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How Caring Attitudes and Patient-Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient-Family Centered Care

Jennifer Shamloo
Kennesaw State University

HOW CARING ATTITUDES AND PATIENT-FAMILY CENTERED CARE BELIEFS OF CRITICAL CARE REGISTERED NURSES INFLUENCE FAMILY MEMBERS' PERCEPTIONS OF PATIENT-FAMILY CENTERED CARE

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JENNIFER SHAMLOO

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Name Jennifer Shamlou

Email jennifershamlou@gmail.com

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ABSTRACT

Purpose: To examine the relationships between caring attitudes and PFCC beliefs of critical care nurses and family members' perceptions of PFCC.

Design: A descriptive, cross-sectional research design was used.

Methods: One hundred and six critical care registered nurses and 76 critical care family members were recruited from a healthcare organization located in the southeastern United States. Data collection occurred from October 2012 to November 2012.

Results: Nurses reported a high level of caring efficacy and moderately high beliefs about PFCC principles. Family members reported a moderate level of PFCC needs being met. No statistically significant relationships were found between nurses' caring attitudes and PFCC beliefs or between critical care nursing units' caring attitudes and family members' perceptions of PFCC. In addition, nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, and certification were not found to be predictors of nurses' caring attitudes and PFCC beliefs.

Conclusion: Nurses perceived themselves as highly caring and providing PFCC. However, there is an obvious incongruence between nurses' perceptions and family members' realities. It is the responsibility of the nursing profession to bridge the gap that exists to ensure that nurses provide care in a way that is safe, caring, and respectful.

Keywords: patient-family centered care, critical care nursing, caring, caring attitudes, family members.

CHAPTER 1: INTRODUCTION

Research has shown that patient-family centered care (PFCC) has positive effects on both the patient and participating family members (Davidson, 2009). However, critical care providers are less quick to adopt the principles of patient-family centered care. In a time when patients and family members may find themselves most vulnerable, physically and emotionally, the impetus for caring and supporting patients and families based on patient-family centered care beliefs is derived from the positive benefits associated with these values.

This chapter presents the purpose of this study, background and significance information, statement of the problem, and theoretical and conceptual frameworks. In addition, this chapter presents the research questions, definitions, assumptions and limitations for this study.

Purpose

The purpose of this study was to examine the relationships between critical care nurses' caring attitudes and patient-family centered care beliefs and family members' perceptions of patient-family centered care. This study described critical care nurses' caring attitudes and PFCC beliefs in addition to family members' perception of patient-family centered care. Furthermore, the study examined the influence of nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, and certification on nurses' caring attitudes and PFCC beliefs. Finally, this study explored

the relationships between critical care nursing units' caring attitudes and PFCC beliefs and family members' perception of patient-family centered care.

Background and Significance

In the United States, it is estimated that over 5 million patients are admitted annually to critical care units (Society of Critical Care Medicine, 2005). The top five admitting diagnoses include respiratory insufficiency/failure, postoperative management, ischemic heart disorder, sepsis, and heart failure (Society of Critical Care Medicine, 2005). The Department of Health and Human Services reports that 503,124 nurses in the United States work in critical care units providing care to critically ill patients (2004).

Admission to critical care units is often a sudden, unexpected event that can result in adverse effects on family members (Van Horn & Dautz, 2007). Many times family members are left out of the care planning process until they are requested to make decisions for their loved ones (Lee et al., 2007). Research shows that communication deficits, contradictory information, and lack of support leads to anxiety and depression (Paparrigopoulos et al., 2005: Pochard et al, 2006) in family members as well as family dissatisfaction (Fumis, Nishimoto, & Deheinzelin, 2008; Bailey, Sabbagh, Loiselle, Boileau, & McVey, 2010).

Downey, Engleberg, Shannon, and Curtis (2006) cites technological advances, ethical dilemmas, fluctuations in patient populations, staffing needs, professional attitudes, organizational structure and economic trends as factors that create barriers to providing care in a manner that is patient and family centered. In addition, the nursing profession has a history of underestimating the level of importance of family's needs (Davidson, 2009). There is very little information that bridges the gap between nurses'

caring attitudes and perceptions of patient-family centered care principles and the families' perceptions of family centered care.

With the increasing acuity in hospitals and ICUs as well as nurses seen as front line care providers, it is imperative to research the relationship between caring and patient-family centered care. Exploring the relationships between nurses' caring attitudes and patient-family centered care beliefs and family members' perceptions of patient-family centered care provided further knowledge in understanding the dynamics in creating and maintaining a patient-family centered care environment in critical care units.

Statement of the Problem

Caring is the foundation for nursing practice. When patients and their families enter into critical care areas they may be experiencing feelings of anxiety, hopelessness, distress, fear, and uncertainty (Davidson, 2009). A critical care unit poses unique issues that do not extend beyond the confines of the critical care unit walls such as physical and psychosocial barriers that may inhibit the inclusion of family in the patient's care. These barriers include machinery such as ventilators, medication infusion pumps, bedside monitoring, wires that attach all of the machinery together, intravenous tubing that is used to administer medications to patients, and invasive lines that may be required for direct patient care. In addition, the physical size of these areas and the critical nature of work performed may inhibit personal touch and communication with patients and family members (Kinrade, Jackson, & Tomnay, 2009).

Nurses have the responsibility to care for the needs of their patients and their family members. The principle of family inclusion in the care of the patient has been termed patient and family centered care. The Institute for Patient and Family Centered

Care has established four core concepts that encompass what it means to be family centered (Frampton et al., 2008). The four concepts are: respect and dignity, information sharing, participation, and collaboration (Frampton et al., 2008).

The clinical skills and communication skills of nurses influence the interactions between patients and their families (Agard & Maindal, 2009). If interactions between a nurse and a family member are reliant upon caring, and caring is altered, a breakdown in patient-family centered care principles may occur. Consequences of decreased caring and noncompliance with patient-family centered care beliefs can result in families having poor perceptions of patient-family centered care, increased emotional distress for families, and unmet needs of family members (Davidson, 2009). Patient-family centered care has become an important issue for every area of nursing care, with special implications in critical care.

Theoretical/Conceptual Framework

Swanson's (1991, 1993) Theory of Caring (Figure 1) and the Patient-Family Centered Care Philosophy (Frampton et al., 2008) are the frameworks guiding this study. Figure 1 depicts the combination of the two frameworks with integration of the study variables. Swanson developed her theory in 1991 through the use of phenomenological inquiry in three separate perinatal research studies (Swanson, 1990; Swanson-Kauffman, 1986, 1988a, 1988b). First, Swanson researched the caring behaviors of others that were perceived to be helpful by mothers that had miscarried (Swanson-Kauffman, 1986, 1988b). Second, Swanson researched caring processes of providers working in the neonatal intensive care unit (NICU) (Swanson, 1990). Lastly, Swanson researched the effects of nurse caring on the ability of high risk mothers to provide care to their infants

(Swanson-Kauffman, 1988a). Swanson attributes the development of the Theory of Caring to Benner's (Benner, 1984) theory of The Helping Role of Nursing and Watson's (Watson, 1985) Carative Factors theory (Swanson, 1993).

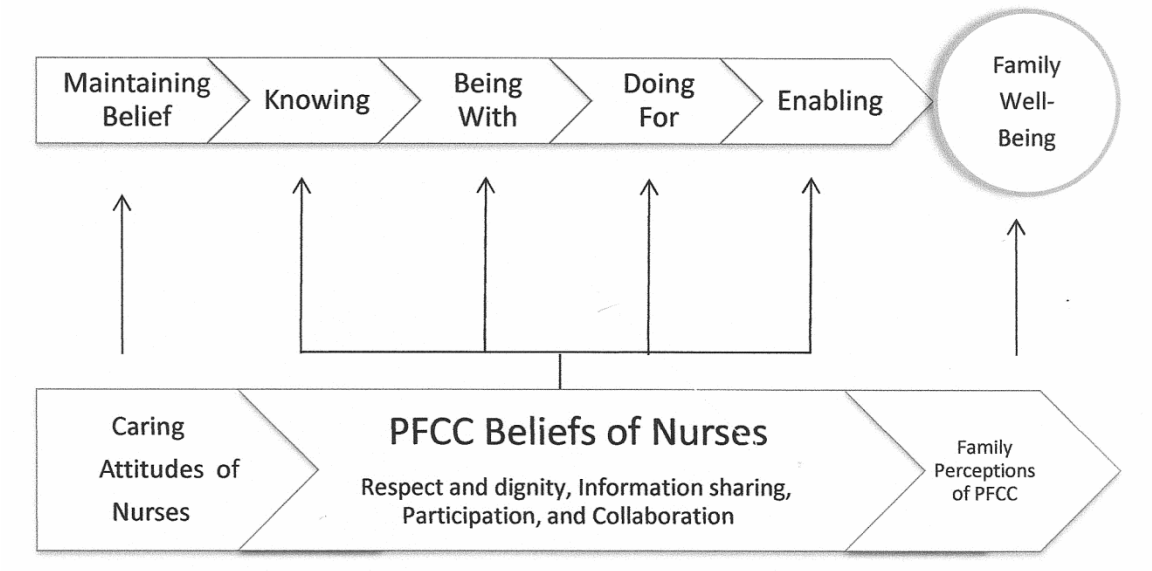

Figure 1. Swanson's Theory of Caring and Relationship to Study Variables

Swanson's Theory of Caring proposes the processes of caring are not solely nursing specific and can be commonly associated with any type of relationship that has been established (Swanson, 1993). Caring, a unique term that has gone ill-defined has been defined by Swanson as the way for one person to relate with another person trough a foundation of personal commitment and responsibility (Swanson, 1993). In addition, the theory provides five caring processes that characterize and explain the phenomenon of caring. The five caring processes are: maintain belief, knowing, being with, doing for, and enabling.

Maintaining belief is the cornerstone of caring in which there is a central belief in a person and their ability to persevere through events with a sense of purpose. Andershed and Olsson (2009) further describe the maintaining belief process as holding a person in

high esteem, helping them maintain a hope-filled attitude, helping them to find meaning in their situation and being present for their loved one. Knowing is described as a sense of self awareness that increases the ability of the nurse to better mirror the reality of the patient and their family members (Swanson, 1993). Awareness of self and perceptions of others is a critical factor in this level of caring due to the varying abilities of nurses to adjust to the realities of others and contain their own needs. Being with refers to the emotional presence of the nurse. This factor is important in conveying that their reality is accepted and appreciated and there is both a physical and emotional presence of the nurse. The fourth caring process refers to the principle of doing for others. Very simply stated, it is doing for one the way they would do for themselves if possible. Lastly, enabling is defined as how a person is able to help another person navigate through unfamiliar events in their lives (Swanson, 1993). The goal of enabling is to provide a client with the tools needed to attain long term well-being.

Patient and family centered care is a term that has gained substantial momentum in the way that healthcare is delivered to patients and their family members over the last decade (Frampton et al., 2008). The Institute of Medicine published a report in 2001, *Crossing the Quality Chasm,* that established patient and family centered care as one of the six key quality improvements in the delivery of health care. The Institute of Patient Family Centered Care identified four core concepts that help to define PFCC: respect and dignity, information sharing, participation, and collaboration (Frampton et al., 2008). Respect and dignity is defined as health care providers listening to and honoring the choices of patients and their family members. Patients and their families are valued for their thoughts, beliefs, customs, cultures, and is incorporated in the delivery of their care.

Information sharing is the act of communicating and sharing information in a way that is complete and unbiased and enables the family to make decisions in a way that is reflective of being truly informed. The goal of information sharing is to provide timely and accurate information to expedite the decision making process of patients and their family members. Participation refers to the patient and family members being welcomed to participate in the planning, coordination, and delivery of care through the care delivery continuum. Lastly, collaboration is the coordinated efforts of patients, families, health care providers, and other multidisciplinary team members in the delivery of care (Frampton et al., 2008).

Research Questions

The research questions that guided this study were:

1) What is the relationship between caring attitudes and PFCC beliefs of critical care nurses?
2) What is the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification and caring attitudes?
3) What is the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, and certification and PFCC beliefs?
4) What is the relationship between critical care nursing units' caring attitudes and PFCC beliefs and family members' perceptions of PFCC?

Conceptual Definitions

Critical care nurse. A licensed professional nurse who is responsible for ensuring that acutely and critically ill patients and their families receive optimal care employed at the recruitment organization.

