceiving the object for what it is not. Object recognition and visual perception differ from individual to individual based on previous past experiences. In a study that examined the influence of experience with psychiatric treatment in the perceived credibility of

psychodynamic cognitive and cognitive behavioural psychology study found that different form of psychotherapy appear to have their own market segment, the size of which varies depending on previous experiences of psychological distress and psychiatric treatment.

This was when three forms of psychotherapy were rated by three groups of subject with different levels of experiences of psychiatric treatment.

System related factors

Patient's satisfaction is not just a product of patient's demographics and nurse's skills, it is also affected by the system in which care is provided.

1. The clinical team: while the nurses' care was most influential to patient's satisfaction, the compassion, willingness to help, and promptness of the nursing/staff were next importance. In another large data-base surveys, nurses were the most important source of satisfaction, ahead of access-to-care issues.
2. **Referrals:** Effective referral play a role in patient satisfaction, one study looked at referrals from the standpoint by the family nurse, patients are more satisfied if it is their nurse that refer them and not they that initiated it.
3. **Community care:** Community care is one of the pillars of family nursing. Patients who reported being treated with dignity and who were involved in decisions were more satisfied and more adherent to their nurses' recommendation. When the nurse:
 - i. Treat patient with dignity and include them in decision making.
 - ii. Work with a team you can be proud of and invest in their ongoing development.

- iii. Elicit patient's concerns by asking questions such as "what do you think is going on?"
- iv. Dress semiformal attire and don't forget to smile.
- v. Lastly, while it may not be as easy, as the above lesions, find pleasure in what you do. Nurses who reported high professional satisfaction have patients who are more satisfied with their care.

Factors affecting Nurses' perception:

Dunn and Schmitz (2003) identified the following factors in the patients as affecting nurses' perceptions. These are bio-physical instability in the patient, psychosocial condition of the patient, support system of patient's family, staff issues, patients and family needs, individual personal factor of patients and organizations context.

1. Bio-physical instability, complex treatment regimens or isolation. Elliott (1997) and Clarke (1996) noted that patients placed in high dependency unit often required close observation and monitoring rather than direct intensive nursing interventions.
2. Psychosocial: Patients who are confused, dementia, disorientation, restlessness, aggression or lacking cooperation. Depression, unrelieved pain and anxiety. O'Connell (2008) contended that emphasis was placed on the physical aspects of care with scant appreciation of patient's psychosocial needs.

Family: Family support needs were readily identified as a common themes influencing nurses' perceptions of patients requiring high levels of nursing resources.

Staff issues, patients and family needs: Patients demand of nursing time and energy reduced when there was a high proportion of senior staff with knowledge, skill and expertise in the specialty areas.

Individual and personal factors: Example, family concerns, lack of sleep or personal role expectations influence perceptions.

Organizational context: There were comments reflecting nurses' perceptions not of the patient, family or staff, but of the organizational context in which the nursing care was delivered. Also, staff levels and support from other staff were often identified as factors important in the perception.

Nursing care: Ranges from simple to complex, encompassing physical, emotional, spiritual and intellectual labour. The nursing role carries with it responsibilities to patients and their families, the employer, the nursing profession and wider society, placing enormous and sometimes conflicting demands on the nurse providing direct patient care.

Nurses' structural variable: Such as level of education and hospital experience influence several aspects of national culture, moderates behaviour, supervision, promotion, pay, work conditions, the job itself, relationship at work, organizational commitment, educational level, years of experience and overall satisfaction.

Patient's appreciation of nurses Cooperation among staff as well as physician's respect towards nurses: Patients' recognition of nurses, influence their perception, feeling important in the eyes of others, realizing one's competence, freedom to make decisions, relationship with supervisors and colleagues, organizational policies, nature of the job, achievement, and commitment, a stable job and income, training, financial and non financial incentives, low salaries and difficult working conditions, well functioning systems, organizational culture and better working environment. All these variables inter-play to influence nurses' perception of nurse caring behaviours.

So also is the: organization or health institution, patients, colleagues, collaborators, environment and their general performance and outcomes too. Others include: high workload, emotional and ambiguous demand, uncertainty, varying level of knowledge and experience, patients' aggression, inability to provide appropriate patient care,

communication in the unit, floating between wards; conflicts with physician and other nurses, budgetary cuts and economic rationalization, insufficient time available, rapid staff turnover, nurses' own perceptions of their work and patients related workload issue, patients' characteristics, energy and time required from nurses to deal with patients' psychosocial needs, family needs, staff issues and organizational context competing for use of nursing resources also affect nurses perception.

Review of Theories Underlying the Study

Two theories were used to understudy this research: Theory of human caring by Watson and Leininger's theory of cultural care, as compiled by Mariner (1994).

1. Theory of human caring by Jean Watson

The theoretical framework being used for this study is a nursing theory known as the theory of Human Caring by Jean Watson.

Theoretical sources

Watson, in addition to traditional nursing knowledge and the works of Nightingale, Henderson, Krueter and Hall, acknowledges the work of Leininger and Gadow as background for her work. Included in this group are Maslow, Heidegger, Erikson, Segle and Lazarus. Watson attributes her emphasis on the interpersonal and transpersonal qualities of congruence, empathy, and warmth to the view of Carl Rogers who asserted that it is the client who knows what hurts and that the facilitator should allow the direction of the therapeutic process to come from the client (Watson, 1989). Yalom's 11 Curative Factors Stimulated Watson's thinking about the psychodynamic and human components that could apply to nursing and caring and, consequently, to her 10 curative factors in nursing. She also used empirical studies in an attempt to study the concept of caring. She used a human science, empirical

phenomenology, transcendent phenomenology and language in her latest work (Marriner, 1994).

Watson's Assumptions of Caring Behaviour

1. Human caring in nursing is not just an emotion, concern, attitude or benevolent desire, caring connotes personal response.
2. Caring is an inter subjective human process and is the moral ideal of nursing
3. Caring can be effectively demonstrated only interpersonally.
4. Effective caring promotes health and individual or family growth
5. Caring promotes health more than does curing.

The practice of caring integrates bio physical knowledge with knowledge of human behaviour to generate or promote health and to provide ministrations to those who are ill. A science of caring is therefore complementary to the science of curing.

6. Caring responses accept a person not only as they are now, but also for what the person may become
7. A caring environment offers the development of potential while allowing the person to choose the best action or the self at a given point in time.
8. Caring occasions involve action and choice by nurse and client. If the caring occasion is transpersonal, the limits of openness expand as do human capacities.
9. The most abstract characteristic of a caring person is that the person is somehow responsive to another person as a unique individual perceives the other's feelings, and sets one person apart from another.
10. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences.

11. The ideal and value of caring is a starting point, a stance, and all attitude that has to become a will, an intention, a commitment, and a conscious judgment that manifests itself in concrete acts.

Watson's assumption is that human care values include:

1. Care and love comprise the primal and universal psychic energy
2. Care and love, often over looked, are the cornerstones of our humanness, nourishment of these needs fulfills our humanity.
3. The ability to sustain the caring ideal and ideology in practice will affect the development of civilization and determine nursing contribution to society.
4. Caring for ourselves is prerequisite to caring for others
5. Historically, nursing has held a human-care and caring stance in regard to people with health illness concerns
6. Caring is the central unifying focus of nursing practice i the essence of nursing
7. Caring, at the human level, has been increasingly deemphasized in the health care delivery system.
8. Nursing's caring foundation has been sublimated by technological advancements and institutional constraints.
9. A significant issue for nursing today and in the future is the preservation and advancement of human care
10. Only through interpersonal relationships can human care be effectively demonstrated and practiced.
11. Nursing's social, moral, and scientific contributions to humankind and society lie in its commitments, practice and research.

Theoretical Assertions

According to Watson, nursing is interested in understanding health, illness and the human experience. Nursing is an interrelationship of quality of life including health, as well as the prolongation of life. She believes nursing is concerned with health promotion and restoration and illness prevention. Health, more than the absence of illness, is an illusive concept because of its subjective nature. Health refers to ñnity and harmony within the mind, body and soulò and is associated with the ñdegree of congruence between the self as perceived and the self as experiencedò (Watson, 1988). According to Watson, caring is a nursing term, representing the factors nurses use to deliver healthcare to clients. She states that by responding to others as unique individuals, the caring person perceives the feelings of the other and recognizes the uniqueness of the other. Using the 10 carative factors the nurse provides care to various clients and each carative factor describes the process of how a client attains, or maintains health or dies a peaceful death. Watson describes curing as a medical term referring to elimination of disease: she describes the basic premises of a science for nursing as caring (and nursing has existed) in every society.

The opportunities for nurses to obtain advanced education and engage in higher level analysis of problems and concerns in their education and practice have allowed nursing to combine its humanistic orientation with the relevant sciences.

Also the following components for the contract of human science theory development was added to her previous work.

Philosophy of human freedom, choice and responsibility

A biology and psychology of holism (non reducible) reducible persons interconnected with others and nature.

An epistemology that allows not only for empirics but also for advancement of esthetics, ethical values, intuition, and process discovery

An ontology of time and space

A context of inter human events, processes, and relationships

A science worldview that is open

A person's mind and emotions are windows to the soul

A person's body is confined in time and space, but the mind and soul are not confined, to the physical universe.

Access to a person's body, mind and soul is possible as long as the person is perceived as and treated as a whole. The spirit, inner self, or soul (giest) of a person exists in and for itself. People need each other in a caring, loving way. To find solutions it is necessary to find meanings. The totality of experience at any given moment constitutes a phenomenal field. The above are a reflection of the interpersonal transpersonal- spiritual aspect of her theory and it represents an integration of her beliefs and values about life, human science and human care Watson (1988). In this study, the theory is going to help me choose my variable of study. All the ten elements of caring are being used for the study.

It was chosen because of its ever evolving, well-developed framework, incorporating ten elements of caring which she termed "caring factors" (Kozier & Erb, 2008) now called clinical caritas process which are as follows:

1. Formation of humanistic – ultraistic system of values becomes: "practice of loving – kindness and equanimity within context of caring consciousness".

2. Instillation of faith ĩ hope, becomes: ñbeing authentically present, and enabling and sustaining the deep belief system and subjective life world of self and one ĩ being ĩ cared ĩ for.ò
3. Cultivation of sensitivity to one's self and others becomes: ñCultivation of one's own spiritual practices and transpersonal self, going beyond ego self.ò
4. Development of a helping ĩ trusting, human caring relationship, becomes: ñdeveloping and sustaining a helping ĩ trusting, authentic caring relationship.ò
5. Promotion and acceptance of the expression of positive and negative feelings, becomes: ñBeing present to, supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one ĩ being cared ĩ for.ò
6. Systematic use of carative problem-solving caring process, becomes, ñcreative use of self and all ways of knowing as part of the caring process; to engage in artistry of caring - healing practicesò.
7. Promotion of transpersonal teaching ĩ learning, becomes: ñengaging in genuine teaching ĩ learning experience that attends to unity of being and meaning attempting to stay within other's frame of reference.ò
8. Provision for a supportive, protective, and/or corrective mental, physical, social and spiritual environment, becomes: ñcreating healing environment at all levels (physical as well as non-physical), subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity and peace are potentiated.ò
9. Assistance with gratification of human needs, becomes: ñassisting with basic needs, with an intentional caring consciousness, administering ñhuman care essentialsò, which potentiate alignment of mind body spirit, wholeness, and

unity of being in all aspects of care. Tending to both embodied spirit and evolving spiritual emergence.

10. Allowance for existential ÷ phenomenological ÷ spiritual ÷ mysterious and existential dimensions of one's own life ÷ death: soul care for self and the one ÷ being ÷ cared ÷ for.

Watson's theory of caring incorporating the CBA tools has been the basis of several research studies looking at the patients perception of nurse caring behaviours. Those patients populations which have been studied include:

(a) Post ÷ myocardium infarction patients (b) Medical-Surgical patients (c) Post-Surgery patients, (d) Emergency department patients and (e) AIDS patients (f) obstetric patients (g) Long term care, assisted living patients and (h) hospitalized cardiac patients (Watson,2002). Watson's theory has a strong foundation of support from theorist from other disciplines and her theory of caring is widely accepted. However, the abstractness of the concept of caring does not allow for a clear instruction on how to form a caring relationship. However, because caring is so important to clinical practice continued research to help operationalize Watson's theory of caring is necessary. How it explains the concept under study:

The first element of the carative process is: formation of humanistic altruistic system of value, second: instillation of faith-hope, and third; cultivation of sensitivity to one's self and others. The first (1st) three (3) carative factors of Watson are combined to form the first (1st) subscale: Subscale I: Humanism/faith-hope sensitivity (**faith**), these are made of nursing activities such as: using soft and gentle voice with patient, really listen when patient talk and being kind and considerate to patient. The Forth (4th)

carative factor is development of a helping-trusting human caring relationship, becomes subscale 2, helping/trusting (**trusting**), which include nursing activities such as: treating patient information confidentially, paying special attention to patient during first time of hospital visit and know what they are doing. The fifth (5th) carative factor which is promotion and acceptance of the expression of positive and negative feelings (**Feelings**) form the Third (3rd) subscale: expression of positive/negative feelings that has the following nursing behaviours such as: talking with patient, encouraging patient to express feelings and including patient in planning patient care. The sixth (6th) carative factor: systematic use of carative problem solving caring process is combined with the ninth (9th) carative factor: Assistance with gratification of human needs form subscale 5: human needs assistance, (**Needs**) with nursing behaviours such as: encouraging the patient to call if he or she has problem, know how to give injections, iv, and giving patient treatments and medications on time.

The seventh (7th) carative factor: promotion of transpersonal teaching-learning formed subscale 4; teaching/learning (**Teaching**) include nursing behaviours as: giving patient information, checks his or her perceptions of the patient with the patient before initiating any action and telling the patient in an understandable language what is important to know about his or her disease and treatment.

The eighth (8th) carative factor provision for supportive, protective and/or corrective mental, physical, social and spiritual environment becomes subscale 6; supportive/protective/corrective environment (**Support**) has nursing behaviour such as: supporting patient, help patient not to feel dumb by giving him/her adequate information. The tenth (10th) carative factor; allowance for existential-phenomenological-spiritual-mysterious and existential dimensions of one's own life-

death becomes subscale 7: existential/phenomenological/spiritual forces (**Spiritual**) has nurse caring behaviours such as: forgiveness facilitation, praying for others and preparing patient for death when it is inevitable. This is the frame work of this study.

2. Madeiline Leininger's Cultural care Theory

Theoretical Sources for Theory Development

Leiningers theory is derived from the discipline of anthropology. She developed her theory of cultural care diversity and universality based on the belief that people of different cultures can inform and best determine most of the kind of care they desire or need from professioner caregivers. Use of empirical evidence: Leininger developed the ethnonursing method to specifically and systematically study nursing phenomena. Eth no nursing focuses on the systematic study and classification of nursing care beliefs, values and practices as cognitively or subjectively known by a designated culture (or cultural representatives) through their local language, experiences, beliefs, and value system about actual or potential nursing phenomena such as care, health, and environmental factors. She holds that caring behaviour and practices uniquely distinguish nursing from the contributions of other disciplines. To date, Leininger has studied several cultures in-dept and has studied appropriately 45 cultures with graduate students and faculty by using mainly qualitative ethnomethods. She has explicated 85 different care constructs in which care has different Linguistic meanings, cultural experiences, and uses by the people of diverse cultures and subcultures. She believes the goal of the care theory is to provide culturally congruent care.

Major Concepts and Definitions

Leininger has developed many terms relevant to the theory, but only a few major ones are defined here:

Care:- Care refers to ñphenomena related to assistive, supportive or enabling behaviour towards or for another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or life way.

Caring:- Caring refers to actions directed toward assisting, supporting or enabling another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition of life way.

Culture: Culture ñrefers to the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guides thinking, decisions, actions and patterned ways.

Cultural Care:- ñcultural care refers to the cognitively known values, beliefs and patterned expressions that assist, support or enable another individual or group to maintain wellbeing improve a human condition or life way or face death and disabilitiesò.

Cultural Value:- Cultural value refers to the highly desirable or preferred way of acting or knowing something that is often sustained by a culture over a period of time.

Culture Care Diversity: Culture Care Diversity refers to the variability of meanings, patterns, values or symbols of care that are culturally derived for health (well-being) or to improve a human condition, life way or to face death.

Cultural care Universality: Cultural care Universality refers to common, similar or uniform meanings, patterns, values or symbols of care that are culturally derived for health (well-being) or to improve a human condition life way or to face death.

Ethnocentrism: Ethnocentrism is the belief that one's own ideas, beliefs, and practices are superior to those of other cultures.

Cultural Imposition: Cultural Imposition refers to the tendency of health personnel to impose their beliefs, practices, and values upon another culture because they believe that their ideas are superior to those of the other group.

Cultural Care Preservation: Cultural Care preservation (or maintenance) refers to those culturally based assistive, facilitative, or enabling phenomena that help individuals preserve or maintain favourable health and caring life ways.

Cultural Care Accommodation: Cultural Care Accommodation (or negotiation) refers to those culturally based assistive, facilitative, or enabling phenomenon that reflect ways to adapt, negotiate or adjust.

Cultural Care Repatterning: Cultural Care Repatterning (or restructuring) refers to reconstructed or altered designs to help clients change health or life patterning that are meaningful to them.

Nursing: Leininger defines nursing as a learned humanistic art and science that focuses upon personalized (individual/group) care behaviours, functions, and process directed toward promoting and maintaining health behaviour or recovery from illness which have physical, psychocultural, and social significance or meaning for those being assisted generally by a professional nurse or one with similar role competencies.

Major Assumptions of Leininger's Cultural care Theory

- 1) Human caring is a universal phenomenon, but the expressions, processes, structural forms and patterns of caring vary among cultures.
- 2) Caring acts, and processes are essential for human birth, development, growth, survival, and peaceful death.

- 3) Caring is the essence of nursing and the distinct, dominant and unifying nature of nursing.
- 4) Care has a biophysical, cultural, psychological, social, and environmental dimension, and the concept of culture provides the broadest means to know and understand care.
- 5) Nursing is a transcultural phenomenon as nurses interact with clients, staff, and other groups and requires that nurses identify and use intercultural nurse-client and system data.
- 6) Care behaviours, goals, and functions vary transculturally because of the social structure, world view, and cultural values of people from different cultures.
- 7) Self and other care practices vary in different cultures and in different folk and professional care system.
- 8) The identification of universal and non universal folk and professional caring behaviours, beliefs and practices is essential to discover the epistemological and ontological bases of nursing care and knowledge.
- 9) Care is largely culturally derived and requires culturally based knowledge and skills for satisfying and efficacious nursing practices.
- 10) There can be no curing without caring, but there can be caring without curing.