Critical care nursing. A specialty within nursing that addresses the human responses to acute problems that are threatening to the sustenance of life (American Association of Critical Care Nurses, 2012).

Family. Refers to a connection between two or more people and can reflect a legal, biological, or emotional relationship. This relationship is determined by patients and their family members (Institute For Patient And Family Centered Care, 2010).

Caring attitude. A concern that relates to the peace, comfort, and harmony of another person (France, Byers, Kearney & Myatt, 2011).

Patient-family centered care. A model of care delivery that is interdisciplinary in nature and includes the patient and their family members (Abraham & Moretz, 2012).

Operational Definitions

Nurses' caring attitude. Caring attitude was measured using the Caring Efficacy Scale (CES) (Coates, 1997). The total mean score of the CES was calculated.

Unit caring attitude. Unit caring attitude was measured using the CES (Coates, 1997). A CES mean composite score of all nurses working on each critical care unit was calculated.

Nurses' patient-family centered care beliefs. Nurses' patient-family centered care beliefs were measured using the Critical Care Family Needs Inventory (CCFNI) (Leske, 1991) total score.

Critical care units PFCC beliefs. Critical care units PFCC beliefs were measured using the CCFNI (Leske, 1991) composite scores of all nurses working on each critical care unit to obtain a unit score.

Family members' perceptions of patient-family centered care. Family members' perceptions of PFCC were measured using the Needs Met Inventory (NMI) (Warren, 1993) total score.

Assumptions

Assumptions for this research study included: 1) families want to be a vital part of the patient care process, 2) families can contribute to the patient's healing process, 3) critical care nurses believe that family members are an essential component in the patient care process, and 4) unit composite scores of caring attitudes and patient-family centered care beliefs of nurses influence the family's perceptions of patient-family centered care.

Limitations

A limitation of this study was the inability to link individual family members' perceptions of PFCC scores to a particular nurse. In the critical care environment, families come in contact with multiple care providers on a daily basis, so it is not realistic to think that only one nurse impacts family members' perceptions of PFCC. Therefore, units' PFCC beliefs and caring attitudes composite scores of all nurses working on each unit were calculated.

Another limitation was that the study was only conducted in one healthcare system located in southeastern United States. This may limit the generalizability of the findings. In addition, critical care nurses were recruited from this one healthcare

organization which may produce a homogeneous population limiting the generalizability of the findings.

Finally, research packet questionnaires were distributed to the break rooms located in the critical care units for nurses to complete. This may have allowed nurses to communicate while filling out the questionnaires and may have influenced their responses to the questionnaires.

CHAPTER 2: REVIEW OF LITERATURE

This chapter provides research literature that supports the purpose of this study. The literature review focuses on nurses' caring attitudes and patient-family centered care within the context of critical care areas.

Caring

Swanson developed her theory of caring in 1991 through the use of phenomenological inquiry in three separate perinatal research studies (Swanson, 1990; Swanson-Kauffman, 1986, 1988a, 1988b). Swanson defines caring as the way for one person to relate with another person trough a foundation of personal commitment and responsibility. Swanson further explains that caring relationships which are a central concern to nursing include nurses to client, nurses to nurses, and nurse to self (1991). Andershed and Olsson (2009) describe this theory as a guide to effective and sensitive clinical practice.

Nelson (2011), reports that we are making a mistake when we do not consider the act of caring as a formal structure in situations that involve our patients and their families. The literature shows that often, the perceptions of needs and caring are often incongruent between the nurses that provide care and the family members that are the recipients of care (Papastavrou, Efstathious, & Charalambous 2011; Papastavrou et al., 2012). The caring of family members by nurses translates to an increased ability and capacity for family members to care for their loved ones (Stayt, 2009).

Several characteristics have been identified as caring: behaviors such as interpreting and explaining information, voice tone, eye contact and attitude, being a capable and competent care provider, taking the time to be wholly present and engaged, and providing physical comfort to families have been associated with a positive perception of caring (Cluckey, Hayes, Merrill, & Curtis, 2009). Communication, both verbal and nonverbal, is a pivotal ingredient in the caring process, and when improperly instituted can cause barriers in the provision of care and the caring process (Betcher, 2010).

O'Connell and Landers (2008) conducted a descriptive, comparative, quantitative study to compare the perceptions of nurses and relatives of critically ill patients on the importance of caring behaviors of critical care nurses. A convenience sample of 40 critical care nurses and 30 relatives of critically ill patients were recruited. Nurses and relatives completed an adapted version of the Caring Behaviors Assessment Tool (Cronin & Harrison, 1988). The researchers found that critical care nurses rated the 'humanism/faith/hope/sensitivity' caring behavior subscale as the most important and included the following caring behaviors as top caring behaviors of critical care nurses: 'knows what you were doing', 'treat the patient with respect', 'treat the patient as an individual', 'reassure the patient' and 'is kind and considerate.' In contrast, relatives rated the 'human needs assistance' caring behavior subscale as the most important caring behaviors of critical care nurses. Relatives felt that the technological caring to ensure the patient's physiological stability took precedence over all other caring behaviors. In conclusion, the researchers summarized that technological caring behaviors of nurses were considered the most important by the relatives.

In a descriptive, qualitative study conducted by Clukey et al. (2009), the researchers interviewed family members of moderately to severely injured trauma patients to explore family members' perceptions of nurses' caring behavior. The sample consisted of 10 family members of patients cared for at a level II trauma center. Semi-structured interviews were conducted within 6 weeks following discharge of the patient. During the interviews, family members were asked to identify behaviors of nurses that were perceived as caring and as uncaring. Family members identified the dominant behavior that demonstrated caring was explaining what was going on and interpreting medical jargon. In addition, appearing hurried and abrupt was identified as non-caring behavior of nurses. The researchers concluded that the interpersonal relationship developed between the nurse and family member influences the family member's perception of caring.

Hayes, Merrill, and Clukey (2010) conducted a descriptive, quantitative study using a survey method to describe what family members identified as caring behaviors of nurses. One hundred family members of traumatically injured patients were recruited to complete the Caring Behavior Inventory-Family survey (Wolf, Zuzelo, Goldberg, Crothers, & Jacobson, 2006). The highest rated caring behavior items identified were 1) helping you and your family make decisions; 2) being honest with you; 3) helping you feel comfortable; 4) speaking to you with a clear, friendly voice; 5) being pleasant with you; 6) protecting your privacy; 7) watching out for your safety; and 8) giving you a hand when you need it. The lowest rated caring behaviors identified were 1) calling you by your preferred name; 2) assisting you to meet your religious or spiritual needs; 3) knowing your likes, dislikes, and routines; and 4) meeting your needs whether or not you ask. Interesting, the researchers found some differences in family members' perceptions

of caring behaviors related to gender, ethnicity, and education levels. Women in the study rated the caring behaviors of 'calling you by your preferred name' and 'responding in a timely manner to your requests' significantly higher than men. Caucasian family members, which were 85% of the sample, rated the following eight caring behaviors more positively than the other ethnic groups: 1) being honest with you; 2) speaking to you in a clear, friendly voice; 3) being pleasant with you; 4) protecting your privacy; 5) watching out for your safety; 6) assisting you to meet your religious or spiritual needs; 7) helping you feel comfortable; and 8) recognizing how you feel. In addition, higher educated family members rated the following caring behaviors higher: 1) knowing your likes, dislikes, and routines; 2) being pleasant with you; and 3) meeting your needs whether or not you ask. No significant associations were found between caring behaviors and family members' reported religion or relationship to the patient.

In a quantitative, survey study, Suliman, Welmann, Omer, and Thomas (2009) explored Saudi patients perceptions of important caring behaviors of nurses and those caring behaviors which were most frequently attended to by nurses. A convenience sample of 393 patients from three hospitals in three different regions of Saudi Arabia was recruited. The patients completed the Caring Behaviors Assessment instrument (Cronin & Harrison, 1988). The Caring Behavior Assessment instrument consists of seven subscales: 1) humanism/faith-hope/sensitivity, 2) helping/trust, 3) expression of positive/negative feelings, 4) teaching/learning, 5) supportive protective corrective environment, 6) human needs assistance, and 7) existential/phenomenological/spiritual forces. The most important caring behavior subscales identified were humanism/faith-hope/sensitivity (96.7%), supportive/protective/corrective environment (95.7%), and

human needs assistance (95.4%). The study results showed that patients rated overall caring behaviors as important (97.2%) and that they frequently experienced these caring behaviors in nurses (73.7%). Although, a statistically significant difference was found between the importance of and frequency of attendance to caring behaviors by nurses (f = -4.689, p = .001). In addition, a statistical significance was found between genders in overall caring behaviors in terms of importance ($p < .001$) and in terms of all caring behaviors subscales with the exception of the existential/phenomenological/spiritual forces subscale in favor of women ($p < .05$). Furthermore, female patients rated the following five caring behaviors subscales (humanism/faith-hope/sensitivity, helping/trust, expression of positive/negative feelings, supportive/protective/corrective environment and human needs assistance) more frequently attended to by nurses than male patients ($p < .05$).

Palese et al. (2011) conducted a multicenter, quantitative, correlational study to examine the correlation between caring as perceived by patients and patient satisfaction and to determine whether caring behaviors affected patient satisfaction. A convenience sample of 1,565 surgical patients from six European countries (Cyprus, Czech Republic, Greece, Finland, Hungary, & Italy) was recruited. Participants completed the short version of the Caring Behaviors Inventory (CBI) (Wu, Larrabee, & Putnam, 2006) and the Patient Satisfaction scale (PSS) (Kim, 1991). The CBI instrument consists of four factors: 1) assurance of human presence, 2) knowledge and skill, 3) respectful deference to the other and 4) positive connectedness. A statistically significant positive correlation was found between caring behaviors and patient satisfaction (r = 0.66, $p < .01$). Additional, a stepwise multiple regression model revealed that 44.1% of the PSS score

variance was explained by three of the CBI factors, with 'positive connectedness' explaining 40.4% of patient satisfaction ($p < .001$), 'assurance of human presence' explaining 3.2% of patient satisfaction ($p < .001$), and 'respectful deference to the other' explaining 0.5% of patient satisfaction ($p < .001$).

Nurses are in a unique, yet demanding position to provide care to both patients and their families. The practice of nursing has developed in to a discipline where caring and emotional involvement is essential in the care of a patient and their family (Stayt, 2009). In critical care settings where both the patient and families are experiencing crises, physical and/or psychological, it is paramount that nurses remember that perceptions of both the patient's and family members' needs may be different from the physical needs that the nurse is prone to focus on.

Patient and Family Centered Care

Agard and Maindal (2009) provide a pivotal conclusion that has led to the origination of the research questions in this study. In light of all of the research and information provided about family centered care and critical care nurses, there is still a pervasive theme of critical care units not adhering to the philosophy of patient-family centered care (Omari, 2009; Mitchell, Chaboyer, Burmeister & Foster, 2009). Agard and Maindal acknowledge that personal values and attitudes influence the interactions that nurses have with their patients and their families.

Patient-family centered care has been researched for decades and has been established in various care settings more readily than in critical care settings (Kuhlthau et al, 2011). France, Byers, Kearney and Myatt (2011) conducted a non-experimental, descriptive study that evaluated nurses' interpersonal communication and nursing care in relationship

to patients and families. The researchers found a statistically significant positive correlation between nurse-to-patient communication (r = .764, p = .01) and nurse-to-patient caring (r = .507, p = .05). However, no significant correlations between nurse-to-family caring and nurse-to-family touch were found (r = .381).

Abraham and Moretz (2012) impressed the long standing history behind patient-family centered care and national involvement from organizations such as Institute for Healthcare Improvement (IHI), Joint Commission, American Hospital Association, and the National Patient Safety Foundation. Although, there is a debate about the caregivers' hesitation to implement such values (Abraham & Moretz, 2012). Factors that influence nurses' hesitation to implement PFCC include a sense of loss of control, drifting away from traditional practices, and interference with daily activities (Abraham & Moretz, 2012). Abraham and Moretz (2012) cite healthcare professionals' attitudinal challenges of family centered care such as: healthcare professionals feeling that families are in the way, families require a lot of time to answer all of their questions, families may have unreasonable requests, families observing and questioning skills that are performed, and families may misunderstand the information that is communicated during interdisciplinary rounds.

In an environment that places the patient at the mercy of their severe illness, ventilator support, analgesics, and sedation, communication and comprehension can be severely impeded and increase the reliance upon family members to act as decision makers for the care of the patient (Hickman et al, 2010). Davidson (2009) cites critical care nurses as underestimating the needs of family members. Such underestimation of needs creates an environment laden with anxiety and depression. Mitchell et al. (2009)

reported higher levels of respect, collaboration, and support when family centered care was implemented.

Research supports that family members of critical care patients have specific needs that must be met in order to assist the family members in coping and dealing with the admission of their loved ones to critical care (Davidson, 2009; Hinkle, Fitzpatrick, & Oskrochi, 2009). These needs have been classified as 1) support, 2) comfort, 3) information, 4) proximity to the patient, and 5) assurance. Support needs include access to resources and support systems for family members of critically ill patients. Comfort needs are reflected more on a personal level for family members and involve such things as access to food, adequate and comfortable waiting areas, and access to telephones. Information needs focus on the family's need to have up-to-date information that is consistent and easily understood from healthcare providers. Proximity needs are centered on access to the patient and visitation. Assurance needs address concepts such as hope, honest communication, and caring behaviors of healthcare providers during interactions with family members.

The top ten needs of family members, as identified by Nelson and Plost (2009) utilizing the CCFNI, are: feel there is hope, feel the staff cares about the patient, have a waiting room near the patient, be communicated with regarding changes in the patients' condition, know the prognosis, have questions answered honestly, know specific facts about the prognosis, receive information about the patient once a day, have explanations provided in terms that are understood, and to be allowed to see the patient frequently. When PFCC is implemented, outcomes are improved and experiences of care are increased (Moretz & Abraham, 2012).

In a descriptive, exploratory study conducted by Omari (2009), the researcher examined the perceived and unmet needs of family members of patients in critical care. A convenience sample of 139 family members of 85 critically ill patients was recruited from three different hospitals in northern Jordon. Family members completed the Critical Care Family Needs Inventory (Leske, 1991) and the Needs Met Inventory (Warren, 1993). The top five needs identified by the family members were 1) to be assured that the best care possible is being given to the patient, 2) to feel that the hospital personnel care about the patient, 3) to feel there is hope, 4) to have questions answered honestly, and 5) to have explanations given that are understandable. Interestingly, the family members indicated that none of the top five needs were perceived as being met by the nursing staff.

Prachar et al. (2010) conducted a prospective, descriptive quantitative study using a survey methodology to evaluate the potential differences in family needs for patients that were admitted specifically to a neuroscience intensive care unit. A convenience sample of 111 family members of neuroscience patients who were admitted to the ICU was recruited. The family members completed the Critical Care Family Needs Inventory (Leske, 1991). In addition, the authors added seven supplemental questions that they felt might better address the needs of the neuroscience ICU family members: to have test results explained, to receive written information about the patient's disease, to have the option of being present during bedside procedures, to have the equipment attached to the patient explained, to know that the patient's pain is being addressed, to receive help in locating affordable lodging near the hospital, and are there any needs that you can identify that are not included in this survey. There were differences between the top ten needs as identified by Molter (1979) and the current study. However, of the top ten needs

identified by both studies, there were five needs that were present in both studies: to have questions answered honestly, to know specific facts concerning the patient's progress, to be called at home about changes in the patient's condition, to receive information about the patient at least once a day, and to feel that the hospital personnel care about the patient.

In 2009, Kinrade, Jackson, and Tomnay conducted a quantitative, descriptive study that examined the relationship between family members' perceptions of their needs and nurses' perception of family needs. Twenty-five family members and 35 nurses completed the Critical Care Family Needs Inventory (Leske, 1991). The results of the study showed a shift from past importance of 'to feel there is hope' to a present importance of 'to have questions answered honestly'. Kinrade et al. concluded that it is currently more important for nurses to foster an environment that promotes families asking questions, assisting their family members with basic patient care tasks, and open visitation for family members.

Bailey et al. (2010) conducted a cross-sectional, descriptive, correlational pilot study that examined the interrelationships between informational support, anxiety, and satisfaction with care of critical care family members. Family members completed the Critical Care Family Needs Inventory (Leske, 1991) and the State Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). Satisfaction with care data was obtained from the healthcare system's satisfaction monitoring system. Twenty-nine family members participated in the study. The researchers found a significant positive correlation between satisfaction with care and informational support ($r = 0.741$, $p < .001$). Although, no significant relationships were found between informational support

and anxiety or between satisfaction with care and anxiety. The researchers concluded that informational support interventions for critical care families is an important aspect of patient-family centered care and healthcare organizations need to implement effective programs to promote effective communication and information sharing with families.

Roberti and Fitzpatrick (2010) assessed the overall satisfaction of family members of critically ill patients. Thirty-one family members participated in filling out the Critical Care Family Satisfaction Survey (CCFSS) (Wasser et al, 2004). While the results yielded a general satisfaction with care provided, there were several areas that were identified as opportunities for improvement for the critical care areas. The lowest ranking areas of satisfaction were: the waiting time for results of tests and radiographs, noise level in the critical care unit, peacefulness of the waiting room, and preparation for my family members transfer from critical care. The implications derived from this study point to increasing awareness amongst staff on the importance of creating a healing environment in which communication is increased.

Striker et al. (2009) conducted a quantitative study of 996 family members using the Family Satisfaction-ICU questionnaire (Wall et al., 2007). The purpose of the study was to assess the level of satisfaction in family members of people admitted to the ICU and identification of interventions that could increase satisfaction rates. Issues identified that offered the most opportunities for improvement in overall satisfaction were: emotional support for proxy, consistency of information, completeness of information, understanding of information, general atmosphere in the ICU, coordination of care, and assessment and treatment of agitation. A higher patient to nurse ratio was associated with lower satisfaction (p = .03). Interestingly, satisfaction levels of next of kin increased for

patients who were more severely ill (p = .01). This finding may be related to the need for increased communication between the family and nurses caring for higher acuity patients.

Mitchell et al. (2009) explored the effects of critical care family members' perception of patient-family centered care by partnering critical care nurses with patients' families to provide fundamental care to patients. The quantitative study was a pragmatic clinical trial with a nonequivalent control group pretest-posttest design. The intervention group of family members participated in providing fundamental care to patients while the control group of family members did not participate in providing fundamental care to patients. The Family-Centered Care survey (FCCS) (Shields & Tanner, 2004) measured family members' perceptions of respect, collaboration, support and overall family care at baseline and 48 hours later. A total of 174 family members participated in the study, 75 in the control group and 99 in the intervention group. Using multivariate logistic regression, the family-centered care intervention was found to be the strongest predictor of scores on the FCCS at 48 hours (odds ratio [OR] = 1.66; $p < .001$). The researchers concluded that partnering with family members to provide fundamental care to patients significantly improved family members' perceptions of PFCC.

Summary

In summary, there is a pervasive incongruence between nurses and their perceptions of caring behaviors and the family and their perceptions of nurses' caring behaviors. Critical care nurses have the perception that being kind and considerate, respectful, knowledgeable, and treating the patient as an individual are all characteristics of caring. Conversely, family members cite communication and development of interpersonal relationships as characteristics of caring. While communication is cited to

be a function of caring, it has also been established as a vital component to the successful implementation of PFCC. As communication increases, interpersonal relationships are formed. The result of increased communication and genuine interpersonal relationships is a caring environment that fosters the importance of family involvement in the care of critically ill patients.

CHAPTER 3: METHODS

This chapter describes the research methodology for this study including the design, setting and sample, data collection procedures, data collection instruments, threats to validity, and procedures for protection of human subjects. In addition, the data analysis plan will be delineated and data security addressed.

Research Design

A descriptive, cross-sectional research design was used. This research design provided a method to describe the relationships between nurses' caring attitudes and PFCC beliefs and family members' perceptions of PFCC. In addition, this research design provided a method to examine the relationships between nurses' demographic variables (age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification) and nurses' caring attitudes and PFCC beliefs. The research questions that guided this study were:

1) What is the relationship between caring attitudes and PFCC beliefs of critical care nurses?
2) What is the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification and caring attitudes?
3) What is the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, and certification and PFCC beliefs?

4) What is the relationship between critical care nursing units' caring attitudes and PFCC beliefs and family members' perceptions of PFCC?

Settings

The research took place in an integrated healthcare organization located in southeastern United States. The integrated healthcare organization consists of five hospitals. The research focused on all critical care units (medical intensive care units, neurologic intensive care units, surgical intensive care units, and orthopedic intensive care units) within the healthcare organization. The critical care units ranged in size from nine beds to twenty beds per unit.

Population and Sample

The population consisted of all critical nurses working within the healthcare organization and family members within these areas. A convenience sample of critical care nurses and family members were recruited. Inclusion criteria for the critical care nurses included: 1) the registered nurse employed at the organization and works in a critical care unit and provides care to patients, 2) able to speak and read English and 3) willingness to participate and complete the study questionnaires. Inclusion criteria for family members included: 1) a family member/guardian of a patient in a critical care unit, 2) able to speak and read English, 3) willingness to participate and complete the study questionnaires, 4) has been utilizing the waiting room for ≥ 24 hours, and 5) 18 years of age or older. Recruitment occurred in October and November 2012. A power analysis was conducted using G Power software (Faul, Erdfelder, Lang, & Buchner, 2007) to estimate sample size to ensure adequate statistical power for data analysis. With a power

of .80, an α value of .05, an effect size of 0.25, and 5 predictor variables, 100 critical care nurses and 100 family members were needed for the sample.

Procedures for Data Collection

The researcher composed a research packet for nurses consisting of: an empty envelope, consent form (Appendix A), a demographic questionnaire (Appendix B), the Caring Efficacy scale (Appendix C), and the Critical Care Family Needs Inventory questionnaire (Appendix D) and a raffle ticket (Appendix E). Recruitment flyers were posted in the critical care nursing units seeking participation in the study (Appendix F). The recruitment flyer was also provided to the unit directors of each critical care unit to distribute to the nursing staff by email. Research packets were distributed to each of the critical care nursing units' break room. Participants who agreed to participate in the study obtained a research packet from the break room. Participants were instructed to place the completed forms in the envelope provided, seal, and place the sealed envelope in a designated, secure research box marked, 'Patient Family Centered Care Research Study' in the break room. The principal investigator collected the surveys from the boxes at least once a week and stored them in a locked file cabinet.

A second packet for family members was composed of: an empty envelope, a cover letter consent form (Appendix G), a demographic questionnaire (Appendix H), and the Needs Met Inventory questionnaire (Appendix I). Family members were identified by their presence in the critical care waiting areas. The researcher visited the critical care family waiting areas at least once per week to recruit family members for the study. The researcher took into consideration the status of the family situation and was careful not to approach families who were exhibiting outward signs of emotional distress such as

crying. The researcher presented the packet to willing family members' of patients that were being cared for in the critical care units. The researcher allowed ample time for the family members to fill out the two questionnaires and seal their responses in an envelope designating the critical care unit where the family member was waiting.

Instruments

Two demographic questionnaires (nurse and family member), the Caring Efficacy Scale (Coates, 1997), the Critical Care Family Needs Inventory (Leske, 1991), and the Needs Met Inventory (Warren, 1993) comprised the instruments for this study. The nursing demographic questionnaire developed by the researcher consisted of nine items: gender, age, race/ethnicity, years licensed, years practicing in critical care, highest nursing degree, certification status, employment status, and work area. The family member demographic questionnaire also developed by the researcher consisted of six items: gender, age, race/ethnicity, relationship to patient, unit waiting area, and length of time in waiting area.

Caring efficacy scale. The Caring Efficacy Scale (Appendix C) (Coates, 1997) is a 30-item instrument that measures nurses' perceived ability to care within the patient-nurse relationship. Coates developed the Caring Efficacy scale based on Watson's Transpersonal Caring theory (1996) and Bandura's Self-Efficacy theory (Bandura, 1986). The original scale consisted of 46-items with a 6-point Likert response scale. Content validity was established by a panel of nursing faculty in the United States and Canada. Through inter-item correlations and a factor analysis, 16 items were dropped from the scale because of failed significant relationships with other items. The revised Caring

Efficacy Scale then consisted of 30-items with 23 positively worded and 7 negatively worded items.

The initial reliability testing used a convenience sample of graduating nursing students, preceptors, alumni, and nurses employed from baccalaureate, master's, and doctorate academic programs and used two different form formats to test the scale. Cronbach's alpha reliability coefficient for Form A was 0.85 and 0.88 for Form B which indicates acceptable reliability for the instrument (Coates, 1997).