Theoretical Assertions of Leininger's Cultural care Theory

1. Identifiable differences in caring values and behaviours between and among cultures lead to differences in the nursing care expectations of care-seekers.

2. Differences in caring values and norms of behaviour between technologically dependent and non-technologically dependent societies are area of comparative inquiry.
3. As professional nurses work in strange cultures with different values about nursing care or caring behaviour, there will be overt signs of cultural conflicts and problems.
4. The greater the dependence of nursing personnel on technological tasks and activities, the greater the signs of interpersonal distance and the fewer the client satisfactions.
5. Nursing care interventions that provide culture-specific caring practices to client will show positive signs of client satisfaction.
6. From the study of care, beliefs, values and practices, one can discover and predict signs of health or well-being of clients.
7. Cultures that highly value individualism with independence modes will show signs of self-care practices and values whereas cultures that do not value individualism with independence mode will show limited signs of self-care practices and more signs of other care practices.
8. Clients from different cultures can identify caring and non caring behaviours and attitudes of nurses.
9. Technological caring acts, techniques, and practices differ cross-culturally and have different outcomes for health and nursing care practices.
10. Symbolic forms and ritual functions by nursing care behaviour and practices have different meanings and outcomes in different cultures.

11. Political, religious, economic kingship, and cultural values and environmental contexts greatly influence human care and predict well-being of individuals, families and groups.
12. Clients in need of caring services tend to, seek first local (usually non professional caring persons, such as family members or friends), and only later seek professional caregivers if the client's condition is getting worse or if death is feared.
13. Ritualized ethnocaring activities that have therapeutic benefits to clients and their families tend to be largely unknown or are less valued by western professional nurses and physicians as therapeutic.
14. Cultures that emphasize caring behaviours and treatment processes tend to have more male carers than females.
15. Cultures that perceive illness to be largely a personal and internal body experience (i.e. caused by physical, genetic, and intrabody stresses) tend to use more technical and physical self-care methods (pills and physical technique) than cultures that view illness as an extrapersonal or cultural experience.

The relevance of this cultural theory to this work is as follows: This theory is cross-cultural so it will help in the understanding of the opinion, beliefs, values and meaning of caring from the various patients and nurses from various background that form the population of this study. Also, care has a bio-physical, cultural, psychological, social and environmental dimensions, and the concept of culture provides the broadest means to know and understand care hence the use of this cultural theory. Care is largely culturally derived and requires culturally based

knowledge and skills for satisfying and efficacious nursing practices. Clients from different cultures can identify caring and non caring behaviours and attitudes of nurses. This theory of cultural care diversity and universality is based on the belief that people of different cultures can inform and best determine most of the kind of care they desire or need from professional care-givers.

Conceptual/Theoretical model for the study

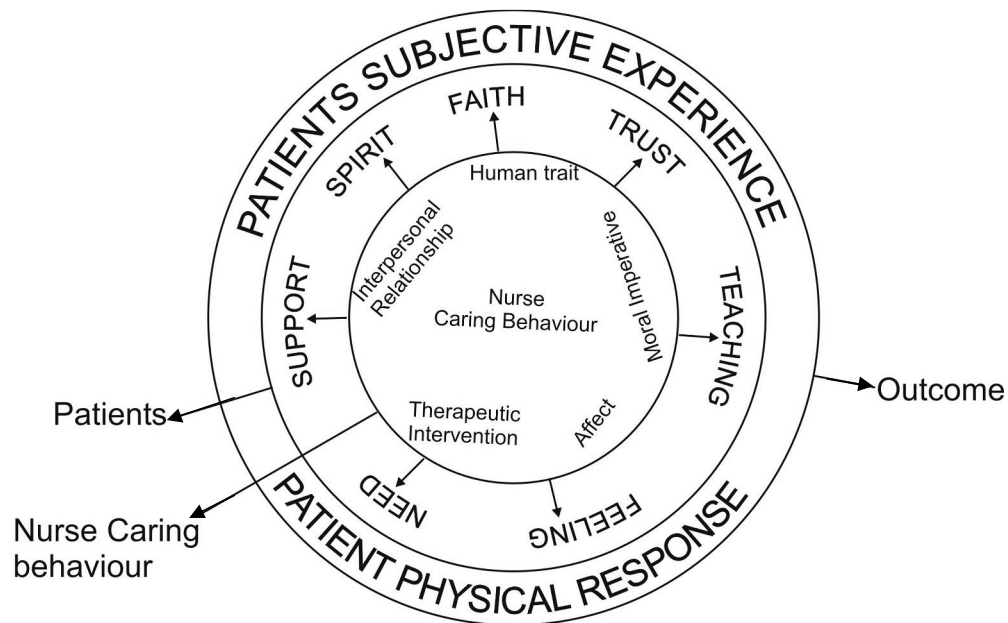


Fig. 2: Conceptual Model for the Study designed by the Researcher based on Watson's 10 Caring Factors and the Five Perspectives of Care.

Explanation of the model of the caring behaviour. When the nurse seeks to recognize, accurately detect and connect with the inner condition of spirit of another through genuine presence and being centered in the caring moment, actions, words, behaviours, cognitions, body language, feelings, thought, senses, the energy field, all contribute to transpersonal caring connection (Watson 2002). The nurse's ability to connect with another at this transpersonal spirit to spirit level is translated via movements, gestures, facial expressions, procedure, information, touch, sound, verbal expressions and other scientific, technical, aesthetic, and human means of

communication into nursing human arts acts or intentional caring-healing modalities. Nurse caring behaviour is action by nurses taken towards their patients to show empathy and this entails things they do or say or both using the five perspectives of caring: human trait, moral imperativeness, inter-personal relationship, affect and therapeutic intervention to positively influence their faith, trust, feelings, teaching, needs, support and spirit.

The outcome of the nurse caring behaviours is patients' subjective experience and physical response.

Empirical Review

The concept of caring has been nearly exclusively studied within the profession of nursing. These studies focused on caring behaviours as perceived by three main groups: patients, practicing nurses and comparison of patients and nurses ranking. In order to gain a better understanding of the concept of nurse caring behaviours, it is important that one review the literature for all the three groups. The following literature review is divided into patient perceptions, perceptions of practicing nurses and comparison of patients and nurses perceptions of nurse caring behaviours with their ranking and summary of reviewed literature.

Patients' and nurses' perception of nurse caring behaviours

Suwanakul (2011) carried out a descriptive research study on nurses and clients' perception of nurse caring behaviours in Virginia and reported as follow:

The descriptive research was designed to identify the nurses' and clients' perception of nurses' caring behaviours for patient in Raying Hospital. Purposive sampling was used to select 192 nurses and 374 clients. The instruments used to obtain data were

the caring behaviour questionnaires as perceived by nurses and clients which was developed by the researchers from 10 primary carative factors from Watson's theory of transpersonal caring. Data were collected during September to October 1998. Results of the study revealed that, the nurses' perception in caring behaviours were statistically significantly different ($p < .05$) in the overall and 8 carative factors, which the mean score of nurses' perception were higher than those of the clients. Only two factors; helping-trust relationship between nurses and patients, and provision for a supportive protective and corrective mental physical sociocultural and spiritual environment were not significant different ($p > .05$). In addition, the study showed that the mean score of registered nurses' perception was significantly higher than those of the technical nurses' and the mean score of nurses' perception in privacy wards was significantly higher than those of other nursing departments ($p > .05$), but the mean score of 21-25 years old and 1-5 years experience nurses' perception were significantly lower than the others. Whereas the clients' perception in medical nursing department was significantly lower than the others ($p > .001$), but there were not significant different ($p > .05$) of nurses' perception according to the differences of gender, age, income, and length of stay in hospital.

An extensive, detailed review was carried out on nursing caring behaviours by Papastavrou, Efstathiou, and Charalambous,(2011), titled Nurses' and patients' perceptions of caring behaviours: quantitative systematic review of comparative studies. Their report is presented below:

Significant differences were found between patients and nurses in their perception of caring and caring behaviours in many of the reviewed studies. The studies that used care-Q instrument revealed marked differences between nurses and patients in the

ranking of how important different nurse caring behaviours are considered to be. Patients appear to value the instrumental, technical caring skills more than nurses do, and perceive behaviours that demonstrate competency on how to perform nursing activities (‘know how’) as more important. On the other hand, nurses perceive their psychological skills and expressive or affective caring behaviour are more important than patients do, leading to the conclusion that nurses may misperceive the necessity of the emotional aspect of caring in comparison with patient judgments. These results, repeatedly reported in the research literature, indicate that nursing staff may not accurately assess patient perceptions of caring and that patient care is not congruent to the patients’ preferences, expectations, or individual needs. The Care-Q that is the most frequently used instrument ranked or organised caring behaviours in six subscales as follows: Accessible, Explains and Facilitates, Comforts, Anticipates, Trusting Relationship, and Monitors and Follows Through.

VonEessen & Sjöden, (1991; 1993; 1994, 1995 and 2000) reported significantly different nurse-patient perceptions of caring, something that is demonstrated both on analyses of the subscales as well as on the individual items. The mean values for Care-Q demonstrated that nurses assign a higher importance to ‘comfort, anticipates, and trusting relationships’ as significantly more important than the patients and they consistently rank the ‘Comfort’ dimension as their first priority. Patients have considered the subscale ‘Monitors and Follows Through’ to be of high importance. This ranking differs from dyadic studies in which this caring dimension is ranked lower by both nurse and patient group. The ‘Explains and Facilitates’ category is ranked high by patients and low by nurses in some studies, meaning that patients rate the information aspect as more important than nurses do and nurses stress the

emotional aspect more than the patients. These authors have challenged the nurse communicative behaviours that may result in superficial assessment skills and planning care on own assumptions.

Similar disparities are observed in the rating of items of the Care-Q and different perceptions were found in many of the items although both nurses and patients were quite diversified in selecting the most important items in terms of making them feel cared for. Patients chose more instrumental behaviours like “knows how to give shots, IVs, and manage equipment” while nurses choose more expressive behaviours like the item “listens to the patient” studies conducted in specialties of hematological malignancies reported a higher ranking of the “Monitors and Follows through” category among nurses and congruence with the patients’ ratings, in contrast to studies in which nurses gave a lower ranking to this specific subscale leading to the hypothesis that in areas of very advanced treatments, nurses also perceive their technical role as more important.

In contrast to the finding that patients rank physical care higher than nurses do in the study of psychiatric inpatients and staff, it was found that patients with 14 mental health problems consider the cognitive aspect of caring as the most important aspect is of care. A comparison of patients with somatic problems in the same study showed that somatic and psychiatric patients differ in their perception of caring behaviours, since the task-oriented aspect of caring was rated as more important from patients hospitalized in medical and surgical settings.

Moyle *et al.*, (2005) Analogous results were found with the use of other instruments with the exception of one that found no significant differences -between the patient

and nurses groups. However, the validity of this 3 later study is compromised by the very small sample (16 nurses and 31 residents) and there are concerns regarding patient samples drawn from old peoples' homes, mainly because of the difficulties in engaging in a Q sort procedure, and the high dependency of patients on nursing care and the feeling of obligation towards the nursing staff.

O'Connell & Landers (2008) another area of differentiation is the critical care settings, where a low ranking was given to caring subscales like a trusting relationship, expression of positive feelings, and existential feelings, suggesting that interpersonal nurse patient relationships may not be considered very important in this area of practice.

Eksrom (1999) Interestingly differences and similarities were also reported by the above researcher who found that patients' expectations regarding caring behaviours are higher when the nurse is a female and lower when the nurse is a male, leading to the assumption that gender stereotypes may affect perception of behaviour in others. This is the end of the quantitative systematic review of comparative studies of patients' and nurses' perceptions of caring behaviours.

Zamanzadeh, Azimzadeh, Rahmani & Valizadh (2010) studied oncology patients' and professional nurses' perceptions of important nurse caring behaviours. The aim was to determine the most important caring behaviour from patients' and nurses' perspective. The study used a comparative descriptive design. 200 patients and 40 nurses were conveniently recruited for the study from Iranian Oncology Centre. Instrument for data collection was caring assessment questionnaire developed by Larson (1981).

Caring behaviours (n=57) were ranked on a 5 likert type scale and ordered in six subscales. The finding show patients' ranking of the 10 most important caring behaviours and their comparison to nurses (n = 200).

1. "Giving the patients' treatments and medication on time" Rank 1 nurses' ranking also 1
2. "Know how to give shots, IV, etc and how to manage equipments like IVS, suction machines", etc rank 2 for both.
3. "Carry out therapeutic care carefully to make at least suffering to patients" ranked 3 and 6 for nurses
4. "Check on the patient frequently" rank 4 and 21 for nurses
5. "Is cheerful" ranked 5 but ranked 35 for nurses
6. "Is patient even with difficult patients" rank 6 and 25 for nurses
7. "Is well organized" ranked 7 but ranked 12 with nurses
8. "Is calm" ranked 8 the same rank (8) for nurses
9. "Gives a quick response to a patients' call ranked 9 but 15 for nurses
10. "Is perceptive of patients' needs and plans and acts accordingly rank 10 and ranked 9 by nurses.

Nurses' ranking of the 10 most important caring behaviours and their comparison to patients'

1. "Gives the patients' treatments and medication on time" 1 patient 1.
2. "Knows how to give shots, IVS etc and how to manage equipments like IVS, suction machines", etc 2 patients ranking 2.
3. "Treat with information of patients confidentially" 3 patients 13
4. "Know when to call the doctor" 4 patient 29.

5. ñIs professional in appearance, wears appropriate identifiable clothing and identificationò 5 patients 32.
6. ñCarry out therapeutic care carefully to make at least suffering for patientsò 6 patients 3.
7. ñTells the patients in understandable languageò 7 patients 21
8. ñIs calmò 8 patients 8
9. ñIs perceptive of the patients needs and plans and act accordinglyò 9 patients 10
10. ñAnticipate that the first time are the hardest and pays special attention to the patients during this timeò 10 patients 22.

The findings of the study show that patients and nurses agreed on 5 of the 10 most important items. The findings supported the Leininger's beliefs that asserted human caring is a universal phenomenon, but the expressions, processes and patterns vary among cultures. In summary, the findings of the study indicate that nurses do know their patients well enough to judge what aspects of caring the latter consider important in order to feel well cared for. It is time to listen to the patients's view and perspectives. Limitation of the study is small size of nurses to compare the two groups. Also convenience sampling for patients and nurses from two wards of one setting were used. Therefore the findings cannot be generalized to other oncology patients or institutes. Most patients pointed out that the many numbers instrument item (n = 57) needed lengthy time for completion. There is very high concordance between the nurses and patients perception of this sample.

Ayako, David, Keiko, Masayuki and Mieko, (2005) studied caring behaviours perceived by nurses in Japanese hospital using the CARE-Q-Japanese (Japanese version of care-Q) and target population was staff nurses and head nurses employed by the government working in Japan. The questionnaire was distributed to 602 Japanese nurses. The sample consisted predominantly of female (97.3%) and majority from nursing school (83.8%). The highest ranked item was "help the patient not to feel dumb by giving him or her adequate information" (mean 6.68, SD 0.58). The second highest ranked item was "listens to the patient" (mean 6.57, SD 0.63). The joint third highest ranking items were "gets to know the patients as an individual person" (mean 6.47, SD 0.78) and "talks to the patients" (mean 6.47, SD 0.73). The fifth ranked item was "knows how to give shots, IVs etc and how to manage the equipment like IV, suction machines etc" (mean 6.39 SD 0.84).

Japanese nurses perceived almost all the caring behaviours identified by CARE-Q-Japanese (Japanese version of care-Q) as important. "Listens to patients, helps the patient not to feel dumb by giving him/her adequate information" and "gets to know the patients as an individual person" were the top three items by both mean score and frequency. This result means that these three items are caring behaviours which Japanese nurses perceive as the most important. When educational background and most important items are correlated, the following items are ranked as the top three by all groups: "listen to the patients", "help the patients not to feel dumb by giving him/her adequate information" and "gets to know the patients as an individual person" become increasingly important for those with the highest qualifications. Japanese nurses' perception of important caring behaviour was affected greatly by educational background. Nurses who have a bachelor's, master's or doctoral degree perceived

knowing the individual as more important than those who graduated only from nursing schools.

Nurses ranked the least important behaviour as 'asked the patient what name he/she prefers to be called'. Limitation of the study is that the research was conducted only in one hospital. 45 of the 50 items were perceived as being important by nurses. It may be that the concept of caring is an integrated concept which is hard to divide into subsets.

Studies that used Care Behaviour Assessment (CBA) Tool

Kimble, (2003) in a non-experimental research study on 'patients' perceptions of nurse caring behaviours' in an emergency department used Cronin and Harison Care Assessment Behaviour Questionnaires to collect data from 59 patients. The caring behaviours assessment instrument is a 63 item questionnaire and used 4 point Likert-type summation scale. The design was a prospective descriptive study using an anonymous questionnaire survey. The setting for the study was a 'not-for-profit teaching hospital in USA. A non-probability convenience sample of fifty-nine patients was asked to participate.

A cronbach alpha coefficient was computed for each of the seven subscales and results indicated a range of = .73-89. The subscale: Human Needs Assistance ($\alpha = .89$) had the highest rank level of nursing behaviours and the subscale teaching/learning ($\alpha = .73$) had the lowest rank level of nursing behaviours. A comparison of the means between the subscales indicated that human need assistance subscale ($m = 4.54$, $SD = .66$) was perceived by the participants as being the most important set of behaviours by the nurse that compelled a sense of caring towards the patient in the emergency

department environment. A comparison of the mean scores for each item on the questionnaire indicated 'be kind and considerate' ($m = 4.81$, $SD, .48$) and 'Treat me as an individual' ($m = 4.77$, $SD = .777$) were the highest ranked specific nursing behaviours.

These highest ranked specific nursing behaviours were part of the Humanism/faith-hope/sensitivity subscale that was ranked second overall in importance of behaviours by the nurse to convey a sense of caring to the patient. Listed in subsequent order of importance the other single item behaviours perceived by the patient to indicate a sense of caring by the nurse included:

1. 'Answer my questions clearly'
2. 'Know what they are doing'
3. 'Know how to handle equipment'
4. 'Know how to give shots, IVs etc'
5. 'Really listen when I talk'
6. 'Give my pain medication when I need it' and
7. 'Keep my family informed of my progress'.