Concurrent validity was assessed by examining the relationships between the CES and the measure of clinical competence (CET) of graduating students and their preceptors. Significant positive correlations (Form A: $r = .34$, $p = .05$; Form B: $r = .37$, $p = .01$) were found between the CES and the CET establishing concurrent validity (Coates, 1997).

The response format is based on a 6-point Likert scale ranging from *strongly disagree* (-3) to *strongly agree* (+3). Nurses are instructed to select the best response for each statement that represents how they feel about working with patients in their clinical setting. The negatively worded items are reversed scored and the scoring format is changed to reflect *strongly disagree* (1) to *strongly agree* (6). The CES total score is calculated by averaging all the items in the scale. Higher scores indicate greater nurses' perceived ability to care within the patient-nurse relationship. Permission was obtained from the author to use the scale in this study (Appendix J).

Critical care family needs inventory. The Critical Care Family Needs Inventory (Leske, 1991) (Appendix D) is a 45-item instrument that measures specific needs of families of critically ill patients. Content validity was established by a panel of five

critical care nurse mangers and 11 nursing faculty with individual item agreement ranging from 64.7% to 96.1%. Construct validity was determined by exploratory stepwise principal components factor analysis, resulting in a five-factor solution explaining 40.2% of the total variance. The five factors were titled assurance, proximity, information, comfort, and support.

Internal consistency reliability has been demonstrated in five studies with Cronbach's alpha coefficients ranging from 0.88 to 0.98. In addition, data from 21 investigator studies which was pooled resulted in Cronbach's alpha coefficients for the subscales: 0.88 for support; 0.75 for comfort; 0.78 for information; 0.71 for proximity; and 0.61 for assurance. Test-retest reliability was determined in a study with 51 family members who were tested 48 hours apart. Response agreement for items on the instrument ranged from 64.7% to 96.08%.

The response format is based on a 4-point Likert Scale ranging from *not important* (1) to *very important* (4). All items are summed to obtain a total instrument score and subscale scores are obtained by summing all subscale items.

In this study the CCFNI was used to measure nurses' beliefs about patient-family centered care. The nurses were instructed to rate each statement on how important they believe each need is to the families of critical care patients. A total score was calculated to determine nurses' beliefs of patient family centered care. Higher scores indicated a greater belief in patient-family centered care. Permission was obtained from the author to use the instrument in this study (Appendix K).

Needs met inventory. The Needs Met Inventory (Warren, 1993) (Appendix I) is comprised of the same 45 questions and subscales used in the CCFNI. Warren revised the

CCFNI with permission to evaluate the degree to which perceived needs of the family members of critically ill patients are met. The response format consists of a 4-point Likert scale ranging from *never met* (1) to *usually met* (4). The NMI is different from the CCFNI in that the family member is asked to rate how well their perceived needs are met rather than the importance of the need. Internal consistency reliability has been reported with Cronbach's alpha reliability coefficients ranging from 0.92 to 0.93 (Omari, 2008; Maxwell, Stuenkel, & Saylor, 2007) and Cronbach's alpha reliability coefficients for the subscales are reported as: 0.75 for support, 0.68 for comfort, 0.79 for information, 0.71 for proximity, and 0.82 for assurance (Omari, 2008; Maxwell, Stuenkel, & Saylor, 2007). Permission was obtained from the author to use the instrument in this study (Appendix L).

Threats to Validity

A threat to external validity may be what is known as reactivity (Schmidt & Brown, 2012). Nurses and family members may have reacted to being in the study, which may have influenced their response on the questionnaires. This phenomenon is more frequently referred to as the Hawthorne effect; people changing their behavior because they are participating in a research study (Polit & Beck, 2012).

This study used a convenience sampling method to obtain nurse and family member participants. Using a non-probability sampling technique may result in sampling bias and may limit the generalizability of the findings (Schmidt & Brown, 2012).

Data Analysis

Data were analyzed with descriptive and inferential statistics using SPSS for Windows Release 18.0. Pre-analysis data screening was conducted prior to statistical analysis to examine coding errors, outliers, and data skewness to determine if any data cleaning

procedures needed to be conducted. Descriptive statistics including frequencies, percentages, means, and standard deviations were performed and reported on nurses' and family members' demographic variables, nurses' caring attitudes, nurses' patient-family centered care beliefs and family members' perception of patient-family centered care according to appropriate level of measurement. Inferential statistics, including regression analysis, was conducted to determine the relationships between the independent variables (age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification) and nurses' caring attitudes and patient-family centered care beliefs. A p value of $\leq .05$ was considered statistically significant.

Protection of Human Subjects

Prior to beginning data collection, approval for the study was obtained from the healthcare organization's Nursing Research Committee (NRC) (Appendix M), Emory University Healthcare's Institutional Review Board (IRB) (Appendix N), and Kennesaw State University IRB (Appendix O, P). Any revisions recommended by each of the IRBs were made and the protocol was resubmitted for IRB review. In addition, a support letter was obtained from the Chief Nursing Executive of Emory Healthcare (Appendix Q).

Nurses. A cover consent letter was given and reviewed by nurses prior to the beginning of data collection (Appendix A). Nurses were informed that they would be asked to complete a demographic data form, the Caring Efficacy Scale (Coates, 1997) and the Critical Care Family Needs Inventory questionnaires (Leske, 1991). Nurses were informed that the questionnaires would take approximately 15 minutes to complete. Nurses were advised that they were free to withdraw from the study at any time. The

nurse's completion of the questionnaires served as his or her consent to participate. Nurses were informed that all information obtained was kept confidential.

Participants were given the opportunity to participate in a raffle to win a stethoscope and a $25.00 gift card. If they chose to participate in the raffle, they filled out a raffle ticket (Appendix E) that was enclosed in their survey packet. The raffle ticket was separated immediately from their survey forms to maintain their anonymity. A drawing for the raffle prize occurred once the data collection period was finished. The winner was notified by mailing the prize to the address that was indicated on the raffle ticket that was submitted.

Family members. A cover consent letter was given and reviewed by family members prior to the beginning of data collection (Appendix G). The researcher reviewed in detail information on the consent form and answered questions to clarify any information. Family members were informed that they would be asked to complete a demographic data form and the Needs Met Inventory (Warren, 1993) questionnaire. Family members were informed that the questionnaires would take approximately 20 minutes to complete. Family members were advised that they were free to withdraw from the study at any time. The family member's completion of the questionnaires served as his or her consent to participate. Family members were informed that all information obtained would be kept confidential and no identifying information would be obtained.

Data Security

The SPSS data file was only stored on a jump drive and was secured in a locked file cabinet in the researcher's office when not in use. Participant confidentiality was assured through restriction of data access. Only the researcher, researcher's faculty, and

statistician had access to participants' data and the SPSS database used for analysis. All data was kept in a locked and secured file cabinet and will remain for a minimum of 3 years and then destroyed. The data belongs to the researcher and may not be used without permission and ethical review.

CHAPTER 4: RESULTS

This chapter presents a summary of the analyzed data from the study. Discussed in this chapter are the data analysis plan, sample characteristics, and results. The data analysis plan answered the following research questions: 1) What is the relationship between caring attitudes and PFCC beliefs of critical care nurses? 2) What is the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification and caring attitudes? 3) What is the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, and certification and PFCC beliefs? 4) What is the relationship between critical care nursing units' caring attitudes and PFCC beliefs and family members' perceptions of PFCC?

Data Analysis

The purpose of this study was to examine the relationships between critical care nurses' caring attitudes and patient-family centered care beliefs and family members' perceptions of patient-family centered care. Data were analyzed with descriptive and inferential statistics using SPSS for Windows Release 18.0. Pre-analysis data screening was conducted prior to statistical analysis to examine coding errors, outliers, and data skewness to determine if any data cleaning procedures were needed. Cronbach's coefficient alphas were calculated to examine the internal consistency reliability of the Caring Efficacy scale, Critical Care Needs Inventory, and the Needs Met Inventory. Descriptive statistics including frequencies, percentages, means, and standard

deviations were performed and reported on nurses' and family members' demographic variables, nurses' caring attitudes, nurses' patient-family centered care beliefs and family members' perception of patient-family centered care according to appropriate level of measurement. Pearson product-moment correlation coefficients were used to examine the relationship between caring attitudes and PFCC beliefs of critical care nurses as well as the relationship between critical care nursing units' caring attitudes and PFCC beliefs and family members' perceptions of PFCC. Inferential statistics, including regression analysis was conducted to determine the relationships between the predictor variables (age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification) and nurses' caring attitudes and patient-family centered care beliefs. A p value of $\leq .05$ was considered statistically significant.

Preanalysis data screening was conducted prior to statistical analysis. Missing data was found at the item level indicating that some participants omitted selected items within multi-item instruments rather than the entire instrument. A total of 106 nursing questionnaires were received but due to missing data three cases were deleted, resulting in a total of 103 nursing questionnaires retained for data analysis. A total of 76 family questionnaires were received but due to missing data ten cases were deleted, resulting in a total of 66 family questionnaires retained for data analysis.

Sample Characteristics

Nurses. Nearly all participants were female (n = 87, 84.5%) with a small representation of males (n = 16, 15.5%). Participants ranged in age from 23 to 66 years with a mean age of 40.92 (SD = 11.55). The majority of participants were Caucasian (n = 59, 57.3%), with the next largest group being Black/African American (n = 24, 23.3%).

The majority held a Baccalaureate degree (*n* = 65, 63.1%), with the next largest group holding an Associate degree (*n* = 22, 21.4%). The range of years licensed as a RN was 1 to 39 years with a mean of 14.07 (*SD* = 10.94). The range of years practicing in critical care was 1 to 38 with a mean of 11.41 (*SD* = 11.05). Overwhelmingly, the majority of participants were employed full time (*n* = 93, 90.3%). Over half of the participants (*n* = 59, 57.3%) held a national certification, while 42.7% (*n* = 44) did not. Table 1 displays the overall demographic characteristics of the RNs participants.

Table 1

Demographic Characteristics of Critical Care Nurses (N = 103)

Characteristic	*M*	*SD*
Age	40.92	11.55
Years Licensed as RN	14.07	10.94
Years Practicing in Critical Care	11.41	11.05
	N	%
Gender		
Male	16	15.5
Female	87	84.5
Race/Ethnicity		
White/Caucasian	59	57.3
Hispanic/Latino	4	3.9
Asian/Pacific Islander	12	11.7
Black/African American	24	23.3
Missing	4	3.9
Highest Education Degree		
Diploma RN	3	2.9
Associate Degree	22	2.14
Baccalaureate Degree	65	63.1
Master's Degree	13	12.6
Certified by National Organization	59	57.3
Employment Status		
Full Time	93	90.3
Part Time	7	6.8
PRN, Flex	3	2.9

Family members. The majority of family members were female (*n* = 45, 68.2%) with 31.8% (*n* = 21)being male. Forty-eight point five percent (*n* = 32) identified themselves as being White/Caucasian and 37.9% (*n* = 25) identified themselves as Black/African American. Family members ranged in age from 20 to 82 years with a mean age of 51.16 (*SD* = 13.26). The majority of family members identified their relationship to the patient as "other" (*n* = 21, 31.8%) followed by 18.2% (*n* = 12) spouse, 13.6% (*n* = 9) sibling, 13.6% (*n* = 9) daughter, 10.6% (*n* = 7) son, 4.5% (*n* = 3) significant other, 3.0% (*n* = 2) mother, and 1.5% (*n* = 1) father. The average number of days that family members had been present in the critical care waiting rooms was 5.33 days (*SD* = 7.25), with a range from one day to 45 days. Table 2 displays the overall demographic characteristics of the family member participants.

Table 2

Demographic Characteristics of Family Members (N = 66)

Characteristic	*M*	*SD*
Age	51.16	13.26
Length of time in waiting room (days)	5.33	7.25
	N	%
Gender		
Male	21	31.8
Female	45	68.2
Race/Ethnicity		
White/Caucasian	32	48.5
Hispanic/Latino	1	1.5
Asian/Pacific Islander	3	4.5
Black/African American	25	37.9
Native American	1	1.5
Arabic	1	1.5
Other	1	1.5
Missing	2	3.0
Relationship to patient		
Spouse	12	18.2
Significant Other	3	4.5
Father	1	1.5
Mother	2	3.0
Sibling	9	13.6
Son	7	10.6
Daughter	9	13.6
Other	21	31.8
Missing	2	3.0

Instrument Reliability

Internal consistency and reliability was assessed for the three instruments, Caring Efficacy Scale, Critical Care Family Needs Inventory, and Needs Met Inventory. In this study, Cronbach's alpha coefficients were highly acceptable, Caring Efficacy Scale (.85), Critical Care Family Needs Inventory (.95), and Needs Met Inventory (.96).