A comparison of the mean scores for each item indicated 'visit me if I move to another hospital unit' ($m = 2.32$, $SD = 1.35$) and 'Touch me when I need it for comfort' ($M = 2.86$, $SD = 1.40$) are the lowest ranked items for nurse caring behaviours by the patient. Each of these items were part of the items in helping/trusting subscale which was ranked fifth in importance overall. These findings indicate that regardless of the patient's age or their perception of severity of illness parents and patients alike share the same perception regarding which nursing behaviour are most

indicative of the sense of caring. The lack of correlations between the subscale and the socio-demographic variable demonstrate the versatility of using the CBA tool in various research population. The implication for this study is that new graduates and experienced staff are taught during workshop on how to relay a sense of caring to the patient in today's hectic emergency department environment. The information can be given to staff in practice area in order to enhance the way they provide care to the patient. The result enhance research in the concept of caring as well as the patient's expectations of the nursing staff. This study used only patients.

Schultz, Bridgham, Smith and Higgins (1998) conducted an exploratory comparative survey examining the perception of nurse caring behaviours of the hospitalized long-term ante partum patient and the short stay postpartum patient. The purpose of the study was to identify differences between the groups regarding what nurse caring behaviours were most and least important. The caring behaviours assessment tool was the instrument used for this study.

Computation of mean scores and standard deviations for each item showed no statistically significant differences in total mean scores between the groups. Individual item scores ranged from means of 2.29-4.9. There was no significant correlation between the total score for the CBA and age, year of education, parity, or gravida of the respondents. The subscale scores also showed no significant difference between the groups and items in the Human Needs Assistance subscale ranked highest as seen in previous studies. The researchers in this study suggested that since items in this subscale reflected the nurses' level knowledge; patient may equate caring with competence. Items in the existential/phenomenological/spiritual group ranked the

lowest for both groups. Limitation to the study included use of a small sample size and the length of the CBA tool.

Dorsey, Phillips, and Williams (2001) conducted a descriptive correlational study to explore differences in adult patient's perceptions of nurse caring behaviours between a group of patients with Sickle Cell Disease (SCD) and a group of patient with general medical conditions. They also examined the differences of perceptions of nurse caring behaviours between men with Sickle-Cell Disease (SCD) and women with SCD in South Carolina. A modified version of the Caring Behaviours Assessment tool (CBA) was used.

Adults with SCD reported a lower perception of nurses' caring behaviours than adults with other medical conditions. The mean score calculated for females with SCD was 216 (SD = 44) and the mean score calculated for males with SCD was 262.7 (SD = 34.3). Men with SCD reported a greater perception of nurses' caring behaviours than women with SCD. Limitations to the study includes a small sample size (SCD sample 29 and general medical condition sample consisted of 34), inability of the patient to distinguish nurses from other healthcare providers such as nurse aids, and participants' responses were retrospective of previous admissions.

Baldursdotir and Jonsdotir (2002), conducted a non-experimental, descriptive study to explore patients' perceptions of caring behaviours received in an emergency department environment. The purpose of the study was to identify which nurse caring behaviours are identified as important indicators of caring to the patient. A sample of one hundred and eighty two returned the questionnaire out of the 300 patients. The results showed women's scores were significantly higher than men's score in all

subscales except humanism/faith-hope/sensitivity and expression of positive/negative feelings. Kruskal–Wallis one-way analysis of variance on the subscales in relation to age, education level, and perception of illness showed that age (older people) rated nurse caring behaviour as more important. People with low educational level scored higher on the subscales of (a) Human Need Assistance, (b) Teaching/learning, (c) Humanism/Faith–Hope/sensitivity, and (d) expression of positive/negative feelings. The single most important item from the patients’ perception was ‘know what they are doing’.

Limitations to the study included using only one hospital to collect data, use of a convenience sample, and absence of data from those patients who were too ill and were admitted to the hospital.

Huggins, Gandy and Kohut (1993) conducted a descriptive non-experimental study attempted to replicate Cronin and Harrison’s study in Southern United States. Results of the study were consistent with Cronin and Harrison’s findings. The highest ranked subscale across all triage designations that was the most important indicator of nurse caring was labeled human needs assistance. The subscale consist of items that reflect the technical competency of the nurse. Interestingly the non-urgent group of patients listed more nurse caring behaviours as ‘must have’ than both the urgent and emergent group. This result indicates that the least ill patients have the highest expectations of nurses for their care. Limitations to this study included inability to generalize the results to other patient populations outside the ED setting. Also, the time interval from the ED experience to data collection may have affected the result because it was as long as 30 days before the data collection.

Marini (1999) conducted a non experimental, descriptive study to explore patients' perceptions of caring behaviours at two long term care communities.

The purpose of the study was to identify which behaviours performed by the nursing staff were important indicators of caring to the older adult patients. Mean scores and standard deviations were calculated for each item on the questionnaire and result ranged from 4.57 for the most important item "knowing what they are doing" to 2.76 "talk to me about my life before coming to the facility". Overall item mean scores for each of the seven subscales were calculated and the highest ranked scale was "Human Needs Assistance", which consisted of items such as "know when it is necessary to call the doctor" and "check me very closely". Limitations of the study include a small sample size and long length of the instrument.

Patistea and Siamanta (1999) published a literature review of patients' perception of caring compared with nurses' perceptions of caring. The literature review presented shows that whereas nurse clinicians focus on the psychosocial aspects of caring, patients assign the highest value to technical skills and professional competence. Similarly to patients, a small proportion of nurses view competent clinical expertise as the fundamental component of caring. Non caring behaviours included physical and emotional absence, belittling and inhumane actions, and a lack of recognition of a patient's uniqueness. Patients' participation in decisions regarding their care may or may not have been an element of caring interaction. From this literature review, the authors conclude that caring meanings and behaviours are context specific and suggest that nurse clinicians should determine caring needs and actions in the context of practice.

Practicing Nurses' Perceptions of Caring

Arthur, (1999) survey a total of 1,957 registered nurses from 11 countries. The purpose of the study was to compare and contrast the responses of a large international sample of nurses with regard to caring, professional self-concept and technological influences. Overall, the findings revealed that the nurses sampled in this study believed in creating a sense of trust and developing a confident relationship between nurses and patients based on truth and respect. The relationship should allow the patient to express feelings and nurse should listen to and pay attention to the patient. The sample expressed the importance of feeling concern, not avoiding and the importance of involving the patient in their care. In terms of caring attributes, all respondents scored greater than 3, the arbitrary mid-point of the caring continuum.

Dyson (1996) completed a pilot study in which she investigated nurses' conceptualization of caring. After grid data were analysed, nurse common themes were identified. These nine themes were: consideration and sensitivity, giving of self, work style, motivation, communication and meeting needs, knowledge and learning, individual approach, general approach, and honesty and sincerity. The findings of this study largely supported the concept that caring is a combination of what the nurse does and what the nurse is like as a person. The results from this study highlighted some of the key elements in nurses' conceptualizations of care. These largely supported the findings of previous studies, with the emphasis on the humanistic and psychosocial components of care.

Hegedus (1999) examined providers' and Consumers' perspectives of nurses' caring behaviours. The purpose of her study was to develop and test a scale designed to examine nurses' caring behaviours.

She reported on a pilot study conducted with a convenience sample of 42 nurses (providers) and 39 patients (consumers) in two community hospitals in the New England Region. There was a significant difference between the providers and the consumers in the ranking of nine of the 20 items. The consumers valued behaviours that recognized their individual perspective as well as that of their family and behaviours that helped them anticipate and prepare for change. The providers placed a greater emphasis on the behaviours that were more geared towards the comforting aspects of care by encouraging patients to express and vent their feelings. The findings of this study might allow clinicians to be sensitized to their caring behaviours by increasing their realization of how behaviours are perceived by patients.

Brunton and Beaman (2000) explored nurse practitioners' perspective of their own caring behaviours, the relations between socio-demographics variables, environmental factors, and nurse practitioners' perceptions of their caring behaviours of 40 caring behaviours. Were measured using a reversed caring Behaviours inventory (CBI). The inventory assessed five dimensions of caring: Courteous regard, investment in others' needs, readiness to help, knowledge and skill, and appreciation of others' perspective. After the data was analysed, the top ten caring behaviours, in rank order: were appreciating the patient as human being, showing respect for the patient, being sensitive to the patient, talking with the patients, treating patient information confidentially, treating patient as an individual, encouraging the patient to call when

in problem, being honest with the patient, and listening attentively to the patient. The authors maintained that caring is nurses' hidden work that may go unrecognized, except when the caring behaviours are missed by the patients or their families.

Summary and analysis of empirical review

Major findings: there are areas of agreement between nurses and patients perceptions; but there were also discrepancies in patients and nurses' perception (Zamanzadeh *et al.*, 2010). Since caring is culture based, the concept of caring from this population (Jos) need to be ascertained since it is absent from these literatures studied. The absence of literature on this topic from Jos, North central Nigeria is what this study seeks to provide.

The dearth of literature on this issue in Nigeria has in addition prompted the desire for this study.

Summary of Reviewed Literature

Conceptual review of the concept of caring behaviour shows that caring was categorized into five: Caring as human trait, caring as moral imperative or ideal, caring as affect, caring as an inter-personal relationship and caring as an intervention. The theory of human caring by Jean Watson and Leininger's cultural care diversity and universality were the theories underlying the study and were reviewed because they informed the choice of variables to the study. Empirical review on concept of nurse caring behaviour as perceived by patients and nurse were extensive covered various populations of patients and nurses; used different tools, and in different countries, with large and small samples and sampling procedure. However, non of the studies were report from Nigeria and Jos in particular.

CHAPTER THREE

RESEARCH METHOD

This chapter presents the methods used for the study such as the research design, area of study, population of study, sample/sampling procedure, instrument for data collection and so forth.

Research Design

The study adopted a descriptive, cross sectional survey design, and made comparative analysis of nurse caring behaviours that patients and nurses perceived to be indicators of caring in Jos University Teaching Hospital and Plateau State Specialist Hospital, Jos. The reason for the use of this design was to bring out the underlying features, characteristics, trends and relationships inherent in the body of the data Burns and Grove, (2005) noted that descriptive surveys are designed to describe specific phenomenon or to find relationships among variables as they occur at of the time of study.

Area of Study

Jos:

Jos is the area of study. It is the capital of Plateau State, the twentieth largest state of Nigeria and is roughly located in the centre of the country. Jos is located in the North. Central geo-political zone of Nigeria and is one of the 6 states that make up the zone. Jos is bounded by Toro Local Government Area of Bauchi State to the southwest, Taraba state to the Southeast, Saminka Local Government Area of Kaduna state to the North. Jos is made up Jos North, Jos South and Tudun Wada Local Government Area. It is located between latitude $8^{\circ} 32'$ and $10^{\circ} 38'$ East. The altitude ranges from around 1,200 metres (about 400 feet) to a peak of 1,829 metres above sea level in the Sherill-hills range Jos. It has a population size of two (2) million people. Jos is a

metropolitan city. The Northern part is predominantly inhabited by Hausas, who are mostly Muslims, while the southern parts are inhabited by the Natives and are majorly Christians. The capital is a mixture of many Nigerian ethnic groups but majorly Hausas, the natives: Briom, Angas, Jarawas, Miangos etc, the Ibos, Yorubas and a reasonable number of whites and people of diverse culture, walks of life, age groups, occupation, (civil servant businessmen and traders) religion and educational qualifications. The common language of Jos is Hausa, English, Angas and Miango. The slogan of Jos, Plateau State is "Home of peace and tourism". The capital is full of rocks and a presence of a big dam called "lamingo dam" on the way to JUTH. Tertiary institutions in Jos include: University of Jos a Federal Institution, Federal School of forestry, all located along Bauchi Road, Jos and Plateau State polytechnic Pariki-Ladin, Jos Campus. There are also numerous banks such as First Bank of Nigeria Plc University of Jos branch, Market Branch. The major market in Jos is "Terminal Market". There are numerous banks in this "terminal" area. It is called terminal because the rail line from Port Harcourt through Enugu terminated at that point. The Governor's office and Lounge was formally in Ray-field (a residential area for the affluence) but has now been relocated to Jishe, near "Hill station Hotel", Tudun Wada, Local Government Area, Jos. As a city centre and commercial area, movement (transport) constitute some problems especially around the morning hours and closing hours when almost all children, adolescent, young adults and adults leave and return from schools and work, usually witness an out-surge of commuters (especially work days i.e. Monday to Friday). During hot season, the temperature is usually 30°C and during cold season, it can drop to as low as 18°C, so all throughout the year (seasons) Jos is cold. There are three (3) tertiary hospitals in the city: Jos University Teaching Hospital, Plateau State Specialist Hospital and Bingham

University Teaching Hospital (ECWA Evangel Hospital). Only the first two (2) hospitals are being used for this present study.

Jos University Teaching Hospital

This Federal Tertiary Health Institution was formally located at the centre of the town but has been relocated to its permanent site at Lamingo, on the skirts of the town, it is meant for research, teaching and service provision. The hospital has 601 bed capacity and nurses of various specialties, educational qualifications and various levels of cadre. The hospital has various units such as out patients department, Emergency department, medical wards, surgical wards, paediatric wards, intensive care units, all for males and females. Nurses of different cadres and specialties work in these various units. The hospital receives referrals for surgical and other health problems from neighbouring states such as Nasarawa, Benue, Taraba, Adamawa, Gombe, Bauchi and Kaduna. The institution was chosen because of large patient turn out, nurses that have various years of professional experiences, educational qualifications and availability of various units/wards.

Plateau State Specialist Hospital Jos

This state hospital was established in 1933. It is the referral centre for all the state owned health institutions. It is located at the central area of Jos Metropolis. The hospital has 201 adult beds spaces and ten wards: (one) surgical ward, (two) medical wards, (three) paediatric wards, amenity, labour, maternity, emergency paediatric unit and intensive care unit. The hospital has good functional laboratory, theatre and radiological unit. There are nurses of various experiences, qualifications, and cadres in her cadres in her employment and as a referral centre, attends to large number of medical and surgical patients.

Population of the Study

Jos University Teaching Hospital (JUTH) admits an average of 500 patients per month and has 501 nurses in her payroll. **(Source: hospital statistics/records).**

Likewise, Plateau State Specialist Hospital (PSSH) attends to an average of 222 in-patients per month while the nurses in her payroll are 201 in number (Hospital records).

However, the present study is limited to patients and nurses in medical and surgical wards/units only. There are nine (9) medical and surgical wards in JUTH.

An estimated number of 336 patients were admitted in these wards per month at JUTH. There are three (3) medical and surgical wards in PSSH and an estimated number of 96 patients were admitted in these wards per month. The total number of in-patients in the two hospitals per month are 432. This constitutes the target population for patients. As regards the number of nurses in these wards, there were 134 nurses in the 9 medical and surgical wards in JUTH and 44 nurses in the 3 medical and surgical wards at PSSH. This gave a total of 178 nurses in the two hospitals and this constitute the target population for nurses for the study. The target population for the present study therefore comprised 610 which constituted of 432 patients and 178 nurses (please see Table 1).

Table 1: Distribution of Patients and Nurses in Medical and Surgical Wards in the Two Hospitals

Hospital	Wards	No of Beds	Estimate of in-patients per ward	Number of nurses
JUTH	Male medical 1	34	54	15
	Male Medical II	34	37	15
	Male surgical	34	57	15
	Male Orthopedic	32	18	15
	Female Medical I	32	38	15
	Female Medical II	32	23	15
	Female Surgical/Orthopedic	34	43	14
	APIN ward (Male Medical)	32	26	15
	APIN ward (Female Medical)	32	40	15
	Total	296	336	134
PSSH	Male Medical	32	38	14
	Female Medical	32	30	15
	Surgical Ward (Male and Female)	32	28	15
	Total	96	96	44
	Grand Total	392	432	178

Subjects for Study

The total number of 610 subjects which comprised of 432 patients and 178 nurses were included for the study because of the following reasons. The total number of 432 patients were included for the study because only patients who can read, write and speak English language were used for the study because the questionnaire was written in English language. The patients have different local languages such as Hausa, Birom, Angas, Jarawa, Igbo, etc; and therefore the questionnaire cannot possibly be translated into all these local languages. Hence the decision to include all the 432 patients so that an adequate sample size could be obtained after the questionnaire had been administered to patients who were literate. In addition this is

to take care of patients who met the inclusion criteria but were discharged during the period of data collection before data could be collected from them. Patients who were admitted during the data collection period who had not stayed in the wards up to 5 days were not studied. Also the number of nurses (178) is small so all the nurses were included in the study.

Sample Procedure

No sampling procedure was employed to select the respondents since the total population of nurses and patients (610) were all included in the study.

Inclusion Criteria

- a) Patient: Willingness to participate in the study
- b) Literate Patients who can read, speak understand and write in English language.
- c) Patients who have been on admission not less than 5 days before data collection in the ward. This is to enable the patients form their opinion or perception about nurse caring behaviour.
- d) Must be adults aged 18 years and above.
- e) Patients who have not undergone surgical operation at time of data collection.
- f) Patient who are not in severe physical or emotional distress.
- g) Ability (physically or mentally) to complete the questionnaire

Nurses:

- a) Willingness to participate in the study.
- b) Nurses that have worked in the wards for at least one (1) year.
- c) Only nurses working in medical or surgical ward of JUTH or PSSH.
- d) Nurses who are available at time of data collection

Instrument for Data Collection

The instrument that was used for data collection was the Caring Behaviour Assessment (CBA) tool developed by Cronin and Harrison in 1987. Cronin and Harrison were the first to develop an instrument that they named Care Behaviour Assessment Tool, which was based on Watson's theory and that reflects Watson's 10 Carative factors.

The CBA is a 63 item questionnaire on caring behaviour indicators that was designed on a 5 point Likert-type scale and organized in 7 subscales.

The sub-scales include: Humanism/faith-hope sensitivity (faith); Helping/trusting (Trusting); Expression of positive/negative feeling (feeling); Teaching/learning (Teaching); Supportive/protective/corrective environment (support); Human needs assessment (Need); and Existential/phenomenological/spiritual forces (spirit)

The instrument consists of 3 Sections, A, B and C. Section A is on demographic characteristics of the respondents. Section B contains 62 items on caring behaviour indicators while Section C contains the last question number 63 which was an open ended question asking respondents "what else could the nurse do to make you feel cared for".

The authors of CBA tool established face and content validity for the instrument by using four (4) content specialists who were conversant with Watson's human caring theory. The interrater validity was reported to be $\kappa = 0.75$. The internal consistency reliability was determined by using the study responses to calculate the Cronbach alpha for the instrument and for each of the seven sub-scales which ranged from 0.66 to 0.90. Other researchers who used the instrument had high validity and reliability indices of the instrument which include: Dorsey, Philips and Williams (2001) alpha = 0.58 to 0.94; Baldursdottir and Jonsdottir (2002) $\kappa = .69$ to $.89$; Kimble (2003) Cronbach Coefficient alpha = 0.66 to 0.90; and O'Connell and Landers (2008) $\kappa = 0.88$.