Descriptive Statistics for CES, CCFNI, and NMI

CES. Caring Efficacy Scale scores ranged from 3.48 to 6.0. The mean score was 5.29 with a standard deviation of .49, indicating that nurses reported a high level of caring efficacy.

CCFNI. Critical Care Family Needs Inventory scores ranged from 107.00 to 180.00. The mean score was 153.77 with a standard deviation of 17.94, indicating that nurses held moderately high beliefs about patient-family centered care principles (Table 3).

The top five important needs for family members as perceived by nurses were as follows: to have questions answered honestly (*M* = 3.88, *SD* = .32), to have explanations given that are understandable (*M* = 3.88, *SD* = .40), to be assured that the best care possible is being given the patient (*M* = 3.87, *SD* = .39), to feel that the hospital personnel care about the patient (*M* = 3.82, *SD* = .50), and to know the expected outcome (*M* = 3.79, *SD* = .48) (Table 4).

Nurses reported the following needs as least important to meeting family members' needs: to have another person with the family member when visiting the critical care unit (*M* = 2.70, *SD* = .96), to be alone at any time (*M* = 2.71, *SD* = .88), to have a place to be alone while in the hospital (*M* = 2.85, *SD* = .92), to have a pastor visit (*M* = 3.07, SD = .83), and to have good food available in the hospital (*M* = 3.09, *SD* = .90) (Table 4).

NMI. Needs Met Inventory scores ranged from 74.00 to 180.00. The mean score was 146.41 with a standard deviation of 24.36, indicating family members felt a moderate level of patient-family centered care needs being met (Table 3).

Family members rated the following top six needs as being met more often: have the waiting room near the patient (*M* = 3.68, *SD* = .71), to see the patient frequently (*M* = 3.61, *SD* = .72), to visit at any time (*M* = 3.62, *SD* = .70), to talk to the nurse every day (*M* = 3.61, *SD* = .76), to have another person with the family member when visiting the critical care unit (*M* = 3.55, *SD* = .71), and to have friends nearby for support (*M* = 3.55, *SD* = .73). Comparatively, family members' assessed the following needs as least met: to be told about someone to help with family problems (*M* = 2.38, *SD* = 1.26), to talk about the possibility of death (*M*= 2.56, *SD* = 1.24), to have good food available in the hospital (*M* = 2.80, *SD* = 1.03), to be called at home about changes in the patient's condition (*M* = 2.82, *SD* = 1.28), to have a pastor visit (*M* = 2.85, *SD* = 1.17), and to be told about someone to help with family problems (*M* = 2.85, *SD* = 1.18) (Table 4).

Table 3

Ranges, Means, and Standard Deviations for CES, CCFNI, and NMI

	Possible Score Range	*M*	*SD*
CES	1.00-6.00	5.29	.49
CCFNI	45.00-180.00	153.77	17.94
NMI	45.00-180.00	146.41	24.36

Table 4

Means and Standard Deviations of Nurses' Important Family Needs versus Family Members' Needs Met

Item	Nurses		Family Members	
	M	*SD*	*M*	*SD*
1. To know the expected outcome	3.79	.48	3.03	.94
2. To have explanations of the environment before going into the critical care unit for the first time	3.50	.70	3.15	.98
3. To talk to the doctor every day	3.78	.44	3.18	.99
4. To have a specific person to call at the hospital when unable to visit	3.29	.85	3.09	1.21
5. To have questions answered honestly	3.88	.32	3.50	.70
6. To have visiting hours changed for special conditions	3.42	.79	3.24	1.15
7. To talk about feelings about what has happened	3.41	.76	3.03	1.02
8. To have good food available in the hospital	3.09	.90	2.80	1.03
9. To have directions as to what to do at the bedside	3.32	.80	3.12	1.02
10. To visit at any time	3.22	.91	3.62	.70
11. To know which staff members could give what type of information	3.29	.89	3.15	.86
12. To have friends nearby for support	3.39	.68	3.55	.73
13. To know why things were done for the patient	3.77	.58	3.42	.77
14. To feel there is hope	3.61	.63	3.44	.90
15. To know about the types of staff members taking care of the patient	3.34	.76	3.35	.83
16. To know how the patient is being treated medically	3.71	.50	3.47	.71
17. To be assured that the best care possible is being given to the patient	3.87	.39	3.50	.75
18. To have a place to be alone while in the hospital	2.85	.92	3.27	.90
19. To know exactly what is being done for the patient	3.75	.52	3.42	.66
20. To have comfortable furniture in the waiting	3.13	.75	3.05	.97

Table 4

Means and Standard Deviations of Nurses' Important Family Needs versus Family Members' Needs Met

Item	Nurses		Family Members	
	M	*SD*	*M*	*SD*
room				
21. To feel accepted by the hospital staff	3.29	.85	3.52	.71
22. To have someone to help with financial problems	3.22	.80	2.38	1.26
23. To have a telephone near the waiting room	3.15	.87	3.39	.98
24. To have a pastor visit	3.07	.83	2.85	1.17
25. To talk about the possibility of the patient's death	3.43	.82	2.56	1.24
26. To have another person with the family member when visiting the critical care unit	2.70	.96	3.55	.71
27. To have someone be concerned with family member's health	3.39	.76	3.32	.88
28. To be assured it is alright to leave the hospital for awhile	3.47	.74	3.50	.73
29. To talk to the nurse every day	3.68	.53	3.61	.76
30. To feel it is alright to cry	3.51	.70	3.27	1.06
31. To be told about other people that could help with problems	3.25	.87	2.88	1.16
32. To have a bathroom near the waiting room	3.30	.83	3.44	.83
33. To be alone at any time	2.71	.88	3.21	.96
34. To be told about someone to help with family problems	3.18	.74	2.85	1.18
35. To have explanations given that are understandable	3.88	.40	3.32	.86
36. To have visiting hours start on time	3.31	.90	3.38	.96
37. To be told about chaplain services	3.28	.80	3.21	.96
38. To help with the patient's physical care	3.24	.87	3.30	.94
39. To be told about transfer plans while they are being made	3.53	.59	3.00	1.10
40. To be called at home about changes in the	3.67	.57	2.82	1.28

Table 4

Means and Standard Deviations of Nurses' Important Family Needs versus Family Members' Needs Met

Item	Nurses		Family Members	
	M	*SD*	*M*	*SD*
patient's condition				
41. To receive information about the patient at least once a day	3.69	.64	3.52	.77
42. To feel that the hospital personnel care about the patient	3.82	.50	3.45	.75
43. To know specific facts concerning the patients' progress	3.67	.55	3.41	.78
44. To see the patient frequently	3.63	.56	3.61	.72
45. To have the waiting room near the patient	3.29	.87	3.68	.71

Research Questions

Research question one. Research question one examined the relationship between caring attitudes and PFCC beliefs of critical care nurses. A statistically significant relationship was not found between caring attitudes and PFCC beliefs of critical care nurses, r (103) = 0.179, p = .071. Nurses caring attitudes were not associated with PFCC beliefs.

Research question two. Research question two examined the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification and nurses' caring attitudes. Simultaneous multiple regression results indicated that the overall model did not significantly predict the dependent variable, caring attitudes. R^2 = .056, R^2 *adj* = -.009, F (88,94) = .862, p =

.526. Review of the β weights indicated no one predictor variable significantly contributed to the model (Table 5).

Table 5

Simultaneous Multiple Regression Examining the Relationship Between Critical Care Nurses' Age, Race/ethnicity, Years Licensed, Years in Critical Care Nursing, Highest Nursing Degree, and Certification and Caring Attitudes.

Regression Variable	B	SE B	β
Age (in years)	.000	.009	-.011
Race/Ethnicity	-.002	.043	-.004
Years Licensed	.000	.015	-.008
Years in Critical Care	.006	.013	.132
Highest Nursing Degree	-.115	.084	-.149
Certification	.146	.110	.14
R^2		.056	
Adjusted R^2		-.009	
F (p-value for model)		.862	

*$p < .05$. ** $p < .01$.

Research question three. Research question three examined the relationship between critical care nurses' age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, and certification and nurses' PFCC beliefs. Simultaneous multiple regression results indicated that the overall model did not significantly predict the dependent variable, patient family centered care beliefs. $R^2 = .092$, $R^2\ adj = .030$, $F(88,94) = 1.489$, $p = .191$. Review of the β weights indicated no one predictor variable significantly contributed to the model (Table 6).

Table 6

Simultaneous Multiple Regression Examining the Relationship Between Critical Care Nurses' Age, Race/ethnicity, Years Licensed, Years in Critical Care Nursing, Highest Nursing Degree, and Certification and PFCC Beliefs.

Regression Variable	B	SE B	β
Age (in years)	.334	.330	.214
Race/Ethnicity	.171	1.52	.012
Years Licensed	.535	.516	.322
Years in Critical Care	-.600	.456	-.364
Highest Nursing Degree	-2.21	2.98	-.080
Certification	-4.81	3.86	-.133
R^2		.092	
Adjusted R^2		.030	
F (p-value for model)		1.489	

*$p < .05$. ** $p < .01$.

Research question four. Research question four examined the relationship between critical care nursing units' caring attitudes and PFCC beliefs and family members' perceptions of PFCC. A statistically significant relationship was not found between the critical care nursing units' caring attitudes and family members perceptions of PFCC, r (66) = -.055, p = .663. Critical care nursing units attitudes were not associated with family members perceptions of PFCC. In addition, no relationship was found between critical care nursing units' PFCC beliefs and family members perceptions of PFCC, r (66) = -.065, p = .607.

CHAPTER 5: DISCUSSION

This chapter discusses the interpretations of findings and the relationship of the findings to theory and previous literature. In addition, limitations to the study are presented. The chapter ends with recommendations for implications for nursing practice, education, and future research.

Simultaneous multiple regression results indicated that the demographic variables (age, race/ethnicity, years licensed, years in critical care nursing, highest nursing degree, certification) did not significantly predict caring attitudes or patient-family centered care beliefs, existing literature supports otherwise. Hayes, Curtis, and Clukey (2010) and Suliman et al. (2009) conducted studies that identified statistically significant relationships between gender, ethnicity, and level of education when compared to respondents' reporting their perceived level of importance of carative factors.

A statistically significant relationship was not found between caring attitudes and PFCC beliefs of critical care nurses. Currently, there is little research that has been conducted to evaluate the relationship between caring and PFCC beliefs. However, Swanson's Theory of Caring (Swanson, 1991; 1993) strongly supports the caring aspect of nursing and the residual effects on the recipients of care. Similarly, PFCC beliefs are grounded in caring for patients in a manner that relays respect and dignity, information sharing, encourages participation, and welcomes collaboration.

When patients and their families enter into critical care areas they may be experiencing feelings of anxiety, hopelessness, distress, fear, and uncertainty (Davidson,

2009). In addition, just the physical size of these areas may inhibit personal touch and communication with patients and family members (Kinrade, Jackson, & Tomnay, 2009). Consequences of decreased caring and noncompliance with patient-family centered care beliefs can result in families having poor perceptions of patient-family centered care, increased emotional distress for families, and unmet needs of family members (Davidson, 2009). It is critical that nurses acknowledge these feelings and barriers and use their knowledge to positively influence the care delivered to both patients and families to ensure positive patient and family outcomes.

Although a statistically significant relationship was not found between caring attitudes and PFCC beliefs, valuable information has been extrapolated from the data. An individual assessment of items on the CCFNI/NMI was conducted to compare the nurses' mean scores of each item and compare the means scores of family members' needs met for each item. The top five needs as perceived by nurses were as follows: to have questions answered honestly, to have explanations given that are understandable, to be assured that the best care possible is being given the patient, to feel that the hospital personnel care about the patient, and to know the expected outcome. In comparison, these items were rated lower as needs being met by family members. While nurses perceive that these items are the most important to family members, family members assessed these needs as being met at a lower level than the importance they were rated by the nurses.