The adapted CBA instrument used to collect data for the present study has only 37 items instead of 63 in the original instrument. The reason for this is that the long length of the 63 items creates "response burden" on the respondents. As a result the number of items were reduced to 37 to make it more respondent (patient) friendly and also for cultural reasons. Also Kimble (2003), Schultz, Bigham, Smith and Higgins (1998), and O'Connell and Landes (2008) commented on this issue.

The adapted CBA tool used in the present study has Sections A and B. Section A contains items on demographic profile of the respondents. Section B contains 37 items on caring behaviour indicators arranged in 7 sub-scales namely:

Humanism/faith-hope sensitivity (faith) (9 items) Helping/trusting (Trust) (9 items) expression of positive/negative feelings (feelings) (3 items); Teaching/learning (Teaching) (3 items); Supportive/protective/corrective (Support) (2 items); Human needs assistance (needs) (8 items); and existential/phenomenological/spiritual forces (Spirit (3 items).

The CBA 37 items are scored on a 5 point Likert-type scale ranging from undecided (0), strongly disagree (1), disagree (2), agree (3), and strongly agree (4). There are no negatively worded items so responses on all items are summed to give a total scale score ranging from zero (0) to 148, with a scale mean of 2.5. An item mean score above the scale mean (2.5) means a high or good indicator of caring behaviour.

Validity

Although the validity and reliability of the CBA tool have been well established, there is need to determine its validity and reliability in Nigeria, which is a different culture from where it was originally developed and used. This is also necessary since some part of the items have been removed for the presented study.

Face validity was determined through the judgment of the project supervisor and other two senior lecturers in the Department of Nursing Sciences, UNEC. Their suggestions were effected thus reducing the items from 63 to 37.

Reliability of the Instrument

The final draft of the CBA tool was administered to 40 respondents (20 patients and 20 nurses) once in a Pilot Study at Bingham University Hospital (ECWA, Evangel) Jos. The data generated were used to establish the internal consistency of the instrument using Crombach Alpha. The reliability coefficient for each of the 7 subscales and the overall reliability coefficient for the entire scale are presented on Table 2 below:

Table 2: Reliability Index (Cronbach's Alpha) of the CBA tool

Subscale	Internal consistency reliability Cronbach's Alpha	Computed correlation with entire scale	No of Item
Humanism/faith-hope sensitivity	.88	.85	9
Helping/trusting	.86	.88	9
Expression of positive/negative feelings	.67	.74	3
Teaching/Learning	.62	.80	3
Human Needs assistance	.86	.76	8
Supportive/protective/corrective/environment	.31	.55	2
Existential/phenomelological /spiritual forces	.74	.62	3
Overall Scale	.95	.	37

The internal consistency reliability estimate for the entire scale (37 items) was Cronbach's Alpha = .95 (Table 2 above). The internal consistency reliability estimate for the components (subscales) were as follows: Humanism/faith-hope sensitivity .88, Helping/Trusting .86, Expression of positive/Negative feelings. .67, Teaching/Learning .62, Human Needs Assistance .86, Supportive/Protective/corrective/Environment .31, and Existential/Phenomenological/Spiritual force .74. The correlations of the subscales with the entire scale were as follows: Humanism / Faith-hope Sensitivity .85, helping / Trusting .88, Expression of Positive/Negative feelings .74, Teaching /Learning .80, Human Needs Assistance .76, Supportive/protective/Corrective/Environment .55, and Existential/ Phenomenological /Spiritual Forces .62. This showed that the instrument was reliable and was therefore appropriate for the present study.

Ethical Consideration

With an introductory letter from the department of nursing sciences, (see Appendix 1) an application for permission to carry out the research was written to the Chairman, research, ethical committee of the Jos University Teaching Hospital (JUTH) and Plateau State Specialist Hospital, Jos, for ethical Board Review and permission to conduct the research in their facilities which was granted after the proposal defence (See Appendices II and III)

From the Department of Nursing services in each of the two hospitals, permission for access to the patients and nurses for data collection were obtained (see Appendix IV) Prior to administering the questionnaire, individual informed consent of patients and nurses were obtained in writing (see Appendix V and VI) as patients and nurses were required to fill the informed consent form attached to the questionnaire considering those who met the inclusion criteria.

Procedure for Data Collection

Prior to data collection, initial visits were made to each hospital by the researcher and the 4 research assistants. These visits provided the forum for introduction and the establishing rapport between the researcher and the nurses.

Four (4) research assistants were recruited from undergraduate nursing students of Department of Nursing Science of the University of Jos. They accompanied the researcher during the initial familiarization visits to the hospitals to enable them get acquainted with the environments.

They were trained on ways of maintaining good inter-personal relationship with the respondents, the purpose and benefit of the study to the patients that it was to improve patient care, patients were not to be coerced or forced into participating but be allowed to decide voluntarily. Confidentiality were to be ensured in the handling of all patients's information.

Following the health ethical research clearance/approvals, permission was obtained from the assistant directors of nursing services, and from nurses in-charge of the wards in the two hospitals. The patients and nurses were approached for participation in the research study.

In each of the ward, patients were addressed collectively wards are long and open during which time the objectives, benefits and the part they are to play in participating in the study were explained to them. Patients were told that only those who are able to speak and understand English and could write in their responses will participate in the study. Eligible respondents were approached individually with an explanation of the study purpose and objectives. All respondents were assured of anonymity and confidentiality. The CBA tool was administered to all the eligible patients and nurses who met the inclusion criteria in a ward the same day. Some patients and nurses completed their questionnaires and returned them the same day. Others took some time (days) to complete and return their questionnaires.

The administration of the questionnaire in each ward was between 10am and 5pm. Data collection was done on daily basis from Monday to Friday. Questions from the respondents were answered as needed. Data collection lasted for 12 weeks from 3rd June to 23rd August, 2012. At the end of data collection, all respondents were thanked for their cooperation in completing the questionnaire.

Method of Data Analysis

The quantitative data generated were subjected to data analysis using Statistical Package for Social Sciences (SPSS.v.16), software for both descriptive and inferential statistical analyses. Descriptive statistics including frequencies and percentages were used in analysing Socio-demographic characteristics of respondents. Data were analyzed item by item and standard deviations and student t-test were used to summarize the data. The decision rule was weighted mean of 2.50 because it was a five (5) points likert scale with the following rankings: 4, 3, 2, 1, 0. Items with mean scores above 2.5 were accepted as indicators of caring behaviour while item means below 2.5 were seen as poor indicator of caring behaviour. The data was analysed item by item to indicate the means and standard deviations of each item on a 5 point likert-scale. The means and standard deviations were extracted and presented in Tables which answered the research questions. The means was used in determining patients' and nurses' ranking of most and least important nurse caring behaviour statements. Student t-test was used in testing the significance of analyses. To test the hypothesis, a one-way Analysis of Variance was performed on the mean scores for the comparison of patients' and nurses' mean scores on the CBA. Hypothesis was tested at .05 level of significance ($\alpha = .05$). The results of all analyses were presented in Tables.

CHAPTER FOUR

PRESENTATION OF RESULTS

One hundred and ninety six (196) questionnaires were administered to the patients. 189 were retrieved but only 167 were properly completed and that is 85.2% return rate. Nurses returned 169 out of the 172 questionnaires administered but only 165 copies were completed appropriately and that gives a 95.9% return rate.

All data, except data on demographic characteristics, were collected at interval level of measurement using a five points Likert type scale ranging from strongly agree (4), agree (3), disagree (2), strongly disagree (1), and undecided (0). Data were analysed using both descriptive (e.g. frequencies, percentages, means and standard deviations) and inferential statistics (e.g. one sample t-test and analysis of variance (ANOVA). Results of data analyses are presented below according to the objectives and hypothesis set for the study.

Socio-demographic profile of the respondents.

Table 2: Demographic characteristics of respondents

n = 332

Variables	Patients (n = 167)		Nurses (n = 165)	
	f	%	f	%
Sex:				
Male	79	47.3	39	23.6
Female	88	52.7	126	76.4
Age:				
18-30	55	32.9	57	34.5
31-40	67	40.1	48	29.1
41-50	28	16.8	34	20.6
51 and above	17	10.2	26	15.8
Mean	35.43 ± 10.03		36.74 ± 11.30	
Religion:				
Christianity	130	77.8	159	96.4
Islam	37	22.2	6	3.6
Patients Educational Qualification:				
No formal education	15	9.0	-	-
Primary	29	17.4	-	-
Secondary	74	44.3	-	-
Tertiary	49	29.3	-	-
Nurses Professional Education:				
Diploma	-	-	120	72.7
Degree	-	-	45	27.3
Patients' Occupation:				
Trading	59	35.3	-	-
Farming	29	17.4	-	-
Artisan	8	4.8	-	-
Student	17	10.2	-	-
Civil Servant	54	32.3	-	-
Nurses' Professional Experience:				
1-10 years	-	-	56	33.9
11-20 years	-	-	47	28.5
21-30 years	-	-	44	26.7
31 years and above	-	-	18	10.9
Severity of illness (as perceived by patients):				
Mild	21	12.6	-	-
Moderate	80	47.9	-	-
Severe	66	39.5	-	-

Mean age for patients is 35.43 ($\pm$ 10.03) years and mean age for nurses is 36.74 ($\pm$ 11.30) years. The data presented on Table 2 above shows that majority of the patients 88(52.7%) were females while 79(47.3%) were males. Similarly, majority of the nurses were females 126(76.4%) while only 39(23.6%) were males. Majority of patients 122(73.05%) and of nurses 105(63.64%) were within the age range of 18-40 years and with a mean age of 35.43($\pm$ 10.03) and 36.74 ($\pm$ 11.30) years for patients and nurses respectively. More than three quarters 130(77.5%) of patients and almost all nurses 159(96.4%) except 6(3.6%) were Christians. Majority 74(44.3%) of patients had secondary education while 49(29.3%) had tertiary education and only 15(9.0%) had no formal education. As regards occupation, majority 59(35.3%) of patients were traders and a similar number 54(32.3%) were civil servants.

Majority 80(47.9%) of patients perceived their illness as moderate in severity, while 66(39.5%) saw their illness as severe, however, 21(12.6%) perceived their illness as mild. A little above two thirds 120 (72.7%) of nurses had diploma in nursing while only 45(27.3%) had university degree in nursing. About one third 56(33.9%) of nurses had between 1-10 years work experience, 47(28.5%) had worked between 11-20 years and 44(26.7%) had worked between 21-30 years, while 18(10.9%) had up to 31 and above years of work experience.

Objective 1:

To determine caring behaviours statements that patients perceived as indicators of care

To realize this objective data collected from 167 patients were analysed item by-item using descriptive statistics to indicate the mean scores of patients to each item with

corresponding standard deviation, in each subscale on a 5-points scale in which an item mean of 2.5 and above is regarded as indicator of care while an item mean below 2.5 is regarded as poor indicator of care. In addition, one sample t-test was computed for each item to establish the acceptability or otherwise of each item as indicator of care. The patients' total mean score on the CBAQ was 120.04 (SD = 22.53). Comparisons of the seven sub-scales on patients' perceptions of nurse caring behaviour, each with a different number of items, was facilitated by the use of mean derived by dividing the total mean of each sub-scale by the number of items in that sub-scale. The means and standard deviations of each sub-scale, and the item means of the 37 caring behaviour statements are presented in Tables 3 and 4 respectively (see Table 4 in Appendix VII).

Table 3: Mean scores and standard deviations of patients' perceptions of nurse caring behaviours n = 167

Sub-scales	No of items	Observed Mean	SD	Mean criteria	t value	Decision
Humanism/faith-hope sensitivity	9	30.28	6.11	22.50	16.46	Accepted
Helping/trusting	9	28.95	5.84	22.50	14.28	Accepted
Expression of positive/negative feelings	3	9.53	2.33	7.50	11.26	Accepted
Teaching/learning	3	9.40	2.63	7.50	9.36	Accepted
Human needs assistant	8	26.64	5.69	20.00	15.09	Accepted
Supportive/protective/corrective environment	2	6.31	1.88	5.00	8.98	Accepted
Existential/phenomenological/spiritual forces	3	8.93	3.13	7.50	5.91	Accepted
Patients' total mean response on CBAQ items	37	120.04	22.53	92.50	15.80	Accepted

The data on Table 3 above shows the mean scores and standard deviations for each sub-scale together with the t-values. The result shows that all sub-scales were accepted as indicators of care. The three highest scored subscales were humanism/faith-hope sensitivity (mean = 30.28; SD = 6.11), helping/trusting (mean = 28.95, SD = 5.84); human needs assistance, ñ(mean = 26.64; SD = 5.69). The three lowest scored sub-scales were supportive/protective/corrective environment (mean = 6.31, SD = 1.88); existential/phenomenological/spiritual forces (mean = 8.93; SD = 3.13); and teaching/learning (mean = 9.40; SD = 2.63).

The data on Table 4 (placed in Appendix VII) showed that the patients' item means of the 37 CBA caring behaviour statements ranged from 2.63 (SD = 1.33) to 3.52 (SD = 0.70). The t-values (t-observed) for all the items (except item 17) were significantly higher than the mean criterion value of 2.50, $p \leq 0.05$. The result indicated that all the 37 caring behaviour statements, except item 17 (ñvisiting patient if patient moves to another hospital unit' with item mean of 2.63; SD = 1.33 and t-value of 1.24 which is below the mean criterion value of 2.50) were accepted as indicators of care by patients. The 10 highest and 10 lowest scored nurse caring behaviour statements, together with their means, standard deviations and numerical rankings are presented in tables 5 and 6 respectively.

Objective two: To determine the most and least important nurse caring behaviours as perceived by patients.

Table 5: The 10 highest scored caring behaviour statements by patients with their ranking.

n = 167

Sub-scale	Items	Mean	SD	Rank
Humanism/faith-hope sensitivity	Using soft gentle voice with patients	3.52	0.70	1
	Being cheerful with patient	3.41	0.82	7
	Being kind and considerate to patient	3.50	0.74	2
	Really listen when patient talks	3.40	0.94	8
Helping/trusting	Answering patient's question clearly	3.46	0.75	3
	Being honest with patient	3.36	0.93	9
	Paying special attention to patient during first times	3.43	0.71	5
Human needs assistance	Encouraging patient to call if he or she has problem	3.36	0.85	10
	Knowing how to give injection, IV's, etc	3.43	0.93	6
	Giving patient treatments and medication on time	3.46	0.83	4

$P < 0.05$

The highest scored items by patients were from the three sub-scales of humanism/faith-hope sensitivity (four out of nine items), helping/trusting (three out of nine items), and human needs assistance (three out of eight items). The mean values of these 10 items, ranged from 3.36 to 3.52 (SD = 0.85-0.70). The findings that "using soft gentle voice with patients", "Being kind and considerate to patients" and "answering patient's questions clearly" were the three highest scored items. Rank 3, 4, 9, and 10 were based on non-approximated values of the means. Thus rank 3 has the mean of 3.4641, rank 4 = 3.4571, rank 9 = 3.3615 and rank 10 = 3.3592.

Table 6: The 10 lowest scored caring behaviour statements by patients with their ranking.

n = 167

Sub-scales	Items	Mean	SD	Rank
Helping/Trusting	Touch patient when patient needs it for comfort	3.13	1.14	7
	Visiting patient if patient moves to another hospital unit	2.63	1.33	1
	Is professional in appearance, wears appropriate identifiable clothing and identification	3.09	1.05	6
Expression of Positive/Negative/Feelings	Include patient in planning patient care	3.02	1.14	5
Teaching/Learning	Giving patient information so that patient can make decision	3.16	1.04	9
	Checks his or her perception of the patient with the patient before initiating any action	2.96	1.14	4
Supportive/Protective/Corrective/Environment	Supporting patient	3.16	1.14	10
	Helping the patient not to feel dumb by giving him or her adequate information	3.14	1.03	8
Existential/Phenomenological/Spiritual Forces	Praying with and or for patient	2.94	1.20	3
	Preparing patient for death when it is inevitable	2.80	1.47	2

The 10 lowest scored items were derived from five sub-scales of helping/trusting (three out of nine items), expression of positive/negative feelings (one out of three items), teaching/learning (two out of three item), supportive/protective/corrective environment (two out of two items), and existential/phenomenological/spiritual forces (two out of three items). The means of these 10 items ranged from 2.63 to 3.16 (SD =

1.33 to 1.14). The findings that 'visiting patient if patient moves to another hospital unit', 'preparing patient for death when it is inevitable', 'praying with and or for patient', and 'checks his or her perception of the patient with the patient before initiating any action' were the four lowest scored items. Rank 9 and 10 were based on non-approximated values of the means. Thus rank 9 has the mean 3.1572 and rank 10 = 3.1602. (See Table 6). All the 10 items indicated the least important caring behaviours items to patients.

Objective Three: To determine nurse caring behaviour statements that nurses perceive as indicators of care

To realize this objective, data generated from nurses were analysed item-by-item using descriptive statistics to compute the mean response of the nurses to each item statement in each sub-scale on a 5 point scale in which an item mean of 2.5 and above is regarded as indicator of care while an item mean below 2.5 is regarded as poor indicator of care (Appendix VIII).

The nurses' total mean score on the CBAQ was 125.80 (SD = 22.23). Comparisons of the seven sub-scales on nurses' perceptions of nurse caring behaviour, each with a different number of items, was done by the use of an adjusted means derived by dividing each sub-scale total by the number of items in that sub-scale. The means and standard deviations for each sub-scale and the item means of the 37 nurse caring behaviour statement are presented in the Tables 7 and 8 respectively.

Table 7: Mean scores and standard deviations for nurses perceptions of nurse caring behaviour.

n = 165

Sub-scales	No of items	Observed Mean	SD	Mean criteria	t value	Decision
Humanism/faith-hope sensitivity	9	31.25	4.14	22.50	27.13	Accepted
Helping/trusting	9	30.17	4.23	22.50	23.31	Accepted
Expression of positive/negative feelings	3	10.19	1.81	7.50	19.04	Accepted
Teaching/learning	3	9.98	1.71	7.50	18.55	Accepted
Human needs assistant	8	27.61	3.86	20.00	25.35	Accepted
Supportive/protective/corrective environment	2	6.70	1.27	5.00	17.16	Accepted
Existential/phenomenological /spiritual forces	3	9.93	1.87	7.50	16.18	Accepted
Nurses total mean response on CBAQ items	37	125.83	22.33	92.50	28.18	Accepted

Key: P < .05

The result presented on Table 7 show the mean scores and standard deviations for each sub-scales together with their t-values. The result revealed that all sub-scales were accepted as indicators of care. The three highest scored sub-scales were humanism/faith-hope sensitivity (mean = 31.25 SD = 4.14); helping/trusting (mean = 30.17; SD = 4.23), and human needs assistant (mean = 27.61; SD = 3.86). The three lowest scored sub-scales (by nurses) were supportive/protective/corrective environment (mean = 6.70, SD = 1.27), existential/phenomenological/spiritual forces (mean = 3.93; SD = 1.87), and teaching/learning, (mean = 9.98; SD = 1.71).

Table 8: Nurses' means scores, standard deviations and t-values for the 37 items of the CBAQ

The data presented here (see Table 8 in Appendix 10) shows that the nurses' item mean scores for the 37 nurse caring behaviour statements ranged from 2.62 (SD = 0.90) to 3.66 (SD = 0.55). The t-values for all the item (except item 17) were significantly higher than the t critical value of 2.50, $p < 0.05$. The result is indicative that all the caring behaviour statements, except item 17 (visiting patient if patient moves to another hospital unit), with item mean of 2.62; SD = 0.90; and t-observed value of 1.69 which is below the mean criterion of 2.50) were accepted as indicators of care by nurses. The 10 highest and 10 lowest scored nurse caring behaviour statements, together with their means, standard deviations and numerical rankings are presented in Tables 9 and 10 respectively.

Objective four: To determine the most and least important nurse caring behaviours as perceived by nurses.

Table 9: The 10 highest scored caring behaviour statements by nurses with their ranking

n = 165

Sub-scales	Items	Mean	SD	Rank
Humanism/faith-hope sensitivity	Using soft gentle voice with patient	3.59	0.61	3
	Being cheerful with patient	3.55	0.69	7
	Being kind and considerate to patient	3.54	0.66	9
	Showing patient love	3.59	0.60	4
	Treating patient with respect	3.59	0.72	5
Helping/Trusting	Get to know (treat) the patient as an individual	3.54	0.61	10
	Answering patient's questions clearly	3.55	0.69	8
	Being honest with patient	3.56	0.63	6
	Treating patient's information confidentially	3.62	0.78	2
Human Need Assistance	Giving patient treatments and medications on time	3.66	0.55	1

P < .05

The 10 highest scored items by nurses were from the three sub-scales of humanism/faith-hope sensitivity (five out of nine items); helping/trusting (three out of nine items, helping/trusting (one out of nine) and human needs assistance (one out of eight items). The means of these 10 items ranged from 3.54 to 3.66 (SD = 0.61-0.55). The findings that "giving patient treatments and medications on time", "treating patients information confidentially", "using soft gentle voice with patient", were the three highest scored items. Ranks 3, 4, 5, 7, 8, 9 and 10 were based on non-

approximated value of the means. Thus rank 3 has the mean of 3.5885, 4 = 3.5866, while rank 5 = 3.5854, rank 7 = 3.5542, rank 8 = 3.5562 rank 9 = 3.5432 and rank 10 = 3.5384. All the 10 items indicated the most important nurse caring behaviours to nurses.

**Table 10: The 10 lowest scored caring behaviour statements by nurses
with their ranking**

n = 165

Sub-scales	Items	Mean	SD	Rank
Humanism/faith-hope sensitivity	Is calm	3.10	1.15	2
	Know what they are doing	3.24	0.96	6
Helping/Trusting	Helping patient plan ways to meet goals	3.31	0.92	9
	Touching patient when patient needs it for comfort	3.21	0.89	5
	Visit patient if patient moves to another hospital unit.	2.62	0.90	1
Teaching/Learning	Checks his or her perception of the patient with the patient before initiating any action	3.19	0.74	4
Human needs assistant	Being patient and tireless with patient	3.24	0.83	7
	Checks on the patient frequently	3.26	0.81	8
Supportive/protective/corrective environment	Help the patient not to feel dumb by giving him or her adequate information	3.31	0.70	10
Existential/phenomenological/ spiritual forces	Preparing patient for death when it is inevitable	3.18	0.95	3

The 10 lowest scored item statements were derived from the six sub-scales of humanism/faith-hope sensitivity (two out of nine items), helping trusting (three out of nine items), expressions of positive/negative feeling (one out of three items), teaching/learning (one out of three items), human needs assistant (one out of eight items), supportive/protective/corrective environment (one out of two items), and existential/phenomenological/spiritual forces (two out of three items). The means of these 10 items ranged from 2.62 to 3.31 (SD = 0.90 ÷ 0.70). The findings that "visit patient if patient moves to another hospital unit", "is calm", and "preparing patient for death when it is inevitable" were the three lowest scored items (see Table 10). All the 10 items indicated the least important indicators of care to nurses based on their items means. The item means of the 37 nurses caring behaviour statements with their standard deviations are presented in Appendix 10. Rank 6 and 7 were based on non-approximated values of the means, thus rank 6 has the mean of 3.2363 and rank 7 = 3.2447.

Objectives Five: To determine if differences exist in the nurse caring behaviour statements that patients and nurses perceive as indicators of care

Sub-Scale Analysis

The mean scores and standard deviations for each of the CBAQ seven subscales were computed for the patients and nurses' groups. The sub-scale means scores ranged from 6.31 (SD = 1.88) to 30.28 (SD = 6.11) for patients and 6.70 (SD = 1.27) to 31.25 (4.14) for nurses. The ranking of the seven sub-scales in order of importance from patients and nurses groups are presented in Table 11.

Table 11: Mean scores and Standard Deviation of Patients and Nurses on CBAQ subscales in rank order and their comparison

CBAQ Subscales	Patients (n = 167)			Nurses (n = 165)		
	Mean	SD	Rank	Mean	SD	Rank
Humanism/Faith-Hope Sensitivity (9 items)	30.28	6.11	1	31.25	4.14	1
Helping / Trusting (9 items)	28.95	5.84	2	30.17	4.23	2
Human Needs Assistance (8 items)	26.64	5.69	3	27.61	3.86	3
Expression of Positive/Negative Feelings (3 items)	9.53	2.33	4	10.19	1.81	4
Teaching/Learning (3 items)	9.40	2.63	5	9.98	1.71	5
Existential / Phenomenological Spiritual Forces (3 items)	8.93	3.13	6	9.93	1.87	6
Supportive/Protective/Corrective Environment (2 items)	6.31	1.88	7	6.70	1.27	7
Total Response on CBAQ subscales (37 items)	120.04	22.53	-	125.83	15.18	-

The result on Table 11 showed that patients and nurses perceived "Humanism/Faith-hope sensitivity", "Helping/trusting", and "Human needs assistance" as the most important and "Existential/phenomenological/Spiritual forces", "Supportive/Protective/corrective environment" as the least important subscales. The result also shows that each of the seven CBAQ subscales attracted same ranking from patients and nurses. The mean scores however showed that nurses gave higher mean values than did patients to all the seven subscales. This indicates that nurses to a greater extent than patients gave higher mean scores to subscale items. This also indicates that nurses consider several CBAQ dimensions to be of a very high importance. The

total mean scores on the CBAQ for nurses was 125.83 (SD = 22.33) and 120.04 (SD = 15.18) for patients.

Item analysis

Mean score were computed for each of the 37 CBAQ items for patients and nurses. The maximum possible score for each item was 4 and the minimum was zero (0). Mean scores for items ranged from 2.63 to 3.52 for patients and 2.62 to 3.66 for nurses. Nurses had higher mean score values for 31 (83.78%) items on the CBAQ than the patients who scored higher than nurses in only 5 (13.51%) items namely: "is calm", "Know what they are doing", "Know how to give injections, IVc. Etc", "Being patient and tireless with patients", and "Visit patient" if patient moves to another hospital unit. The 10 highest scored items for the patients and for nurses with their rankings and comparisons are presented on Tables 12 and 13.

Table 12: Patients' ranking of the 10 most important Nurse caring Behaviour Statements and their comparison to Nurses (n=167).

CBAQ Items	Subscales *	Patients			Nurses		
		Mean	SD	Ranking	Mean	SD	Ranking
1. Using soft gentle voice with patient	HFS	3.52	0.07	1	3.59	0.61	3
3. Being kind and considerate	HFS	3.50	0.74	2	3.54	0.66	9
11. Answering patients question clearly	HT	3.46	0.75	3	3.55	0.69	8
28. Giving patient treatments and medications on time	HNA	3.46	0.83	4	3.66	0.55	1
15. Paying special attention to patient during first times (such as hospitalization and/ or treatment.	HT	3.43	0.71	5	3.47	0.73	17
26. Know how to give injection, IVôS, etc.	HNA	3.43	0.93	6	3.35	0.96	24
2. Being cheerful with patient.	HFS	3.41	0.82	7	3.55	0.69	7
6. Really listen when patient talks.	HFS	3.40	0.94	8	3.52	0.79	13
12. Being honest with patient	HT	3.36	0.93	9	3.56	0.63	6
25. Encouraging patient to call if he or she has problem	HNA	3.36	0.85	10	3.52	0.64	14

***HFS = Humanism/faith-hope sensitivity, HT = Helping / Trusting; HNA = Human Needs Assistances.**

Table 13: Nurses Rankings of the 10 most important caring behaviour statements and their comparisons to patients (n = 165)

CBA-Q Items	Subscales *	Nurses			Patients		
		Mean	SD	Ranking	Mean	SD	Ranking
28. Giving patient treatments and medications on time.	HNA	3.66	0.55	1	3.46	0.83	4
14. Treating patient's information confidentially.	HT	3.62	0.78	2	3.35	1.01	12
1. using soft gentle voice with patient	HFS	3.59	0.61	3	3.52	0.70	1
4. showing patient love	HFS	3.59	0.60	4	3.34	0.93	11
5. Treating patient with respect	HFS	3.59	0.72	5	3.33	0.87	14
12. Being honest with patient.	HT	3.56	0.63	6	3.36	0.93	10
2. Being cheerful with patient	HFS	3.55	0.69	7	3.41	0.82	7
11. Answering patient's question clearly	HT	3.55	0.69	8	3.46	0.75	3
3. Being kind and considerate.	HFS	3.54	0.66	9	3.50	0.74	2
7. Get to know (treat) the patient as an individual.	HFS	3.54	0.61	10	3.30	0.92	17

* HNS = Human Needs Assistance, HT = Helping/Trusting; HFS = Humanism/Faith-hope Sensitivity

A comparison of these top 10 CBAQ items between patients and nurses perception revealed similarities as well as differences. Patients and nurses agreed on 6 out of 10 most important items. These six items were ranked among the top 10 by both patients and nurses and they include: "Using soft gentle voice with patient", "Being cheerful with patient", "Being kind and considerate", "Answering patients questions clearly", "Being honest with patient", and "Giving patient treatments and medications on time". (See Tables 11-12). Item 2 on the CBA-Q "Being cheerful with patient" was ranked same by both patients and nurses. These results demonstrated a basic harmony between the two groups with respect to the priorities of care. Patients and nurses do not agree on the remaining 4 top 10 caring behaviours items (See Tables 12-13).

The results also indicated that nurses more than patients value the subscale, "Humanism/ Faith-hope sensitivity" while patients value the subscale, "Human needs

assistance more than nurses. In total, nurses score higher in 31 (83.78%) items than patients who scored higher than nurse in only 5 (13.5%) items. A comparison of the 10 least important caring behaviours between patients and nurses was made and the result is presented in Table 13 and 14.

Table 14: Patients Rankings of the 10 least important caring behaviours and the comparison to nurses
(n=167)

CBA-Q Items	Subscales *	Patients (n=167)			Nurses (n=165)		
		Mean	SD	Ranking	Mean	SD	Ranking
17 Visit patient when patient moves to another hospital unit.	HT	2.63	1.33	1	2.62	0.90	1
37 Preparing patient for death when it is inevitable	EPSF	2.80	1.47	2	3.18	0.95	3
36 Praying with and or for patient.	EPSF	2.94	1.20	3	3.42	0.72	21
23 Checks his or her perception of the patient before initiating any action.	TL	2.96	1.14	4	3.19	0.72	4
21 Including patient in planning patient care.	EPNF	3.02	1.14	5	3.33	0.86	11
18 Is professional in appearance, wears appropriate identifiable clothing and identification.	HT	3.07	1.05	6	3.55	1.02	23
16 Touch patient when patient need it for comfort.	HT	3.13	1.14	7	3.21	0.85	5
34 Help the patient not to feel dumb by giving him or her adequate information.	SPCE	3.14	1.03	8	3.31	0.70	30
22 Giving patient information so that patients can make decision	TL	3.16	1.04	9	3.34	0.72	25.
33 Supporting patient	SPCE	3.16	1.14	10	3.39	0.74	22

* HT = Helping/Trusting, EPSF = Existential/Phenomenological/Spiritual forces, TL = Teaching/Learning, EBNF = Expression of Positive /Negative Feeling, SPCE = Supportive/Protective/Corrective Environment.

Table 15: Nurses rankings of the 10 least important caring behaviour and the comparison to patients

(n = 165)

CBAQ Items	Subscales *	Nurses (n = 165)			Patients (n=167)		
		Mean	SD	Rank	Mean	SD	Rank
17 Visit Patient if Patient moves to another hospital unit.	HT	2.62	0.90	1	2.63	1.33	1
8 Is calm	HFS	3.10	1.15	2	3.23	1.06	24
37 Preparing patient for death when it is inevitable	EPSF	3.18	0.95	3	2.80	1.47	2
23 Checks his or her perception of the patient with the patient before initiating any action.	TL	3.19	0.74	4	2.96	1.14	4
16 Touch patient when patient needs it for comfort	HT	3.21	0.89	5	3.13	1.14	7
9 Know what they are doing	HFS	3.24	0.96	6	3.25	1.09	22
30 Being patient and tireless with patient	HNA	3.24	0.83	7	3.36	1.07	21
32 Check on the patient frequently	HNA	3.26	0.81	8	3.26	1.07	20
13 Helping patient plan ways to meet goals.	HT	3.31	0.92	9	3.22	1.03	25
30 Helping the patient not to feel dumb by giving him or her adequate information.	SPCE	3.31	0.70	10	3.14	1.03	8

* HT = Helping/Trusting, HFS = Humanism/faith-hope sensitivity, EPSF = Existential/phenomenological/Spiritual forces, TL = Teaching/Learning, HNA = Human needs assistance, SPCE = supportive/protective/corrective environment.

A comparison of the 10 least important CBAQ items as presented in Table 13-14 also showed some similarities as well as differences. Patients and nurses agree on 5 out of the 10 least important items. These 5 items were ranked among the bottom 10 (least important) by both patients and nurses and they include, "Visiting patient when patient moves to another hospital unit", "Preparing patient for death when it is inevitable", "Checks his or her perception of the patient with the patient before initiating any action", "Touch patient when patient needs it for comfort", and "Helping the patient not to feel dumb by giving him or her adequate information" (see Table 14 i 15). Items 17 and 23 on the CBAQ, "Visit patient of patient moves to another hospital unit, and "checks his or her perception of the patient with the patient before initiating any action" were ranked same by both patients and nurses. These results also demonstrated a basic harmony between patients and nurses with respect to the priorities of care. The two groups do not agree on the remaining 5 bottom 10 caring behaviors (see Table 14 i 15).

Table 16 Correlations in Patients' and nurses' ranking of nurse caring behaviour as indicators of care

		Items ranks	Components ranks
Spearman's rho	correlation	.750	.96
	Sig (2-tailed)	.000	.000
	N	37	7

The ranking of the patients and nurses on the individual items as indicators of care: Spearman rho = .75, $P < .05$. The rankings of the components as indicators of care by the patients and nurses: rho = .96, $P < .05$. There is positive correlation in ranking between patients' and nurses' perceptions of nurse caring behaviours.

Test of significance

Hypothesis 1:

There will be no significant difference in the perceptions of caring behaviour of patients and nurses. To test this hypothesis, a one-way analysis of variance was performed on the adjusted overall mean scores of patients and nurses. The results of these analysis are presented on Tables 17 and 18.

Table 17: Mean scores and standard deviation of patients and nurses on CBAQ caring behaviour items

	Patients (n = 167)		Nurses (n = 165)	
	Mean	SD	Mean	SD
Humanism/Faith-Hope Sensitivity (9 items)	30.28	6.11	31.25	4.14
Helping / Trusting (9 items)	28.95	5.84	30.17	4.23
Human Needs Assistance (8 items)	26.64	5.69	27.61	3.86
Expression of Positive/Negative Feelings (3 items)	9.53	2.33	10.19	1.81
Teaching/Learning (3 items)	9.40	2.63	9.98	1.71
Existential / Phenomenological Spiritual Forces (3 items)	8.93	3.13	9.93	1.87
Supportive/Protective/Corrective Environment (2 items)	6.31	1.88	6.70	1.27
Total Response on CBAQ subscales (37 items)	120.04	22.53	125.83	15.18

Table 17 shows a difference in the mean scores of patients and nurses on CBAQ items. Nurses scored higher ($\bar{x} = 125.83$), than the patients ($\bar{x} = 120.04$).

Table 18: Summary of one-way analysis of variance on patients and nurses perceptions of CBAQ caring behavior as indicators of care

Source	Sum of squares	df	Mean square	f	Sig	eta square
Group	2757.605	1	2.76	7.456	.007	0.022
Error	122046.501	330	369.838			
total	124804.105	331				

P = .007 (P < 0.05)

The result as presented on Table 18 indicates a significant mean score difference in the perception of CBAQ items as indicators of care between patients and nurses (F=7.456; P <0.05). This indicates that there is a significant difference in the perceptions of CBAQ caring behaviors as indicators of care between patients and nurses. Nurses have higher perceptions of CBAQ items as indicators of care than the patients. The hypothesis is therefore rejected.

Summary of Research Findings

The following findings were made from the analysis of the data presented in Chapter Four.

1. All the 37 CBA caring behaviour statements except item 17 (‘visiting patient if patient moves to another hospital unit’ with mean of 2.63, SD = 1.33 and t-value of 1.24) were accepted as indicators of care by patients.
2. The three most important nurse caring behaviours as perceived by patients were (using soft gentle voice with Patients’ ‘Being kind and considerate to patients’, and answering patients’ questions clearly’.
3. The three least important nurse caring behaviours as perceived by patients were ‘visiting patient if patient moves to another hospital unit’, preparing patient for death when it is inevitable’ and praying with and or for patients’.