Davidson (2009) identified five family need domains as 1) support, 2) comfort, 3) information, 4) proximity to the patient, and 5) assurance. The literature shows that often, the perceptions of needs and caring are often incongruent between the nurses that

provide care and the family members that are the recipients of care (Papastavrou, Efstathious, & Charalambous 2011; Papastavrou et al., 2012). If interactions between a nurse and a family member are reliant upon caring, and caring is altered, a breakdown in patient and family centered care principles may occur.

The top five most important needs as identified by the nurse participants have been previously identified by Nelson and Plost (2009) and Omari (2009) as five of the ten top needs as identified by family members. While it is encouraging to know that nurses are moving away from old behaviors and perceptions associated with patient and family centered care such as feelings that families are getting in the way, questions are too time consuming, there are unreasonable requests, they are being watched, and information will be misunderstood (Abraham and Moretz, 2012), it is evident that perceptions do not necessarily match the current practice. This is the true challenge for the future.

Family members rated the following top six needs as being met more often: to have the waiting room near the patient, to see the patient frequently, to visit at any time, to talk to the nurse every day, to have another person with the family member when visiting the critical care unit, and to have friends nearby for support. The literature, presented by Cluckey et al. (2009) supports these findings. In their study, the following characteristics were identified as caring: interpreting and explaining information, voice tone, eye contact and attitude, being a capable and competent care provider, taking the time to be wholly present and engaged, and providing physical comfort to families have been associated with a positive perception of caring (Cluckey et al., 2009).

The healthcare organization, where the research was conducted, has strongly embraced PFCC principles. As part of their journey to provide care to both patients and

their families that is reflective of the core principles of PFCC, they have instituted specific measures in their organization. One measure that has been instituted in all of the critical care areas is open visitation. This measure can be directly correlated with family members' high perceptions that they were able to visit at any time. In addition, a second intervention that may have influenced two other measures: the ability to see the patient frequently and to have a waiting room close to the patient, is the location of ten of the seventeen critical care units. The waiting area of each patient is directly on the outside of their room in a secluded layer that surrounds the ten critical care units. This provides family members direct access to patients at all times.

Similarly, the bottom five needs were compared as rated by nurses and family members. Nurses reported the following needs as least important to meeting family members' needs: to have another person with the family member when visiting the critical care unit, to be alone at any time, to have a place to be alone while in the hospital, to have a pastor visit, and to have good food available in the hospital. Comparatively, family members' assessed the following needs as least met: to be told about someone to help with family problems, to talk about the possibility of death, to have good food available in the hospital, to be called at home about changes in the patient's condition, and to have a pastor visit. There are two commonalities present in these findings. While nurses feel that pastoral services and food quality are two of the least important factors that influence a family members' perception of care, the family members rated these two items as being met the least frequently. It appears that feelings and beliefs of the nurses of these two needs negatively influence the perception of these needs being met by family members. The remainder of the least met needs that were identified by families were: to

be called at home about changes in the patient's condition, to be told about someone to help with family problems, to talk about the possibility of death. These three items rely primarily on the skill of communication. These findings are also supported in the literature (Agard & Maindal, 2009). The clinical skills and communication skills of nurses influence the interactions between patients and their families (Agard & Maindal, 2009). Effective communication skills are essential in sharing information with family members to ensure family members' understand and interpret the information correctly.

Limitations

One limitation of the study was the sample size. The required sample size for family members was not obtained as indicated by the power analysis. This may have led to the non-significant findings in this study.

A second limitation was lack of diversity in both the nurse and family participants. The majority of nurse respondents were overwhelmingly Caucasian females. In addition, the majority of family participants were female. This may limit the generalizability of the study findings.

A third limitation of this study was the inability to link individual family members' perceptions of PFCC scores to a particular nurse. In the critical care environment, families come in contact with multiple care providers on a daily basis, so it is not realistic to think that only one nurse impacts family members' perceptions of PFCC.

A fourth limitation was that the study was only conducted in one healthcare system located in southeastern United States. This may limit the generalizability of the findings. In addition, critical care nurses were recruited from this one healthcare

organization which may produce a homogeneous population limiting the generalizability of the findings.

A fifth limitation was the cross-sectional data collection method of the research study. The choice of conducting a cross-sectional study lends itself as a limiting factor. Cross-sectional studies convey results based upon one moment in time. This method does not allow for varying perceptions based upon different interactions with caregivers and situations that their loved ones encounter during their stay on the critical care units.

Finally, research packet questionnaires were distributed to the break rooms located in the critical care units for nurses to complete. This may have allowed nurses to communicate while filling out the questionnaires and may have influenced their responses to the questionnaires.

Implications

Although this study was unable to identify statistically significant relationships between nurses' caring attitudes, nurses' perceptions of PFCC beliefs and family members' perceptions of PFFC, there is strong evidence that there is incongruence between nurses' beliefs of family needs and family perceptions of met needs. In a time where people are living longer but less healthy, the population of patients seen in the acute care setting will require more resources to care for them. Additionally, nurses are challenged to care for patients in a way that improves access, quality, and cost. The findings from this research study have implications in the areas of nursing practice, education, and future research.

Nursing practice. Clukey et al. (2009) concluded that the interpersonal relationship developed between the nurse and family member influences the family member's perception of caring. Research shows that communication deficits,

contradictory information, and lack of support leads to anxiety and depression (Paparrigopoulos et al., 2005: Pochard et al, 2006) in family members as well as family dissatisfaction (Fumis et al., 2008; Bailey et al., 2010). In addition, Palese et al. (2011) demonstrated a statistically significant relationship between caring behaviors and patient satisfaction.

As the number of people that are being cared for in critical care areas steadily increases along with the ever increasing demands to provide care that is high in quality and low in cost, the need to create relationships with the very people nurses do business with is tantamount. This is a call for an increased sense of both personal and professional commitment and responsibility to the people that nurses care for.

Education. Although statistical significance was not found in this research study, there is still the presence of incongruence between nurses beliefs about patient-family centered care needs and the family's perceptions of needs that are most fulfilled and least fulfilled. This information shows that there is still a gap somewhere between the knowledge of impact of caring and patient-family centered care, the practice of these principles, and the perception of these principles.

Increased knowledge of the relationships between nurses' caring attitudes and patient-family centered care beliefs and family members' perceptions of patient-family centered care will further the understanding of the dynamics that are required to create and maintain a patient-family centered care environment in critical care units. It is imperative that nurses truly acknowledge that their personal values and attitudes influence the interactions that they have with their patients and their families (Agard & Maindal, 2009). This call for knowledge will require the nursing profession to reflect

back to Swanson's concept of knowing, which is described as a sense of self awareness that increases the ability of the nurse to better mirror the reality of the patient and their family members (Swanson, 1993). Awareness of self and perceptions of others is a critical factor in this level of caring due to the varying abilities of nurses to adjust to the realities of others and contain their own needs. Without this vital component, caring is falsely represented.

As professionals, nursing is called to a commitment of lifelong learning. There are endless learning opportunities about PFCC and caring in the healthcare setting. Through increasing the profession's knowledge about PFCC and caring, a culture can be developed that truly supports relationships where the model of care delivery is interdisciplinary in nature and includes the patient and their family members (Abraham & Moretz, 2012).

Further education is needed to ensure nurses embrace the principles of PFCC and continued efforts to incorporate PFCC principles into their nursing practice. Numerous education programs and resources are available online such as *PFC 101: Dignity and Respect* offered by the Institute for Healthcare Improvement (2011), *Advancing the Practice of Patient-and Family-Centered Geriatric Care* offered by the Institute for Patient-and Family- Centered Care (2012), and *Strategies for Leadership: Patient-and Family-Centered Care* offered by the American Hospital Association (2012), in addition to continuing education journal articles and peer-reviewed research articles.

Future research. Further research on this topic should aim to recruit a larger sample size. There are several reasons for this recommendation. First, it is postulated that statistically significant data may be derived from a larger sample size. Second, a more

demographically diverse population could lend for a higher rate for generalizability of the findings.

Another recommendation would be for future research to include multiple organizations. This would allow for different organizational cultures to present through both the nurses' beliefs and attitudes and how that translates to the family members' experience at varying healthcare organizations.

Lastly, the researcher would recommend continued research in varying areas of care. More specifically, it may lend beneficial information to research the varying beliefs and attitudes of medical-surgical nurses and how they influence their families' perception of patient family centered care in comparison to their medical-surgical intensive care unit counterparts, etc.

Conclusion

Nurses perceived themselves as highly caring both within the domain of providing direct patient care and providing patient family centered care. Nurses also reported moderately high beliefs about patient family centered care principles, while family members reported only moderate levels of patient family centered care needs being met. There is an obvious incongruence between nurses' perceptions and family members' realities. It is the responsibility of the nursing profession to bridge the gap that exists to ensure that we provide care in a way that addresses the multitude of needs of patients and families in a way that is safe, caring, and respectful.

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Appendix A

Nurse Informed Consent

Kennesaw State University

Title: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence the Family Members' Perceptions of Patient Family Centered Care

Principal Investigator: Jennifer Shamloo, RN, BSN
Faculty Advisor: Patricia Hart, PhD, RN

I am seeking nurses in critical care units to participate in this research study. The purpose of the study is to:

1. Examine the relationship between nurses' caring attitudes and beliefs about patient family centered care
2. Examine the effect of nurses' caring attitudes and patient family centered care beliefs on family members' perceptions of patient family centered care

Procedures: If you decide to participate, you will be asked to complete a short demographic questionnaire consisting of nine questions, the Caring Efficacy Scale (CES) consisting of 30 questions, and the Critical Care Family Needs Inventory (CCFNI) consisting of 45 questions. It should take you approximately 15 minutes to complete the three questionnaires. The demographic questionnaire will contain questions that pertain to your gender, age, race/ethnicity, years in critical care, highest degree earned, certification, employment status, and unit where you work. The CES will contain questions that measure your perceived ability to care within the patient-nurse relationship. The CCFNI will contain questions that measure how important you feel specific needs are to family members of a patient in your critical care unit. Your completion of the questionnaires is your consent to participate.

Risks: There is no physical risk for taking part in this study. You may experience uneasy feelings by answering the questionnaires and reflecting on your feelings in relation to your patients and their family members.

Benefits: There may be no direct benefit to you for participating in this study. It is possible that with your information, the researcher will identify areas that will provide further knowledge and understanding in creating and maintaining an environment that is reflective of patient family centered care principles.

Incentives: If you choose to participate in the study, you will also have the choice to participate in a raffle to win a Littmann stethoscope and $25.00 Visa giftcard. If you choose to participate in the raffle, complete the raffle ticket that is enclosed in your survey packet and return it with your completed survey forms. The raffle ticket will be separated immediately from your survey forms to maintain your anonymity.

Confidentiality: The results of the research study will be confidential and reported in group form without any identifying information. You will not be identified personally. The information that you provide will only be shared with the individuals that are directly involved with the research study. You maintain all of your rights while participating in the study.

Voluntary Participation/Withdrawal: Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or discontinue participation at any time.

Data Security: A file will be created and contain the demographic data and questionnaire data and will be stored on a jump drive and will be secured in a locked file cabinet in the researcher's offices when not in use. Participant confidentiality is assured through restriction of data access. Only the researcher, faculty advisor, and statistician will have access to the data file. The data will only be used for this research study and any identifying information will not be shared with any person(s) within the healthcare system not associated with this study. All data will be kept in a locked and secured file cabinet for a minimum of 3 years and then destroyed.

Contact Person: If you have any questions or concerns about this study, you may contact the investigator: Jennifer Shamloo, RN, BSN @ Jennifer.shamloo@emoryhealthcare.org

Institutional Review Board: Research at Kennesaw State University that involves human participants is carried out under the oversight of their Institutional Review Board. You may contact the Institutional Review Board with any questions or concerns regarding the protection of your rights. The address is as follows: Institutional Review Board, Kennesaw State University, 1000 Chastain Road, Kennesaw, GA, 30144, (678) 797-2268.

Appendix B

Nurse Demographic Questionnaire

Nurse Demographic Questionnaire

Please place a check mark (✓) in the appropriate box or fill in the blank.