4. All the 37 CBA caring behaviour statements except item 17 'visiting patient if patient moves to another hospital unit' with item mean of 2.62, SD = 0.90 and t-observed value of 1.69 which is below the mean criterion of 2.50 were accepted as indicators of care by nurses.
5. The three most important nurse caring behaviours as perceived by nurses were 'giving patient treatment and medication on time', 'treating patients' information confidentially', and 'using soft and gentle voice with patient'.
6. The three least important nurse caring behaviours as perceived by nurses were 'visiting patient if patient moves to another hospital unit', 'is calm' and 'preparing patient for death when it is inevitable'.
7. All the CBA sub-scales of nurse caring behaviour statement were accepted as indicators of care by patients.
8. The three highest scored subscale were humanism/faith-hope-sensitivity helping/trusting, and human need assistant as perceived by patients.
9. The three lowest scored subscales were supportive/ protective/corrective environment as existential phenomenological/spiritual forces and teaching/learning perceived by patients.
10. All nurses perceived (accept) all the 7 CBA subscales as indicators of care.
11. The three highest scored subscales of the CBA by nurses were humanism/faith-hope-sensitivity, helping/trusting and human needs assistant.
12. However, the following three subscales were scored lowest by nurses: supportive/protective/corrective environment, existential/phenomenological forces and teaching/learning.

13. Patients and nurses perceived "humanism/faith-hope-sensitivity", helping/trusting, and "human needs assistance" as the most important and "existential/phenomenological/spiritual forces" and "supportive/protective/corrective environment" as the least important subscales.
14. comparison of the ten (10) items patients and nurses selected most important caring indicators revealed that they agreed on 6 out of 10 most important items. These were "using soft gentle voice with patient", "being cheerful with patient", being kind and considerate with patient, answering patients' questions clearly, Being honest with patient, "giving patient's treatments and medications on time". "Being cheerful with patient" was ranked same by both patients and nurses.
15. The result of the ANOVA showed a statistical significant difference in the perceptions of CBA items as indicators of care between patients and nurses. Nurses had a higher perceptions of the CBA items as indicators of care than the patients.

CHAPTER FIVE

DISCUSSION OF FINDINGS

The findings of this research on comparative analysis of patients' and nurses' perception of nurse caring behaviours in the tertiary hospitals in Jos are hereby discussed using the following outlines: Specific objectives set for the study, explaining possible reason why the results came out the way it did, discussing the result in the light of other findings from other researches to see whether my results agree with them or not. Examine findings in the light of the theoretical underpinning of this study, state implications of findings, peculiarity and limitations of this study, summary, conclusion, suggestions for further research and recommendations.

Objective One (1): To determine nurse caring behaviour statements that patients' perceive as indicators of care

All the caring behaviour statements except 'visit patients if patient moves to another hospital unit' mean 1.24, were perceived by all the patients as eliciting a sense of caring. Patients did not consider 'visiting them if they move to another hospital unit' by nurses as caring because they consider actions that are technically oriented procedure not to be caring and so they did not see any difference between relations of friends and well-wishers visit and that of the nurses. All the other nursing behaviours were considered to elicit caring because they fulfilled either physical, psychological or social needs of the patients. This is because the t-observed mean values of each of the item nurse caring behaviour statement was significantly higher than the mean criterion (2.50) except for the visiting patient if patient move to another hospital unit (t-value 1.24). This therefore meant that this sample of patients perceived all the thirty six items of nurse caring behaviours as indicators of care. The patients' total mean score on the CBAQ was 120.04, (SD = 22.53).

All the seven (7) sub-scales were perceived as indicators of care. This is so because the subscale is the product of the items therefore since all the items contained in the subscales were all perceived as indicators of care, it naturally follows that all the subscales are perceived as connoting caring. The three (3) highest scored sub-scale were Humanism/faith-hope sensitivity (mean 30.28; SD = 6.11); Helping/Trusting (mean 28.95; SD = 5.84) and human needs assistance (mean 26.64; SD = 5.69). This is because these subscales involve personal responses and inter-subjective human process of the nurse and the patient as affecting caring is demonstrated majorly inter-personally. The practice of caring integrates bio-physical-knowledge and practice to generate or promote health and ministrations to those who are ill, and the above three subscales fulfilled them. The three (3) lowest scored sub-scale were supportive/protective/corrective environment (mean 6.31; SD=1.88); existential/phenomenological/spiritual forces (mean = 8.93; SD = 3.13); and Teaching/Learning. This is because patients considered that nurses should perform their bio-physical function first more especially these are medical and surgical patients, before bringing in their humanistic orientation to bear as these subscales involved aesthetic, artistic and spiritual aspects of caring. Mariner (1994) asserted that there is often a discrepancy between theory and practice or between the scientific and artistic aspects of caring partly because of the disjunction between scientific values and humanistic values. These 3 lowest subscales unlike the first 3 that connect person to person, these ones interconnected persons with others and nature. These also reflected in the ranking of the subscales in the items scored highest, the trend also followed same, hence the same explanation holds for the most and least perceived caring behaviour indicators by patients. Just as low ranking (mean = 9.40, SD = 2.63)

was given to existential/phenomenological/spiritual forces in this study, low ranking was equally given to this sub-scale by patients in ÓConnell and Landers (2008) study. Just as humanism/faith-hope sensitivity Sub-scale has the highest mean score in this study, that was how it was in Kimble 2003 study. Other studies found human needs assistance to be higher (Tucket, 2009), Suwanakul (2011). All the nurse caring behaviour sub-scales were perceived as indicators of care by all the patients in these studies.

In subscale ranking by patients, humanism faith-hope sensitivity, was ranked 1st followed by Helping trusting, and 3rd was human need assistance. The fourth was supportive/protective/corrective environment, and lastly existential/phenomenological spiritual forces (Table 3). Patients must have valued the affective domain of care highly because it gives them fulfillment, confident, and a sense of being wanted and loved by nurses rather than the routine dutiful administration of physical procedures with no evidence of emotional concerns. In the northern part of Nigeria people valued respect to each other very highly, this is reflective in this finding. In Baldursdottir & Johnsdottir (2002) study Human Needs Assistance subscale was ranked first by patients. The finding from this study was similar to Kimble (2003) in many respects: The highest ranked specific nursing behaviors were from humanism/faith-hope sensitivity subscale. The findings in this present study differed from Papastavrou *et al.* (2011) who reported literature reviewed that in several studies, patients have considered the subscale monitors and follows through (which is equivalent to Human Needs Assistant Subscale in this study), to be of high importance (Larson 1987; Major 1987; Keane *et al.* 1987; VonEssen and Sjoden, 1991, 1994, Widmark-Peterson *et al.* 1998; Tucket *et al.* 2009).

Objective two: To determine the most and least important nurse caring behaviours as perceived by patients.

Most important nurse caring behaviours

The 10 highest scored items by patients were from the three sub-scales of humanism/faith-hope sensitivity (four out of nine items), helping trusting (three out of nine items), and human needs assistance (three out of eight items). The mean values of these 10 items ranged from 3.36 to 3.52 (SD = 1.01-0.70). The findings that using soft gentle voice with patients, being kind and considerate to patients, answering patients questions clearly, and giving patients treatments and medications on time were the four highest scored items.

All the 10 statements indicated the most important nurse caring behaviour to patients. The highest ranked item using soft, gentle voice for patient was not reported as one of the most important nurse caring behaviours in the reviewed empirical studies. The patients' perception of this behaviour was not surprising as Nigerian nurses working in government health institutions have on several occasions been accused by patients and their relatives of being shouted upon. Patients therefore preferred being spoken to using soft and gentle voice instead of being shouted upon. Using soft and gentle voice is soothing, reassuring and calming to the patients, thereby making the patient feel the nurse is accessible and as a result reducing patients' anxiety. The second ranked most important item was Being kind and considerate to patient. The nurse should not be too officious, formal, bureaucratic, but courteous and not harsh but handle patients' issues appropriately. This was also the first ranked most important caring behaviour in study done by Kimble (2003) 9th in study done by Baldusdottir and Jonsdottir (2002). The third most important ranked item by patients was Answers patients' questions

clearly. This would create a mutual understanding and patients perspectives will be understood by the nurse leading to co-operation of the patient to treatment regimen. This item was ranked third by patients in Kimble's (2003) study. 'Giving patients treatments/medications on time' was ranked the 4th most important caring behaviour by patient in the present study. Patient do not like being 'dumped' on bed without attending to them. In most government hospitals, prompt attention is lacking. This could be as a result of increased work-load, low nursing work force, increased nurse-patient ratio or hospital bureaucracy. This has led to many patients patronizing private health institutions, so these patients would want the nurses to give medications and treatments on time to improve government health institution patronage. In Azimzadeh, Rahmani, Valzadeh and Zamanzadeh's (2010) and Kimble (2003) this item ranked first and ninth respectively. The same was ranked seventh in study done by Baldursdottir and Jonsdottir (2002). 'Paying special attention to patient during first times of hospital' was ranked fifth by patients. This was not reported as one of the most important nurse caring behaviours in the reviewed empirical studies. Hospital is believed to be frightening to patient especially for fear of the unknown and impaired judgment because of illness, so this sample of patients perceived that attention given by the nurse would help to alleviate their anxiety and fear. The sixth most important nurse caring behaviour as perceived by patients was 'know how to give injections, ivs etc'. The art of administration of drug parenterally (by injection) require skillfulness, carefulness and tactics. Patients might have heard of or experienced complications arising from administration of injections, such as injection abscess, sciatic nerve damage, or wrong route of administration. They therefore, perceived that nurses who 'know how to give injections, ivs etc' is one of the most important indicator of care. In Azimzadeh, Rahmani, Valzadeh and Zamanzadeh (2010) study

this, item was ranked second most important indicator of nurse caring behaviour while in Kimble (2003) it was ranked fifth. It was also among the highly rated items in studies by (Larson 19 85); Major 1987; VonEssen 1991; Chart 1991; Gooding, Sloan and Gagnon (1993); O'Connell and Lander (2008). In Baldursdottir and Jonsdottir (2002), it was ranked third in importance by patients. "Being cheerful with the patient" was ranked seventh. Being cheerful, with the patient by nurses in terms of their verbal approaches, facial expressions and body languages shows that the nurse is humorous, and courteous, thereby making the patient to relax, feel free to approach the nurse and this gives the patient assurance that the nurse knows his/her job, hence patient's anxiety, and fear of the unfamiliar environment would reduce tremendously, as a friendly atmosphere is being created. This has potential for meeting the patient's social and psychological needs. This item was ranked fifth by patients in Azinzadeh *et al.* (2010) study. "Really listen when patient talks" was ranked eighth by patients in the present study. This creates confidence in patients that having listened to their fears, anxieties, ideas, history of the disease and their expectations, the nurse stands a better chance of doing the right thing for them. The verbalization of the patient's emotions would go a long way in enhancing his/her psychological well-being. But this was ranked forth and second in importance in studies by Kimble (2003) and Azinzadeh-*et al* (2010) respectively. "Being honest with patients" was ranked ninth. Honesty on the part of the nurse in his or her dealings or interactions with the patient would enable the patient to know facts and then face reality of his/her illness. This would enable him/her to cooperate with the nurse, treatment regimen prescribed and follow-up advice. Patients therefore do not want to be deceived but that nurses should be forthright in their dealings. "Encouraging patients to call if patient have any problem" is ranked ten. The atmosphere in most government health institution is that

nurse is busy, being over whelmed with responsibilities and have to meet up with time. This creates fear in patients of being looked upon by nurses as "disturbing", "uncooperative" and "insensitive". Patients therefore perceived as caring indicator if they are encouraged to call if they have any problem inspite of the prevailing atmosphere highlighted above. This item was not among any of the reviewed literatures as most important nurse caring behaviours. Caring has no universal or standard definition, therefore each study's definition differs. Patient desired that even though nurses are over-loaded, highly busy, should be approachable outside their (patient) individual treatment schedules, without being offended and that their interactions should be with all sincerity and honesty.

Least important nurse caring behaviours

The 10 lowest scored items were derived from five (5) sub-scales of helping/trusting (three out of nine items) expression of positive/negative feelings (one (1) out of three (3) items), teaching /learning (two (2) out of three (3) items), supportive/protective/corrective environment (two (2) out of two (2) items), and existential/phenomenological/spiritual forces (two (2) out of three (3) items).

The means of these ten items ranged from 2.63 to 3.16 (SD = 1.33-1.14). The finding that "visiting patient if patient moves to another hospital unit", "preparing patient for death when it is inevitable", "praying with and or for patient", and "checks his or her perception of the patients with the patient before initiating any action" were the four lowest scored items (see Table 5). All the 10 items indicated the least important nurse caring behaviour to patients.

Among these 10 items, 'visit patient if patient moves to another hospital unit' was ranked first by patients as the least important nurse caring behaviour. Patients felt this does not fall within the scope of nurses' schedule of duty, so they do not perceive this behaviour as indicative of caring. It does not involve physical or technical action of the nurse. This statement was also ranked the first least important caring behaviour indicator in Kimble (2003) study and second in Baldurstottir and Jonsdottir (2002). 'Preparing patient for death' when it becomes inevitable was the second least important caring behaviour in the present study by patients' ranking. It is the nature of human beings not to desire to die. They want to live like Melchizedek of the Bible. Patient's motive of seeking nurses' attention is because they want to live more on earth, hence they perceived this item as one of the least important nurse caring behaviour. The fear of the unknown that surrounds death might also be responsible for their perception. The third least important nurse caring behaviour as perceived by patients was 'praying with, or for patient'. This is not consistent with studies carried out previously. Nigerians are known to be highly religious, but it is surprising that patients do not consider this nursing behaviour as one of the most important. Probably they preferred it being handled by a clergy man or priest. This was from existential phenomenological, spiritual forces subscales from which other studies' least important items of nursing behaviour indicators were mostly derived from. The fourth least important indicator of nurse caring behaviour item as perceived by patients was 'check his or her perception of the patient with the patient before initiating any action'. Nurses can not assume that patients perceive their caring efforts as they are intended. To avoid this problem, it is imperative that nurses validate with the patients that their care needs are being met (Zamazadeh et al 2010). There is therefore need to ascertain patient's perception that it is in congruence with that of the nurse since

patients determine what caring actions are (Morse 1991) in Masayuki et al 2005). Perception is a subjective phenomenon, so patients expected the nurse to cross-check that what they perceived of them (patient) was correct. This was ranked seventh in Baldursdottir and Jonsdottir (2002) least important selected items. It is not appropriate to assume that the identified least important items in this study are unimportant for the patients. They are also important but to some degree when compared to other items in the scale. As Baldursdottir and Jonsdottir (2002) asserted, these items certainly are important because they also yielded relatively high scores.

Objective Three: To determine nurse caring behaviour that nurses perceived as indicators of care

The result on Table 7 in Appendix xii show that the nurses' item mean scores for the 37 caring behaviour statements ranged from 2.62 (SD 0.90) to 3.66 (SD = 0.55). The t-values for all the item (except item 17) were significantly higher than the mean criterion of 2.50, $P < 0.05$ (Table 7). This result is indicative that all the caring behaviour statements except item 17 (visiting patient if patient moves to another hospital unit), with item mean of 2.62, SD = 0.90; and t-mean value of 1.63 which is below the mean criterion of 2.50, were accepted as indicators of care by nurses. This finding was similar to Mizuno, Ozawa, Evan, Okada and Takeo (2005) who found that Japanese nurses perceived all the caring behaviour as important.

The means and standard deviations for each sub-scale presented in Table 6 revealed that all the sub-scales were accepted as indicators of care. The three (3) highest scored sub-scales were humanism/faith/hope sensitivity (mean 31.25, SD = 4.14); helping Trusting (mean = 30.17; SD = 4.23); and human needs assistance (mean 27.61; SD =

3.86). The three lowest scored sub-scale (by nurses) were supportive/protective/corrective environment (mean = 6.70; SD = 1.27); existential/phenomenological/spiritual forces (mean = 3.93; SD = 1.87) and teaching/learning (mean = 9.98, SD = 1.71).

The study revealed that all the nurse caring behaviour subscales were perceived as indicators of care. This finding revealed that nurses perceive all the nurse caring behaviours as eliciting sense of caring. Human needs assistance was consistently scored highest in most of the empirical reviewed studies such as in: (Dyson 1996; Hegedus 1999; Bruntrn and Beaman, 2000). Unlike humanism hope-sensitivity that was ranked highest in this study.

Objective four: To determine the most and least important nurse caring behaviours as perceived by nurses

Most important nurse caring behaviour.

The 10 highest scored items by nurses were from the three subscales of humanism/faith-hope sensitivity (six out nine items), helping/trusting (three out of nine items); and human needs assistance (one out of eight items). The means of these 10 items ranged from 3.54 to 3.66 (SD = 0.61-0.55). The findings that "giving patients treatments and medications on time", "treating patients information confidentially", showing "patients love", "treating patient with respect", "using soft voice with patient", were the five highest scored items. The explanation of the result coming out this way is that these behavioural statements match the defining attributes of altruistic motivation to help. In a clinical setting, human caring will be achieved through the nurses' daily behaviour towards patient's care. A caring moment can be

created when the nurse is morally conscious and authentically present with patients in fulfilling their unmet needs utilizing his or her knowledge base and clinical competence. These findings supported the concept that caring is a combination of what the nurse does and what the nurse is like as a person.

All the 10 highest scored items indicated the most important caring behaviour to nurses. "Giving patients treatment and medication on time" was ranked first by nurses in this study and was equally ranked first by nurses in Azimandeh, Rahmani, Valizadeh & Zamanzadeh, (2010) study. This could be as a result of nurses' believe that their first duty was giving patient treatment and medications on time as prescribed and their believe in medical and disease model. The second most important indicator of caring behavior as perceived by nurses in this study was "treating patients' information confidentially". This item was ranked third in Azinzadeh *et al.* (2010) study. "Using soft and gentle voice with patient" was ranked third and "showing patient love" was ranked fourth, most important indicators of caring behaviour respectively by nurses. They were not amongst the most important caring behaviours reported in the reviewed empirical studies. The fifth ranked most important caring behaviour was "treating patient with respect". This was not also reported as one of the most important nurse caring behaviours in the reviewed empirical studies. "Being honest with the patient" was ranked sixth among the most important nurse caring behaviour in the present study and was ranked eighth in Brunton & Beaman (2000) study, as well as in Dyson (1996) study. The seventh most important nurse caring behaviour item as perceived by nurses in this study was "Being cheerful with patient". Patients admitted to hospitals are usually anxious about their health concerns. This makes them sad, so cheerful posture by nurses would go a

long way in giving them psychological relief as this nurses cheerfulness create in patients the boldness to approach the nurse. This was ranked fifth by patients and ranked third five by nurses in Zamanzadeh et al (2010) study. "Answer patients's questions clearly" was ranked eighth most important caring behaviour indicator by nurses in present study and was ranked seventh most important item in Azimzadeh, Rahnani, Valizadeh & Zamanzadeh (2010). The ninth perceived most important caring behaviours statement by nurses "Being kind and considerate to the patient" was ranked ninth. Majority of these nurse respondents were Christians. Their religion preach the "good Samaritans" philosophy which enjoined its followers to be kind and have fair human consideration in all their dealings for them to be rewarded in heaven, hence this was considered by them as being one of the "most important" caring behaviour indicator. This was not in any of the reviewed literature as nurses perceived most important nurse caring behaviour. "Get to know (Treat) patient as an individual" was ranked 10th most important nurse caring behaviour perceived by nurses and was ranked sixth in Brunton & Beaman (2000) study. Patients desired that nurses treat them with respect and respect their unique individuality. Nurses should address patient properly e.g. Sir, Chief, Reverened, Mrs. etc for titled persons and not to treat all patients individually as the case may be.

Least important nurse caring behaviours:

The 10 lowest scored caring behaviour item statements by nurses were derived from the six sub-scales of humanism/faith-hope sensitivity (two out of nine items), helping/trusting (three out of nine items), teaching/learning one out of three items), human needs assistance (two out of eight items), supportive/protective/corrective/

environmental (one out of two items), and existential / phenomenological /spiritual forces (one out of three items).

The means of these 10 items ranged from 2.62 to 3.31 (SD = 0.90-0.70). The findings that 'visit patient if patient moves to another hospital unit', 'is calm' and 'preparing patient for death when it is inevitable' were the three lowest scored items (see Table 14). All the 10 items indicated the least important indicators of care to nurses based on their item means. 'Visit patient if patient moves to another hospital unit' was ranked fourth among the least nurse important caring behaviour by Kimble (2003). 'Is calm'. In caring practice, being with someone may be just as important as doing something for the person. Being calm makes the patient feel that the nurse is confident and so makes them to trust the nurse. This item was ranked eighth most important by nurses in Zamanzadeh *et al.* (2010) study. 'Preparing patient for death when it becomes inevitable' was the third in ranked nurses' least important nurses caring behaviour indicators. Although death is as old as life, human beings are still not used to its occurrences, and so nurses as they attempt to save lives always feel the pains when death occurs. This was not reported as one of the least important nurse caring behaviours in the reviewed empirical studies. However, the existential/phenomenon logical/spiritual forces subscale under which this item comes was among the least important subscales in majority of reported previous studies. The fourth ranked least important nurse caring behaviour indicator was 'checks his perceptions of the patient with the patient before initiating any action.' To be meaningful, Azimzadeh, Rahmani, Valinzaadeh and Zamanzadeh (2010), maintained that nurse caring must be based upon mutual agreement between nurses and patients as to what constitutes nurse caring behaviours. Nurses cannot be certain that their

behaviour is consistent with patients' perception and expectations of their care. The fifth least caring behaviours statement by nurses is 'touch patient when patient need for comfort'. This is a subjective phenomenon because of individual differences. These nurses' perception could be as a result of their knowledge of nosocomial infections hence this nurse behaviour is perceived as least important. This item was not reported in the reviewed literatures. 'Know what they are doing' is the sixth perceived least important nurse caring behaviour by nurses in the present study. This view might have emanated from nurses believe that medical and nursing professions are highly specialized areas and as such patients are not knowledgeable in the field therefore they are expected to trust nurses. 'Being patience and tireless with patient' ranked item seven least important nurse caring behaviour statement. Nurses have been trained to be patience, long suffering, tolerance and persevering in their attempt to ameliorate actual or potential health problem. Therefore this nursing statement was perceived by them as least important. The eighth least important caring behaviour statement by nurses was 'check on the patient frequently'. Checking on patients' vital signs and other observations are nurses routine procedures. This item was ranked by patients and nurses as four and twenty-one respectively in Azimzadeh, Rahmani Valizadeh and Zamanzadeh, (2010) as most important item. 'Helping patient plan ways to met goals' was ranked ninth by nurses as least important indicator of care. The nursing work-load makes it difficult to have adequate time with patients that would give them opportunity to go deep into ascertaining patients' deep feelings that would have warranted good planning with them. This might have contributed to their perceiving this item as least important. This item also was not reported in the reviewed literatures. The tenth perceived least important caring indicator by nurses is 'help the patient not to feel dumb by giving him or her adequate information'.

Keeping patient informed of nurses plans for their care would help the patient not to feel neglected by the nurse. This item was ranked seventh by nurses and 21st by patient in Azimzadeh, Rahmani Valizadeh and Zamanzadeh, (2010) and seventh in Kimble (2003) as most important caring behaviour by patients.

Objective five: To determine if differences exist in the nurse caring behaviour statements that patients and nurses perceive as indicators of care

Mean scores were computed for each of the CBAQ seven sub-scales for the patients and nurses groups which ranged from 6.31 to 30.28 for patients and 6.70 to 31.25 for nurses.

The ranking of the seven sub-scales in order of importance by patients and nurses groups shows that patients and nurses perceived humanism/faith-hope sensitivity, helping/trusting and human need assistance as the most important and existential/phenomenological/ spiritual forces, supportive/corrective/protective environment as the least important sub-scales. The mean scores showed that nurses gave higher mean score values than did patients to all the seven sub-scales. Patients and nurses in this study ranked the seven sub-scales in the same order. The congruency in their ranking could be because the patients had spent not less than 5 days so they had perceived the nurses behaviour that they too have similar perception. Cultural value refers to the highly desirable or preferred way of acting or knowing something that is often sustained by a culture over a period of time. It also shows element of cultural care universality among this population. Leininger (1991) in Marini (1994) defines cultural care universality to be common, similar or uniform meanings, patterns, values or symbols of care that are culturally derived for health

(well-being) or to improve a human condition, life way or to face death. There is very high concordance in the nurse and patients perceptions of this sample in this sub-scale. In summary, the findings of the study, indicate that nurses do know their patients well enough to judge what aspects of caring the latter consider important in order to feel well cared for. It is time to listen to the patients' view and perspectives. This indicates that nurses to a greater extent than patients gave higher mean scores to sub-scale items. This also indicates that nurses consider several CBAQ dimensions to be of a very high importance. According to Waston, caring is a nursing term representing the factors nurses use to deliver healthcare to clients. Using the 10 carative factors the nurse provide care to various clients and each carative factor (which is the prima) of this research) describes the process of how a client attains or maintain health or die a peaceful death. Human caring in nursing is not just an emotion, concern, attitude or benevolent desire, the practice of caring integrates bio-physical knowledge with knowledge of human behaviour to generate or promote health and to provide ministrations to those who are ill. The above premise formed the basis for nurses' perceptions being higher and considering several CBAQ dimensions to be of a very high importance than the patients. This result is similar to (Larson, 1987; Mayer, 1987; Vonessen and Sjöden, 1993; Larson *et al.*, 1998, and Tucket, Hughes, Shulter, & Turner, 2009) and they consistently ranked the 'comfort' (equivalent to humanism/faith-hope sensitivity) dimension as their first priority. The total mean scores on the CBAQ for nurses was 125.83 (SD = 22.33) and 120.04 (SD = 15.18) for patients.

Patients in the present study had considered the subscale 'humanism/faith-hope sensitivity' 'helping/trusting' to be of high importance. These findings is at variance with several previous studies, patients have considered the sub-scale 'monitor and

follows through (equivalent to human needs assistance) to be of high importance (Larson, 1987, Mayer, 1987, Keane, Chastain & Rudisill, 1987, Vonessen & Sjöden, 1991, 1994, Widmark-Peterson, Vonessen & Sjöden, 1998, and Tucket *et al.*, 2009).

The ranking by patients and nurses in the present study of human need assistance sub-scale lower than the humanism/faith-hope sensitivity sub-scale is similar to (Widmark-Peterson *et al.*, 2000) study in which this caring dimension is ranked lower by both patients and nurses group. The finding of the present study that humanism faith-hope sensitivity ranked by the patients as most important sub-scale differed from the following studies that found human needs assistance to be the highest patients ranked subscale. (Caromin and Harrison, 1998, Huggins, Gandy & Kohut, 1993, Schultz, Bridgham, Smith & Higgins, 1998, Marini, 1999 & Baldursdottir, Jonsdottir, 2002 and Kinble, 2003.)

The finding that showed that nurses gave higher mean values than did patients to all the seven sub-scales is similar to Suwanankul (2011) with the mean of scores nurses perception being higher than those of the patients. The finding in this present study that both patients and nurses ranked humanism/faith-hope sensitivity highest was at variance with study by Zamanzadeh, *et al.* (2010) where both patients and nurses ranked human need assistance subscale highest.

Another area of similarity was a low ranking given to CBAQ sub-scales like a trusting relationship, expression of positive/negative feelings, and existential spiritual forces where in a critical care settings, O'Connell and Landers, (2008) also found that a low rating was given to caring subscales of trusting relationship,

expressing of positive/Negative feelings and existential feelings. This suggests that interpersonal nurse-patients relationship may not be considered very important in this area of practice.

A comparison of the top 10 CBAQ items between patients' and nurses' perception revealed similarities as well as difference. Patients and nurses agreed on 6 out of the 10 most important items. These six items were ranked among the top 10 by both patients and nurses and they include: "Using soft gentle voice with patient," "Being cheerful with patient," "Being kind and considerate," "Answering patients' questions clearly," "Being honest with patients," and "Giving patients' treatments and medications on time." (See table 11 & 12). Item 2 on the CBAQ "being cheerful with patient" was ranked (7) by both patients and nurses. These results demonstrated a basic harmony between the two groups with respect to the priorities of care. Patients and nurses do not agree on the remaining 4 top 10 caring behavior (see Table 11 -12).

The first nurses' ranking "giving patient treatments and medication on time" included the human need assistance subscale and is related to physical aspect of nursing care or nurse competence. The result presenting caring as the performance of basic nursing care activities are in accordance with Maslow's hierarchy of needs and the life-saving purpose of professional actions. Nurses should demonstrate their technical skills and scientific knowledge to meet basic needs of patients before they proceed to address the emotional and affective aspect of caring. Palistea, Siamanta 1999, Cronin, Harrison, 1988 in Zamanzadeh *et al.*, 2010). This was demonstrated by the nurses in this present study. Watson's assumptions of caring is that "the practice of caring integrates bio-physical knowledge with knowledge of human behavior to generate or

promote health and to promote ministrations to those who are ill and that a science of caring is therefore complementary to the science of curing and that historically nursing has held a human-care and caring stance in regard to people with health-illness concerns. This has been perceived as such by the samples of nurses used in the present study. Watson asserted that nurses' caring foundation has been sublimated by technological advancement and institutional constraints. Being that as it may be, the present sample of nurses still perceived that after 'giving patients' treatment and medications on time', patients' information have to be treated confidentially (rank 2) (to provide privacy). They now stated the humanistic -faith-hope aspect of care: 'using soft and gentle voice with patients' (rank 3) which is No. 1 patients' ranked most important nurse caring behaviour. Going by this sequence, this sample of nurses had shown human care value as asserted by Watson in his theory that 'a significant issue for nursing today and in the future is the preservation and advancement of human care' because they had perceived as most important caring for the physical and then the emotion/moral aspect of care. For instance nurses' 4th perceived most important nurse caring behavior was 'showing patient love' but patients ranked it 11th. Watson assumption is that human care value includes: 'care and love comprise the primal and universal psychic energy', and also that 'care and love, often overlooked, are the cornerstones of our humanness, nourishment of these needs fulfills our humanity'. These samples of nurses have applauded this Watson's value by their perceptions that 'showing patient love' is most important. Based on Table 11-12, patients perceived as most important that nurses should encourage them to call if they have problems (rank 10), that nurses should know how to give treatment and medications on time (rank 4), as they do that they should 'use soft gentle voice' with them (rank 1) as they 'answer their questions clearly' (rank 3) they should do it in a 'kind and considerate' way

(rank 2). Nurses has perceived as most important that patients' treatments and medications should be given on time (rank 1), maintaining/confidentiality (rank 2) showing them love (rank 4). There is high congruency then between the patients and nurses of this sample when viewed/ this way. This was why Spearman correlation coefficient between their ranking was $\rho = .96$ ($P < .05$) which meant that there was positive relationship between the patients and nurses even though it was only one item (Being cheerful with patient) they ranked same (rank 7).

The finding also showed that nurses more than patients value the sub-scale humanism/faith-hope sensitivity while patients value the subscale human needs assistance more than nurses. In total, nurses score higher in 31(83.78%) items than patients who scored higher than nurses in only 5 (13.5%) items. Patients selected three items (3) as most important indicator of nurse caring behaviour (these are: giving patients treatments and medications on time, rank 4 know how to give injections etc, rank 6, and encourage patient to call if he or she has problem ranked 10 from human needs assistance sub-scale. Nurses on the other hand, selected only one (1) item as most important nurse caring behaviour indicator from human need assistant (this was giving patients treatments and medications on time, ranked 1st)

Table 11-12.

This was why when the patients and nurses selected 10 most important nurse caring behaviours items are compared, it became evidenced and right to conclude and assert that nurses more than patients value the sub-scale humanism/faith-hope sensitivity while patients value the sub-scale, human needs assistance more than nurses. Using this school of thought, the findings of this study is similar to a large number of

earlier studies which showed that patients and nurses did not concur on the items of most important nurse caring behaviours (Larson, 1981; Widmark-Peterson, VonEssen, Sjöden, 2000 Larson, Peterson, Panpic, VonEssen, Sjöden, 1998, Ghang, Lin, Chang & Lin, 2005 all in in Zamanzadeh *et al.*, 2010). Papastavrou, Efstathiou and Charalambous (2011) study titled: "nurses and patients perceptions of caring behaviours: quantitative systematic review of comparative studies", reported as follows "significant difference were found between patients and nurses in their perception of caring and caring behaviours in many of the reviewed studies. The studies that used care-Q, CBA, CBI, CDI etc instruments revealed differences between patients and nurses in the ranking of how important different nurse caring behaviours are considered to be. Patients appear to value the instrumental, technical caring skills more than nurses do, and perceives behaviours that demonstrate competency on how to perform nursing activities (human needs assistance or know how) as more important. On the other hand, nurses perceive their psychological skills and expressive or affective caring behaviour as more important than patients do leading to the conclusion that nurses may misperceive the necessity of the emotional aspect of caring in comparison with patients' judgements. These results repeatedly reported in the research literature, indicate that nursing staff may not accurately assess patients' perceptions of caring and that patients' care is not congruent to the patients' preferences or individual needs."

The finding in this study and the previous studies demonstrate that "caregivers tend to stress the more qualitative dimensions of care and deemphasise physical care issues, which are perceived by patients as more essential." Zamanzadeh *et al.* (2010); VonEssen & Sjöden 1993 in Papastavrou, (2011) revealed that a comparison of

patients with somatic and psychiatric problems showed that somatic and psychiatric patients differ in their perception of caring behaviours, since the task-oriented aspect of caring was rated as more important from patients hospitalized in medical and surgical settings (incidentally the present study was in medical and surgical wards).

However, it seems that there are exceptions to this pattern because other study results clearly indicate that clinical skills are still valued and respected by a portion of nurses. For instance, Moyle, Iselin, Baeslack-Smith and Fleming, (2005), Keane, Chastain, and Rudisill, (1987), Azizzadeh, Alizadeh, Nikian and Nuhi, (1994), Ramanzadeh *et al.*, (2010) all in Zamazadeh *et al.*, 2010) studies explored perception of caring by patients and nurses, they found that both groups viewed competent clinical expertise as the most important components of a nurse-patient caring interaction. Also, Dowling (2008) found that nurses; technical skills were alluded to by both nurses and patients interviewed as a contributory factor. Dowling (2008) opined that when patients trusted the nurses' competence with regard to the technical skills, they wanted that nurse to care for them. It would be appropriate to say that it is in this same spirit that the sample of nurses in the present study ranked as number one (1) giving patient treatments and medications on time as most important nurse caring behaviour before proceeding to psychological aspects of care.

A comparison of the 10 least important CBAQ items caring behaviours between patients and nurses as presented in Tables 13 and 14 showed some similarities as well as differences. Patients and nurses agreed on 5 out of the 10 least important items. These 5 items were ranked among the bottom 10 (least important) by both patients and nurses and they include: visiting patient if patient move to another hospital unit,

"preparing patient for death when it is inevitable," "checks his or her perception of the patient with the patient before initiating any action," "touch the patient when patient needs it for comfort," and "helping the patient not to feel dumb by giving him or her adequate information" (Table 13-14). Patients and nurses perceived the above caring behaviour as subtle environment of energy and consciousness, whereby Wholeness, beauty, comfort, dignity and peace are potentiated so they prioritized them least important unlike caring behaviours which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all aspect of care that were perceived as most important. This find indicate that nurses do know their patient well enough to judge what aspect of caring the latter consider important in order to feel well cared for. It is time to listen to the patients' view and perspectives. Items 17 and 23 on the CBAQ, "visiting patient if patient moves to another hospital unit" and "checks his or her perception of the patient with the patient before initiation any action" were ranked same by both the patients and the nurses. These results also demonstrated a basic harmony between patients and nurses with respect to the priorities of care. Both perceived these two behaviours as not nurses' paid job, or responsibilities that if neglected. Could lead to redress in a court of law unlike the other nursing statements that are systemic use of carative problem-solving caring process involving the use of self and always of knowing as part of caring process to engage in artistry of caring-healing practices. The two groups do not agree on the remaining 5 bottom 10 caring behaviours (see Table 13-14). This is because care has different linguistic meanings, cultural experiences, and uses by the people of diverse cultures and subcultures. It could be as a result of the variability of meanings, patterns, values or symbols of care that are culturally derived for health.

ñVisiting patient if patient moves to another hospital unitsò that is perceived as no 1 least important nurse caring behavior by both patients and nurses was also ranked same (No. 1) by patients in Kimble 2003 study.

Patientsô ranked least important caring behaviour No.8 ñHelping the patient not to feel dumb by giving him or her adequate informationò was ranked first most important nurse caring behaviour by nurses in David et al. (2005).

This study found that there are some agreements and disagreement between the findings of this study and previous ones. The findings of the present study support Leiningerô beliefs that asserted human caring is universal phenomenon, but the expressions, processes, structural form and patterns of cares vary among cultures. She went on in her assertion that care behaviours, goals and functions vary trans-culturally because of the social structure, world view and cultural values of people from different cultures. She therefore concluded that care is largely culturally derived and requires culturally based knowledge and skills for satisfying and efficacious nursing practice, more so that nursing is a trans-cultural phenomenon, as nurses interact with clients, staff and other groups and requires that nurses identify and use intercultural nurse-client and system dataò (Marini, 1994).

Tests of Significance

Hypothesis one states that: there will be no significant difference in the perceptions of caring behaviour of patients and nurses.

To test this hypothesis, a one-way analysis of variance (ANOVA) was performed on the adjusted overall mean scores of patients and nurses on the CBAQ caring behaviour items. It shows a difference in the mean scores of patients and nurses.