1. What is your gender? ☐ Male ☐ Female

2. What is your age? _____

3. What is your race/ethnicity?

   ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Native American ☐ Asian or Pacific Islander ☐ Arabic

   Other (specify):

   _____

4. How many years have you been licensed as a registered nurse? _____

5. How many years have you been practicing in critical care? _____

6. What is the highest educational degree that you have obtained?

   ☐ Diploma LPN ☐ Diploma RN ☐ Associate Degree

   ☐ Baccalaureate Degree ☐ Master's Degree ☐ Doctorate Degree

7. Are you currently certified by a national organization like CCRN, CMSRN, (exclude CPR, ACLS, PALS, NRP, etc)?

   ☐ No ☐ Yes

8. What is your employment status?

   ☐ Full Time ☐ Part Time ☐ PRN, Flex

9. What unit do you currently work on? _____

Please place the questionnaires in the envelope provided and seal the envelope.

Thank you for your participation!

Appendix C

Caring Efficacy Scale

Caring Efficacy Scale

Instructions: When you are completing these items, think of your recent work with patients/clients in the clinical setting. Circle the number that best expresses your opinion.

Rating Scale:

-3 Strongly disagree
-2 Moderately disagree
-1 Slightly disagree
+1 Slightly agree
+2 Moderately agree
+3 Strongly agree

	Strongly Disagree					**Strongly Agree**
1. I do not feel confident in my ability to express a sense of caring to my clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
2. If I am not relating well to a client/patient, I try to analyze what I can do to reach him/her	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
3. I feel comfortable in touching my clients/patients in the course of care-giving	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
4. I convey a sense of personal strength to my clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
5. Clients/patients can tell me most anything and I won't be shock	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
6. I have an ability to introduce a sense of normalcy in stressful conditions	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
7. It is easy for me to consider the multifacets of a client's/patient's care, at the same time as I am listening to them	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
8. I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/patient as a person	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**

Rating Scale:	**-3 Strongly disagree** **-2 Moderately disagree** **-1 Slightly disagree**			**+1 Slightly agree** **+2 Moderately agree** **+3 Strongly agree**		
	Strongly Disagree					**Strongly Agree**
9. I can walk into a room with a presence of serenity and energy that makes clients/patients feel better	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
10. I am able to tune into a particular client/patient and forget my personal concerns	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
11. I can usually create some way to relate to most any client/patient	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
12. I lack confidence in my ability to talk to clients/patients from backgrounds different form my own	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
13. I feel if I talk to clients/patients on an individual personal basis, things might get out of control	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
14. I use what I learn in conversations with clients/patients to provide more individualized care	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
15. I don't feel strong enough to listen to the fears and concerns of my clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
16. Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
17. I seem to have trouble relating to clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
18. I can usually establish a close relationship with my clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
19. I can usually get clients/patients to like me	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
20. I often find it hard to get my point of view across to clients/patients when I need to	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**

Rating Scale:	**-3 Strongly disagree** **-2 Moderately disagree** **-1 Slightly disagree**			**+1 Slightly agree** **+2 Moderately agree** **+3 Strongly agree**		
	Strongly Disagree					**Strongly Agree**
21. When trying to resolve a conflict with a client/patient, I usually make it worse	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
22. If I think a client/patient is uneasy or may need some help, I approach that person	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
23. If I find it hard to relate to a client/patient, I'll stop trying to work with that person	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
24. I often find it hard to relate to clients/patients from a different culture than mine	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
25. I have helped many clients/patients through my ability to develop close, meaningful relationships	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
26. I often find it difficult to express empathy with clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
27. I often become overwhelmed by the nature of the problems clients/patients are experiencing	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
28. When a client/patient is having difficulty communicating with me, I am able to adjust to his/her level	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
29. Even when I really try, I can't get through to difficult clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**
30. I don't use creative or unusual ways to express caring to my clients/patients	**-3**	**-2**	**-1**	**+1**	**+2**	**+3**

Appendix D

Critical Care Family Needs Inventory

Critical Care Family Needs Inventory

Instructions: Please place a check mark (✓) under the number that best represents **how important you believe each need is to the families of critical care patients in this unit**.

	Not Important (1)	Slightly Important (2)	Important (3)	Very Important (4)
1. To know the expected outcome				
2. To have explanations of the environment before going into the critical care unit for the first time				
3. To talk to the doctor every day				
4. To have a specific person to call at the hospital when unable to visit				
5. To have questions answered honestly				
6. To have visiting hours changed for special conditions				
7. To talk about feelings about what has happened				
8. To have good food available in the hospital				
9. To have directions as to what to do at the bedside				
10. To visit at any time				
11. To know which staff members could give what type of information				
12. To have friends nearby for support				
13. To know why things were done for the patient				

	Not Important (1)	Slightly Important (2)	Important (3)	Very Important (4)
14. To feel there is hope				
15. To know about the types of staff members taking care of the patient				
16. To know how the patient is being treated medically				
17. To be assured that the best care possible is being given to the patient				
18. To have a place to be alone while in the hospital				
19. To know exactly what is being done for the patient				
20. To have comfortable furniture in the waiting room				
21. To feel accepted by the hospital staff				
22. To have someone to help with financial problems				
23. To have a telephone near the waiting room				
24. To have a pastor visit				
25. To talk about the possibility of the patient's death				
26. family member when visiting the critical care unit				
27. To have someone be concerned with family member's health				
28. To be assured it is alright to leave the hospital for awhile				
29. To talk to the nurse every day				

	Not Important (1)	Slightly Important (2)	Important (3)	Very Important (4)
30. To feel it is alright to cry				
31. To be told about other people that could help with problems				
32. To have a bathroom near the waiting room				
33. To be alone at any time				
34. To be told about someone to help with family problems				
35. To have explanations given that are understandable				
36. To have visiting hours start on time				
37. To be told about chaplain services				
38. To help with the patient's physical care				
39. To be told about transfer plans while they are being made				
40. To be called at home about changes in the patient's condition				
41. To receive information about the patient at least once a day				
42. To feel that the hospital personnel care about the patient				
43. To know specific facts concerning the patients' progress				
44. To see the patient frequently				
45. To have the waiting room near the patient				

Appendix E

Raffle Tickets

Raffle Ticket

RESEARCH RAFFLE!

ENTER TO WIN!

Please complete the information if you would like to participate in the raffle drawing for a Littmann stethoscope and a $25.oo Visa Giftcard. Please enclose the completed ticket in your questionnaire packet.

Thank You!

Name: _____

Address: _____

_____

RESEARCH RAFFLE

ENTER TO WIN!

Please complete the information if you would like to participate in the raffle drawing for a Littmann stethoscope and a $25.oo Visa Giftcard. Please enclose the completed ticket in your questionnaire packet.

Thank You!

Name: _____

Address: _____

_____

Appendix F

Recruitment Flyer

Recruitment Flyer

CARING AND PATIENT FAMILY CENTERED CARE RESEARCH

I am conducting a research study within this healthcare system that will examine the relationships between caring attitudes and patient family centered care beliefs of critical care nurses and family members' perceptions of patient family centered care.

To be eligible to participate in the study, you must meet the following criteria:

1) Be a registered nurse employed by this healthcare system and work in a critical care unit and provide care to patients
2) Able to speak and read English
3) Willingness to participate and complete the study questionnaires

If you choose to participate, you will be asked to fill out three short questionnaires that should take you no more than 15 minutes to complete. Additionally, if you choose to participate, you will have the opportunity to enroll in a raffle drawing for a Littmann stethoscope and a $25 Visa giftcard.

If you are interested in participating in this research study, you will find the nurse research packet available in your break room. Place the completed questionnaires in the envelope provided, seal, and place the envelope in the designated research box, "Patient Family Centered Care Research Study" located in your break room.

If you have any questions about this study, please contact Jennifer Shamloo @ 678-451-5254 or @ Jennifer.shamloo@emoryhealthcare.org.

Appendix G

Family Member Informed Consent

Family Member Informed Consent

Kennesaw State University

Title: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care

Principal Investigator: Jennifer Shamloo, RN, BSN
Faculty Advisor: Patricia Hart, PhD, RN

I am seeking family members of patients that are being cared for in this healthcare organization's critical care units to participate in this research study. The purpose of the study is to:

1. Examine the relationship between nurses' caring attitudes and beliefs about patient family centered care
2. Examine the effect of nurses' caring attitudes and beliefs on family members' perceptions of patient family centered care

Procedures: If you decide to participate, you will be asked to complete a short demographic questionnaire consisting of six questions and the Needs Met Inventory (NMI) that consists of 45 questions. It should take you approximately 20 minutes to complete the two questionnaires. The demographic questionnaire will contain questions that pertain to your gender, age, race/ethnicity, relationship to the patient, unit waiting room you are in, and length of stay in the critical care waiting room. The NMI will contain questions that will allow you to evaluate and rate how you feel your needs are being met as a family member of a patient in critical care. Your completion of the questionnaires is your consent to participate.

Risks: There is no physical risk for taking part in this study. You may experience uneasy feelings by answering the questionnaires and reflecting on your needs and the needs of your hospitalized family member.

Benefits: There may be no direct benefit to you for participating in this study. It is possible that with your information, the researcher will identify areas that will provide further knowledge and understanding in creating and maintaining an environment that is reflective of patient family centered care principles.

Confidentiality: The results of the research study will be confidential and reported in group form without any identifying information. This means that you, nor your family member, will be identified personally. The information that you provide will only be shared with the individuals that are directly involved with the research study. You maintain all of your rights while participating in the study.

Voluntary Participation/Withdrawal: Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or discontinue participation at any time.

Data Security: A file will be created and contain the demographic data and questionnaire data and will be stored on a jump drive and will be secured in a locked file cabinet in the researcher's' offices when not in use. Participant confidentiality is assured through restriction of data access. Only the researcher, faculty advisor, and statistician will have access to the data file. The data will only be used for this research study and any identifying information will not be shared with any person(s) not associated with this study. All data will be kept in a locked and secured file cabinet for a minimum of 3 years and then destroyed.

Contact Person: If you have any questions or concerns about this study, you may contact the investigator: Jennifer Shamloo, RN, BSN @ Jennifer.shamloo@emoryhealthcare.org

Institutional Review Board: Research at Kennesaw State University that involves human participants is carried out under the oversight of their Institutional Review Board. You may contact the Institutional Review Board with any questions or concerns regarding the protection of your rights. The address is as follows: Institutional Review Board, Kennesaw State University, 1000 Chastain Road, Kennesaw, GA, 30144, (678) 797-2268.

Appendix H

Family Member Demographic Questionnaire

Family Member Demographic Questionnaire

Please place a check mark (✓) in the appropriate box or fill in the blank.

1. What is your gender? ☐ Male ☐ Female

2. What is your age? _____

3. What is your race/ethnicity?

   ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Native American ☐ Asian or Pacific Islander ☐ Arabic

   Other (specify):

   _____

4. What is your relationship to the patient?

   ☐ Spouse ☐ Significant Other ☐ Father ☐ Mother

   ☐ Sibling ☐ Son ☐ Daughter ☐ Other

5. What unit's waiting area are you in?

_____

6. How long (days) have you been waiting in the critical care waiting area? _____Days

Thank you for your participation!

Appendix I

Needs Met Inventory

Needs Met Inventory

Instructions: Please read each statement and place a check mark (✓) under the number that best represents **as a family member the degree to which each specific need has been met for you.**

	Never Met (1)	Sometimes Met (2)	Usually Met (3)	Always Met (4)
1. To know the expected outcome				
2. To have explanations of the environment before going into the critical care unit for the first time				
3. To talk to the doctor every day				
4. To have a specific person to call at the hospital when unable to visit				
5. To have questions answered honestly				
6. To have visiting hours changed for special conditions				
7. To talk about feelings about what has happened				
8. To have good food available in the hospital				
9. To have directions as to what to do at the bedside				
10. To visit at any time				
11. To know which staff members could give what type of information				
12. To have friends nearby for support				
13. To know why things were done for the patient				
14. To feel there is hope				

	Never Met (1)	Sometimes Met (2)	Usually Met (3)	Always Met (4)
15. To know about the types of staff members taking care of the patient				
16. To know how the patient is being treated medically				
17. To be assured that the best care possible is being given to the patient				
18. To have a place to be alone while in the hospital				
19. To know exactly what is being done for the patient				
20. To have comfortable furniture in the waiting room				
21. To feel accepted by the hospital staff				
22. To have someone to help with financial problems				
23. To have a telephone near the waiting room				
24. To have a pastor visit				
25. To talk about the possibility of the patient's death				
26. To have another person with the family member when visiting the critical care unit				
27. To have someone be concerned with family member's health				
28. To be assured it is alright to leave the hospital for awhile				
29. To talk to the nurse every day				
30. To feel it is alright to cry				
31. To be told about other people that could help with problems				
32. To have a bathroom near the waiting room				
33. To be alone at any time				

	Never Met (1)	Sometimes Met (2)	Usually Met (3)	Always Met (4)
34. To be told about someone to help with family problems				
35. To have explanations given that are understandable				
36. To have visiting hours start on time				
37. To be told about chaplain services				
38. To help with the patient's physical care				
39. To be told about transfer plans while they are being made				
40. To be called at home about changes in the patient's condition				
41. To receive information about the patient at least once a day				
42. To feel that the hospital personnel care about the patient				
43. To know specific facts concerning the patients' progress				
44. To see the patient frequently				
45. To have the waiting room near the patient				

Appendix J

Permission to Use Caring Efficacy Scale

---------- Forwarded message ----------
From: **Carolie Coates** <coatescj@comcast.net>
Date: Fri, Aug 10, 2012 at 1:19 PM
Subject: Permiossion to use CES in Masters' thesis at Kennesaw State Univ.
To: Jennifer Shamloo <jennifershamloo@gmail.com>

Jennifer, Attached is the information your requested. Let me know if there is anything else you need with regard to the CES. If you would like a signed copy of the permission letter, please give me your address.