Nurses scores higher ($\bar{X} = 125.83$, $SD = 15.18$) than the patients ($\bar{X} = 120.04$, $SD = 22.53$). There is a significant mean score difference in the perceptions of CBAQ caring behaviours items as indicators of care between patients and nurses ($F=7.456$, $p<0.05$). Nurses have higher perceptions of CBAQ items as indicators of care than the patients. The hypothesis is therefore rejected.

This finding is similar to: Mchance *et al.* (2008); Chang *et al.* (2005); Widmark-Petersson *et al.* (2000); Hegedus, (1999); VonEssen & Sjöden (1995); Suwanakul (2011); O'Connell & Lander (2008) which also found significant differences between patients and nurses in their perception. However Moyle *et al.* (2005) found no statistical significant difference between patients and nurses in their perceptions of nurse caring behaviours.

Implications of Findings to nursing

The results from this study provide improvement implications for the care of patients, nurses to be aware of the need, during their interactions with patients, to validate the effect their intended caring has upon patients. By so doing and in conjunction with further refinement of the concept of caring for nursing in studies such as this, the practical aim of making patients feel cared for can eventually be achieved on prescriptive basis (Zamanzadeh *et al.* 2010).

Peculiarity and Limitations of the Study

The result may not be generalized because it was only medical and surgical units. However, the result of this study compare in many ways and support the results of comparable studies using the CBA instrument with regards to identification of the nurse caring behaviours that most often elicit a sense of being cared for. Participation

also was limited to those who can read and write thus excluding a considerable portion of the patients. The most seriously ill patients were also excluded. Inability to generalise the result to other patients and nurses' population outside medical and surgical wards as they were not part of the wards data were collected from.

Summary

This study titled 'a comparative analysis of patients' and nurses' perceptions of nurse caring behaviours' in two (2) tertiary hospitals in Jos, with specific objectives of determining nurses' caring behaviour statements that patients perceived as indicators of care, determining nurses' caring behaviour statements that nurses perceived as indicators of care, and determining if differences exist in the nurse caring behaviours that patients' and nurses' perceived as indicators of care. Hypothesis tested was: there will be no significant difference in the perceptions of caring behaviours of patients and nurses. Literature review was done under the following subheadings: conceptual review of literature, theories underlying the study, empirical review and the conceptual model for the study, an application of Jean Watson's theory of human caring. Research design was comparative descriptive survey. Results of the study were presented in Tables, percentages, mean, standard deviation and hypothesis tested using analysis of variance (ANOVA) at 0.05 level of significant. It was revealed that patients and nurses perceived all the care behaviours Assessment questionnaire items except 'visiting patient if patient moves to another hospital unit' as indicators of caring. There was similarities and dissimilarities in selections of most and least important nurse caring behaviours between patients and nurses. Differences exist in nurse caring behaviours that patients and nurses perceived as indicators of care as mean scores showed that nurses gave higher mean values than did patients to all the seven sub-scales. This indicates that nurses to a greater extent than patients gave

higher mean scores to sub-scale items. The total mean scores on the CBAQ for nurses was 125.83 (SD = 22.33) and 120.04 (SD = 15.18) for patients. The hypotheses tested revealed there was a significant difference in the perceptions of caring behaviour of patients and nurses ($F = 7.456$; $P < 0.05$). These findings were compared with previous studies (under discussion of findings) and there are areas of congruency and in-congruency with this study which upheld Leininger (1988) assertion that caring is a universal phenomenon but its expression, pattern, process and structural form varies according to culture. Implication of findings, peculiarity and limitation of the study, conclusion, suggestions for further studies and recommendation were discussed.

Conclusion

The instrument for this data collection was both expressive and instrumental in nature. Expressive activities include establishing trusting relationships and offering support, whereas instrumental activities include physical action-oriented helping behaviours and cognitively oriented helping behaviours. Patients appear to value the instrumental, technical skills more than nurses do, which meant that they may not be open or receptive to the expressive caring behaviours until basic physical needs are met through instrumental activities. On the other hand, the psychological orientation of nurses may be explained by the very ñcomplex and technical caring environment in which caring may be seen as losing the affective aspects as well by the fact they need to deal with the shortages of both nurses and time as consequences of a tight economyò (Papastavrou, Efstathiou and Charalambous (2011). Nurses and patients in this study agreed: 152(92%) and 146(88%) respectively, that all the nursing behaviour elements were indicators of care. There was also concordance in their choice of most important care behaviours. The major area of disagreement between them is in ranking of most and least important caring behaviours. This has great potential for

non improvement in meeting patient's preferred care. The result from this study therefore provide improvement implications for the care of patients, like concrete information on what behaviours the patient would like to experience, ie, it make contribution to the debate concerning the definition of caring from the perspective of specific behaviours that convey caring and fulfill patients's expectations of nurse caring.

Suggestion for Further Research

1. Patients and nurses should be investigated to ascertain that nurses exhibit these caring behaviours in their nurse-patient interaction as having the knowledge of the meaning of something is quite different from practicing the concept.
2. This study only investigated the meaning of caring from 2 institutions in Jos City. Further exploration in different clinical settings is needed so as to understand Nigerian culture-based specificities about caring in nursing.
3. Further research is needed to generate more knowledge on the relationship between caring behaviours, patient outcomes and health or nursing costs as well as significant elements of the caring environment.
4. Further study is suggested to investigate relationship between perceived severity of illness and perceptions of caring behaviour.

Recommendation

Since there is a need to promote a patient-focused philosophy (Suhonen, 2008) and develop a common understanding of caring to improve caregiver-patient interaction, to plan, implement, and evaluate caring that is not based on assumption, the result of this study be communicated to nurses of Jos University Teaching Hospital and Plateau

States Specialist Hospital staff nurses, educators, nurse managers and hospital administrators.

In order to plan care that responds to every patient's individualized situation and needs, nurses have to elicit and use individual patients' preferences more systematically in care planning. This information can be given to nurses in other hospitals in order to enhance the way care is being provided to patients. Programs could be developed in order to help nurses meet caring expectations of clients.

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APPENDIX I

INTRODUCTORY LETTER FROM DEPARTMENT OF NURSING SCIENCES UNIVERSITY OF NIGERIA, ENUGU CAMPUS



DEPARTMENT OF NURSING SCIENCES
FACULTY OF HEALTH SCIENCES & TECHNOLOGY

COLLEGE OF MEDICINE
UNIVERSITY OF NIGERIA

Phone: 08068178477
Telegrams: Nigersity Enugu.

Enugu Campus
Enugu State, Nigeria
dnsunec@gmail.com

Your Ref:

Our Ref: UN/CM/DNS/44.....

Date:

HEAD: A.N. ANARADO M.Sc, RN, RM, FWACN.

TO WHOM IT MAY CONCERN!

LETTER OF IDENTIFICATION

RE:

REGISTRATION NO:

The above named is a post-graduate student of the Department of Nursing Sciences,
University of Nigeria, Enugu Campus.

He/She is writing a project in partial fulfillment for the award of M.Sc. degree in
Nursing and therefore, needs to collect data.

Kindly render him/her the necessary assistance.



APPENDIX II

ETHICAL APPROVAL FROM JUTH

JOS UNIVERSITY TEACHING HOSPITAL JOS, NIGERIA

Phone: 073-450226 - 9
E-mail: juth@infoweb.abs.net



Cables & Telegram: JUTH
P.M.B. 2076
Jos.

Ref: JUTH/DCS/ADM/127/XIX/4797

Date: 14th November, 2011

Daniel Cletus Okpe

Department of Nursing Sciences,
University of Jos.

RE: ETHICAL CLEARANCE/ APPROVAL

I am directed to refer to your application dated 30th September, 2011 on the research proposal titled:

"Patients' and Nurses' Perceptions of Nurse Caring Behaviour in Jos University Teaching Hospital and Plateau State Specialist Hospital Jos" and your appearance before the Ethical Committee on 13th October, 2011.

Following recommendation from the Institutional Health Research Ethical Committee, I am to inform you that Management has given approval for you to proceed on your research topic as indicated.

You are however required to obtain a separate approval for use of patients and facilities from the department(s) you intend to use for your research.

The Principal Investigator is required to send a progress report to the Ethical Committee at the expiration of three (3) months after ethical clearance to enable the Committee carry out its oversight function.

Submission of final research work should be made to the Institutional Health Research Ethical Committee through the **Secretary in Room 14, Administration Department**, please.

On behalf of the Management of this Hospital, I wish you a successful research outing.


Hajia R. Danfillo
For: *Chairman, MAC*



APPENDIX III

ETHICAL APPROVAL FROM PSSH JOS

PLATEAU STATE SPECIALIST HOSPITAL JOS



Ref. No. PSSH/ADM/ETH. CO/2011/100
Old Bukuru Road,
P.M.B. 2113,
Jos, Nigeria
Tel. 073-462180
Fax: 073-464031

Email: psshjos@yahoo.com

Date: August 08, 2011

Reg.No: NHREC/05/01/2010b

Notice of Full Committee Review

Re: Application for information for thesis proposal

Name of Principal Investigator: Daniel Cletus Okpe

Address of Principal Investigator: Dept. of Nursing Sciences, Faculty of Medical Sciences, Univ. of Jos

Date of receipt of valid application: 08 August, 2011

Date of meeting when final determination of research was made: 08 August, 2011

This is to inform you that the request described in the submitted application has been reviewed and given a waiver by the Health Research Ethics Committee of the hospital.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code.

No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code.

Dr. Bitrus Matawal, MBBS, FWACS
Chairman, HREC PSSH

ETHICAL APPROVAL FROM PSSH JOS

PLATEAU STATE SPECIALIST HOSPITAL JOS



Ref. No. PSSH/ADM/ETH. CO/2012/018
Old Bukuru Road,
P.M.B. 2113,
Jos, Nigeria
Tel. 073-462180
Fax: 073-464031

Email: psshjos@yahoo.com

Reg.No: NIREC/05/01/2010b

Date: June 04, 2012

Notice of Expedited Review and Approval

Re: A comparative analysis of Patients' and Nurses' perceptions of nurse caring behaviours in tertiary Hospitals in Jos.

Name of Principal Investigator: Daniel Cletus Okpe

Address of Principal Investigator: Dept of Nursing, Faculty of Medical Sciences, University of Jos

Date of receipt of valid application: 18 May, 2012

Date of meeting when final determination of research was made: 04 June, 2012

This is to inform you that the research described in the submitted protocol has been reviewed and given full approval by the Health Research Ethics Committee of the hospital.

This approval dates from 04/06/2012 to 03/06/2013. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.

A copy of the report should be submitted to the Committee Secretary on completion please. The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit to your research site without previous notification.


Dr. Bitrus Matawal, MBBS, FWACS
Chairman, HREC PSSH

PLATEAU STATE SPECIALIST HOSPITAL STATISTICS

S/No.			
1	Total NO of Nurses	201	
2.	Total no of in patient beds	176 beds.	
3.	Rough estimate of in patients and out patients per month.	OUT PATIENTS=3,761 IN PATIENTS=222 G/TOTAL=3,983.	JUNE 2011.
4.	Various units (wards) available in the Hospital	Surgical Ward-1 Medical " - 2 Paediatric " - 3 SCBU, ICU, " "	Amenity Labour maternity E.P.U. dg/10 wards
5.	Date of the Establishment of the hospital.	1933.	

This statistics was compiled by Medical Records department Plateau State Specialist Hospital Jos. (Mwahus Musa N.)

Plateau State Specialist Hospital
Old Bukuru Road,
P.M.B. 2113, Jos.

APPENDIX IV

Letter for Access into the Wards to Deputy Director Nursing Services JUTH

Department of Nursing
Sciences,
University of Jos,
P.M.B 2084 Jos,
Plateau State,
08/05/2012.

The Assistant Director,
Nursing Services Department,
Jos University Teaching Hospital,
Jos.

*Approved as attached
ethical clearance.*

[Signature]
9/5/12

Dear sir/ma,

APPLICATION FOR APPROVAL TO ADMINISTER QUESTIONNAIRE ON PATIENTS AND NURSES.

I write to solicit for your kind approval to administer questionnaire on in - patients and nurses of your hospital. This is in - partial fulfillment of Msc Nursing requirement. I am a student of department of nursing sciences, university of Nigeria, Enugu campus, and a graduate assistant with Department of nursing sciences, university of Jos. The study is aimed at comparing patients' and nurses' perceptions of nurse caring behaviours.

The part the patients and nurses are to play is to answer the questionnaire. I also seek your assistance together with the entire staff in making this a success please. Attach is photocopy of the ethical clearance.

Thanks for your usual co - operation.

Yours faithfully,

[Signature]
08/05/2012

Daniel Cletus Okpe.

08076205470

APPENDIX V

Informed Consent Form for Respondents Attached to Each Questionnaire

CONSENT FORM

I, Daniel Cletus Okpe, Graduate Assistant with the Department of Nursing Sciences, University of Jos, is carrying out a research on the topic "A comparative analysis of Patients' and Nurses' perceptions of Nurse caring behaviours".

Why carrying out this research? This research is chosen to survey patients and nurses in this busy hospital to see what behaviours a nurse demonstrates that would make you, a patient ~~or~~ feel cared for, and to see if there is any difference(s) in nurses' own perceptions.

What will participation entails?

Your participation will only entail answering a structured questionnaire?

How long will participation take? A maximum of 30 minutes is enough for us to administer the questionnaire.

Are discussions and data confidential? Every bid of our discussion and everything concerning your person are kept confidential. You may feel free.

Please tick below as appropriate:

1. I confirm that I have read and understood the information sheet dated 16.5.2012. For study. Yes/No
2. I have considered the information, and is convinced satisfactorily YES/NO.
3. I understood that appropriate sections of any of my medical details and data to be collected during the study will be handled by a responsible individual. I give this individual permission or access to my medical details. YES/NO
4. I understand that my participation is voluntary and can alter at anytime YES/NO.
5. I have agreed to take part in the above research study. YES/NO.

.....
Patients' I.D Number

.....
Date

.....
Signature

Daniel Cletus Okpe

24/05/2012

[Signature]

Researcher

Date

Signature

APPENDIX VI

Department of Nursing Sciences
Faculty of Health Sciences and Technology,
College of Medicine,
University of Nigeria
Enugu Campus

Dear Respondents

To patients and nurses of Jos University Teaching Hospital and Plateau State Specialist Hospital Jos.

I am an M.Sc. student in the Department of Nursing Sciences, University of Nigeria, Enugu Campus. Providing care to patients in a compassionate and sensitive way is a goal of this institution. Today's health care environment has created many challenges for healthcare worker to overcome.

In order to fulfill the requirements for my master's thesis, I have chosen to survey patients and nurses in this busy hospital to see what behaviours a nurse demonstrates that would make you, a patient or parents of a patient, feel cared for.

The information you provide by filling out this questionnaire will be kept anonymous and confidential. No names will be used on any of the papers. You do not have to answer all the questions and your participation in this project is strictly voluntary. The purpose of this project is to gain information that will help nurses better meet the needs of patients.

Thank you for your participation.

Daniel Cletus Okpe
Pg/M.Sc/07/46888

CARE BEHAVIOUR QUESTIONNAIRE (CBA) ON

A comparative analysis of patients and nurses perceptions of nurse caring behaviours in Jos University Teaching Hospital and Plateau State Specialist Hospital Jos.

Instruction: Tick (✓) in the appropriate space/box

Section A: Demographic characteristics of respondents

1. Sex: Male ☐ Female ☐ tribe
2. Ward: Medical ☐ Surgical ☐ Female ☐ Male ☐
3. Age range 18 -30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐
4. Are you patient ☐ Parent of a child who is a patient ☐ Nurse ☐
5. Religion: Christianity ☐ Islam ☐ Traditional religion ☐
6. Perception of severity of illness: Mildly ill ☐ Moderately ill ☐
Severely ill ☐
7. Educational qualification of patient: No Formal education ☐ Primary ☐
Secondary ☐ Tertiary ☐
8. Educational qualification of nurses: graduate nurse ☐ Diploma nurse ☐
M.Sc ☐ Post Basic Diploma ☐
9. Occupation: Trading ☐ Farming ☐ Civil servant ☐ Student ☐
Nursing ☐ Artisan ☐
10. Professional experience of nurses 1-10 ☐ 11-20 ☐ 21-30 ☐
31and above ☐.

SECTION B: Below are Nurse-Patient Interactions/Nursing Interventions/behaviours considered to be indicators of care. Tick as appropriate the following: Strongly Agreed (SA), Agreed (A), Strongly Disagreed (SD), Disagreed (D), or Undecided (U), in the questionnaire tables your perceptions on each of the statements as per being an indicator of care or not appropriately

	Nurse –Patient Interactions/Nursing Interventions/ behaviours	Strongly Agree 4	Agree 3	Disagree 2	Strongly disagree	Undecided 0
A	Humanism/faith – Hope sensitivity (Faith)					
1.	Using soft, gentle voice with patient					
2	Being cheerful with patient					
3	Being kind and considerate to patient					
4	Showing patient love					
5	Treat patient with respect					
6	Really listen when patient talks					
7	Get to know (Treat) the patient as an individual					
8	Is calm					
9	Know what they are doing					
b.	Helping/Trusting (Trust)					
10	Calling patient by his/her preferred name					
11	Answering patients' questions clearly					
12	Being honest with patient					
13	Helping patient plan ways to meet goals					
14	Treating patient information confidentially					
15	Paying special attention to patient during first times (such as hospitalization and/or treatment)					
16	Touch patient when patient need it for comfort					
17	Visiting patient if patient move to another hospital unit					
18	Is professional in appearance, wears appropriate identifiable clothing and identification.					

c	Expression of Positive/Negative Feelings (Feeling)					
19	Encouraging patient to express feelings about his or her disease and treatment					
20	Talking with patient					
21	Including patient in planning patient's care					
d.	Teaching/Learning (Teaching)					
22	Giving patient information so that patient can make a decision					
23	Checks his or her perception of the patient with the patient before initiating any action.					
24	Telling the patient in an understandable language what is important to know about his or her disease and treatment					
e.	Human needs assistant (Needs)					
25	Encouraging the patient to call if he or she has problem					
26	Knowing how to give injections, Iv's etc					
27	Responding quickly to patient's calls					
28	Giving patient treatments and medications on time					
29	Demonstrating professional/knowledge and skill					
30	Being patience and tireless with patient					
31	Know when it is necessary to call a doctor					
32	Checks on the patients frequently.					

f.	Supportive/protective/corrective environment (Support)					
33	Supporting patient					
34	Help the patients not to feel dumb by giving him/her adequate information					
g.	Existential/phenomenological/spiritual forces (spiritual)					
35	Forgiveness facilitation e.g. assisting patient as an individual to forgive and/or experience forgiveness in relationship with self, others and higher power.					
36	Praying with and/or for patient.					
37	Preparing patient for death when it is inevitable					