Carolie Coates, PhD

Coates Research and Measurement Consulting
1441 Snowmass Court
Boulder, Colorado 80305
Tel. and FAX 303 499-5756
Email: coatescj@comcast.net
Website: www.caringefficacyscale.com

August 8, 2012

Jennifer Shamloo
Masters Candidate in Nursing in Health Policy and Leadership
Kennesaw State University
(Supervisor Patricia Hart, PhD email contact: phart@kennesaw.edu)
Email contact: jennifershamloo@gmail.com

Re: How Caring Attitudes and Family Care Beliefs of Critical Care RN's Influence the Perceptions of Patient Family Center Care and Family Satisfaction

Dear Jennifer Shamloo:

Thank you for your request to use the Caring Efficacy Scale (CES), a 30-item item self-report scale for your research project. You have my permission to use the CES in your study outlined in your email of August 10.

Please keep in touch about the scoring process and your progress. I am interested in the validity and reliability information you will generate relevant to the CES.

I ask that you send me a copy of your completed research study and any resulting publications. I would also appreciate a copy of the CES data set.

Sincerely,

Carolie J. Coates PhD

Appendix K

Permission to Use Critical Care Family Needs Inventory Questionnaire

Zimbra **phart@kennesaw.edu**

Fwd: Permission to use CCFNI

From : Gmail <jennifershamloo@gmail.com> Sun, Jul 22, 2012 05:15 PM
Subject : Fwd: Permission to use CCFNI 2 attachments
To : Patricia Hart <phart@kennesaw.edu>

Here is permission to use ccfni

Jennifer

Begin forwarded message:

From: Jane B Leske <jsl@uwm.edu>
Date: July 20, 2012 5:23:32 PM EDT
To: Jennifer Shamloo <jennifershamloo@gmail.com>
Subject: Re: Permission to use CCFNI

Please use the CCFNI as published

----- Original Message -----
From: "Jennifer Shamloo" <jennifershamloo@gmail.com>
To: "Jane B Leske" <jsl@uwm.edu>
Sent: Friday, July 20, 2012 3:15:37 PM
Subject: Re: Permission to use CCFNI

Dr Leske,

In light of the strong reliability and validity information available for your original version of the CCFNI, I have decided to use the 45 question version of the CCFNI. Since I originally asked for permission to use the abbreviated version, I would like to officially ask for your permission to use the 45 question version of the CCFNI.

Thank you in advance for all of your time.
Sincerely,
Jennifer Shamloo, RN, BSN

Dear Researcher,

Please find enclosed a copy of the *Critical Care Family Needs Inventory*. You have my permission to use and/or translate the tool to meet your research needs as long as credit is referenced in your work. The psychometric properties of the instrument are published in Leske, J.S. (1991). Internal psychometric properties of the Critical Care Family Needs Inventory, Heart & Lung, 20, 236-244. Please do not hesitate to contact me if you have any questions. Best wishes for a successful research project.

Sincerely,

Jane S. Leske PhD, RN

Appendix L

Permission to Use the Needs Met Inventory Questionnaire

N. Warren gave permission to use the 45 item version of the Needs Met Inventory. (personal communication, July 20, 2012).

On Tue, Jul 17, 2012 at 3:08 PM, Nancy Warren <nwarren@utm.edu> wrote:

HI Jennifer,

Please feel free to use any of my work.

Sincerely,

Dr. Warren

731-612-2842

Zimbra https://email.kennesaw.edu/zimbra/h/printmessage?id=49272

To: Nancy Warren
Subject: Permission to use NMI

Dr. Warren,

Hello. My name is Jennifer Shamloo. I am currently a student at Kennesaw State University, working on my Master's in Nursing in Health Policy and Leadership. I am finalizing my thesis proposal for IRB approval and respectfully request permission to use the NMI portion of the 30 item version of the CCFNI/NMI as one of my data collection methods. My thesis topic is: How caring attitudes and Family Centered Care Beliefs of Critical Care RN's influence the family members' perceptions of Patient Family Centered Care.

I look forward to hearing from you soon about permission to use your tool. Please, don't hesitate to contact me in regards to any questions you may have about my study.

Thank you in advance for your time and consideration,

Jennifer Shamloo, RN, BSN

<jennifershamloo@gmail.com>

Appendix M

Emory NRC Approval Letter

From: Shapiro, Susan
Sent: Wednesday, October 03, 2012 6:14 PM
To: Shamloo, Jennifer
Cc: Cali, Susan B; Willis, Polly H; 'phart@kennesaw.edu'
Subject: Nursing Research Council review

Jennifer,
Thanks so much for presenting your study to the NRC on Tuesday, October 2nd, 2012. The NRC reviewed and approved your protocol, so you may begin your study immediately after receiving Emory IRB approval. Please note that the NRC had the following comments and requests:

- NRC members have questions about supporting literature to include the study demographic variables. Has a relationship been described between caring and age, ethnicity, race, certification in the literature? If not, please make a statement to the lack of pertinent literature.

- With the study design; perhaps research questions should be stated "what is the relationship" rather than posing a "yes" "no" question as the research questions are currently constructed.

- The NRC expects that you will reply to the questions raised in the review, and that you will report your findings to the Council and to the larger Emory nursing community, ideally through a Grand Rounds presentations.

We're delighted you're doing this study as we think it will add important information to our understanding of how our nurses care for patients and how our patients' families perceive the care they receive. Please let me know if you have any questions about this review. Also, please let me know when you receive your Emory IRB approval so I can distribute your recruiting materials to the UDs throughout the system.

Best regards,
Susan

Susan E. Shapiro, RN, PhD
Associate Chief Nursing Officer for Research and EBP
Emory Healthcare and
Assistant Dean for Strategic Clinical Initiatives
Nell Hodgson Woodruff School of Nursing
550 Peachtree Street NE, Orr 417
Atlanta, GA 30308
phone: Emory University Hospital Midtown (404) 686-7790
School of Nursing (404) 727-4684
fax: (404) 686-4504
susan.shapiro@emoryhealthcare.org
for appointments, please contact Juanita Nelson at
jlnels4@emory.edu<mailto:jlnels4@emory.edu>

Appendix N

Emory IRB Approval Letter

EMORY UNIVERSITY | Institutional Review Board

Date: October 10, 2012

Jennifer Shamloo
Principal Investigator
Adult & Elder Hth

RE: **Exemption of Human Subjects Research**
IRB00061842
How Caring Attitudes and Patient-Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient-Family Centered Care

Dear Principal Investigator:

Thank you for submitting an application to the Emory IRB for the above-referenced project. Based on the information you have provided, we have determined on 10/9/2012 that although it is human subjects research, it is exempt from further IRB review and approval.

This determination is good indefinitely unless substantive revisions to the study design (e.g., population or type of data to be obtained) occur which alter our analysis. Please consult the Emory IRB for clarification in case of such a change. Exempt projects do not require continuing renewal applications.

This project meets the criteria for exemption under 45 CFR 46.101(b)(2). Specifically, you will be having subjects, which includes nurses and families who have a family member in critical care, about their beliefs about critical care treatment ideals.

The following items were approved during this review:

- eIRB Protocol (Version 10/7/2012)
- Family Consent eIRB (Version 10/7/2012)
- Family Packet (Version 10/7/2012)
- Nurse Consent eIRB (Version 10/7/2012)

Appendix O

Kennesaw State University IRB Approval Letter

Zimbra **phart@kennesaw.edu**

Study 13-023: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care

From : zieglerirb@kennesaw.edu Wed, Aug 22, 2012 05:03 PM
Subject : Study 13-023: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care
To : jshamloo@students.kennesaw.edu
Cc : zieglerirb@kennesaw.edu, phart@kennesaw.edu

8/22/2012

Jennifer Shamloo, RN
KSU Wellstar School of Nursing

RE: Your application dated 8/20/2012, Study #13-023: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care

Dear Ms. Shamloo:

I have reviewed your application for the new study listed above. This study qualifies as exempt from continuing review under DHHS (OHRP) Title 45 CFR Part 46.101(b)(2) - educational tests, surveys, interviews, public observations. You are free to conduct your study without further reporting to the IRB.

Please note that all proposed revisions to an exempt study require IRB review prior to implementation to ensure that the study continues to fall within an exempted category of research. A copy of revised documents with a description of planned changes should be submitted to irb@kennesaw.edu for review and approval by the IRB.

Thank you for keeping the board informed of your activities. Contact the IRB at irb@kennesaw.edu or at (678) 797-2268 if you have any questions or require further information.

Sincerely,

Christine Ziegler, Ph.D.
Institutional Review Board Chair

Appendix P

Kennesaw State University IRB Revision Approval

Zimbra **phart@kennesaw.edu**

Study 13-023: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care

From : zieglerirb@kennesaw.edu Sat, Sep 22, 2012 12:10 PM
Subject : Study 13-023: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care
To : jshamloo@students.kennesaw.edu
Cc : zieglerirb@kennesaw.edu, phart@kennesaw.edu

September 22, 2012

Jennifer Shamloo, RN
KSU Wellstar School of Nursing

RE: Request for Revision to Exempted Study, Study #13-023: How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care Registered Nurses Influence Family Members' Perceptions of Patient Family Centered Care

Dear Ms. Shamloo:

I have reviewed your request for revisions to the exempted study listed above, which involves the following change to the protocol: Addition of a recruitment flyer and modification of the way the distribution and collection of research materials will be implemented. This study continues to qualify as exempt from review under DHHS (OHRP) Title 45 CFR Part 46.101(b)(2) - educational tests, surveys, interviews, public observations. You are free to conduct your study as approved.

Please note that any further changes to the study must be promptly reported and approved. Contact the IRB at (678) 797-2268 or irb@kene saw.edu if you have any questions or require further information.

Sincerely,

Christine Ziegler, Ph.D.
Institutional Review Board Chair

Appendix Q

Emory Chief Nursing Executive Approval Letter

EMORY HEALTHCARE
EMORY HOSPITALS

Emory University Hospital
1364 Clifton Road, NE
Atlanta, Georgia 30322-1061
404/712-2000

August 2, 2012

To Whom It May Concern,

I am writing this letter in support of the research proposal by Mrs. Jennifer Shamloo entitled, "How Caring Attitudes and Patient Family Centered Care Beliefs of Critical Care RNs Influence Family Members' Perceptions of Patient Family Centered Care". I understand that Mrs. Shamloo is a graduate student in Kennesaw State University's WellStar School of Nursing program. Mrs. Shamloo is conducting this research study to complete her thesis requirements for a Master's degree.

I fully support Mrs. Shamloo in conducting the research study in our Critical Care units throughout the Emory Healthcare system.

Emory Healthcare strongly believes in the philosophy of patient and family centered care. Creating a healing and caring environment within our Critical Care units and including patients and their families is vital in providing quality patient care.

I enthusiastically endorse Mrs Shamloo's research and request that she be granted permission to conduct her study at Emory Healthcare.

Sincerely,

Susan M. Grant

Susan M. Grant, MS, RN, NEA-BC, FAAN
Chief Nurse Executive
Emory Healthcare