Called to Caring: A Tool to Assess Awareness and Attitudes in Baccalaureate Nursing

Students at Point Loma Nazerene University

by

Melissa Meehan, RN

A Thesis presented to the

FACULTY OF THE SCHOOL OF NURSING

POINT LOMA NAZARENE UNIVERSITY

in partial fulfillment of the requirements for the degree

MASTER OF SCIENCE IN NURSING

MAY 2015

BARBARA TAYLOR, RN, PhD, Chair

JEANNE MAIDEN, RN, PhD, CNS-BC, Member

POINT LOMA NAZARENE UNIVERSITY

School of Nursing

Master of Science in Nursing

NAME OF STUDENT:     Melissa Meehan, RN

TITLE OF THESIS:     Called to Caring: A Tool to Assess Awareness and

Attitudes in Baccalaureate Nursing Students at Point

Loma Nazarene University

COMMITTEE:

*Barbara Taylor*     5-8-15

BARBARA TAYLOR, RN, PhD, Chair          Date

*Jeanne Maiden*          5/14/15

JEANNE MAIDEN, RN, PhD, CNS-BC, Member Date

# Abstract

Given the projected increasing shortage of well-prepared nurses, particularly at the baccalaureate level, the climate of limited resources for adequate RN training, and high attrition rates among NNs, it is imperative every effort is made to effectively prepare actively enrolled BSN students to care. To this end, nurse educators need to be armed with tools and instruments that accurately assess awareness and attitudes of caring and empathy among BSNs as a critical element of curriculum content and development.

*Keywords:*

**Table of Contents**

# List of Tables

CHAPTER ONE

**Introduction**

The phrase "If I knew then what I know now" motivates many to attempt to pass their experiences on to others in a variety of contexts: parent to child, teacher to student, elder to youth, and expert to novice. The concept that lived experience has the ability to transform practice is well documented (Benner, 1982; Benner, Tanner, & Chesla, 1996, 2009). In the healthcare field, this time-honored tradition can be seen in formal preceptor, mentoring, and residency programs essential to the full training and professional socialization of the next generation of providers (Benner & Wrubel, 1982a, 1982b; Goode, Lynn, Krsek, & Bednash, 2009). Even negative or painful experiences have the power to transform or realign priorities toward or heighten awareness about caring and empathy (Brown, 2011; Caserta, Lund, Utz, & de Vries, 2009; Grassman, 1992). For nurses, experiences with patients, and most especially with personal loss, offer growth oportunities to become exceptionally caring and empathetic nurses (Brown, 2011; Caserta et al., 2009; Grassman, 1992).

New graduate novice nurses (NNs) have been noted to be unprepared for practice with regards to their lack of confidence, difficulty prioritizing, struggle to see a whole situation in context, and difficulty developing rapport and trust in the nurse-patient caring relationship (Belcher & Jones, 2009; Burns & Poster, 2008; Etheridge, 2007). While there is a focus on patient safety and safe practice competency in the literature on NNs, caring and empathy are largely unaddressed as competencies NNs should possess (Burns & Poster, 2008; Etheridge, 2007; Evans & Bendel, 2004; Hengstberger-Sims et al., 2008; Ramritu & Barnard, 2001). Of all the functions nurses perform, caring is the most role-

defining trait and many consider it the central domain in nursing education (Como, 2007; DiNapoli, Nelson, Turkel, & Watson, 2010; Roach, 2008; Touhy & Boykin, 2008). As such, much literature has been amassed on the science of caring, theories of caring, and ways to observe or measure dispositions of caring (Cossette, Pepin, Cote, & de Courval, 2008; DiNapoli et al., 2010).

In nursing curricula, the topic of caring is much more nebulous and challenging to teach and test than the signs and symptoms of disease process. Handling material with debatable definitions and subjective attitudes and attributes verses topics with concrete objective facts and figures always presents an added challenge to both the educator and learner. Currently, nursing curricula incorporate the concepts of caring and empathy through a variety of methods including theory lecture, role modeling, simulation labs, journaling, dialogue and reflective discussions, reading, and group projects (Blum, Hickman, Parcells, & Locsin, 2010; Galvin, 2010; Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007; Nelms, Jones, & Gray, 1993; Panosky & Diaz, 2009; Smith & Allan, 2010). The lived experience of caring for patients with catastrophic illness cannot be completely duplicated in the nursing classroom, nor would instructors wish life-altering loss on students to heighten attitudes and awareness about caring and empathy. Still, there remains room to explore transformative learning theories such as narrative pedagogy. This methodology can enhance nurse educators' ability to produce NNs that exhibit greater efficacy and competency in caring and empathy (Adamski, Parsons, & Hooper, 2009; Brown, Kirkpatrick, Mangum, & Avery, 2008; Chan, 2008; Diekelmann, 2001, 2005; Hensel & Rasco, 1992; Ironside, 2003a, 2006; Maccarrick, 2009; McAllister et al., 2009).

A multitude of definitions of *caring* exist, many of which include the term

*empathy*. A simpler dictionary definition of caring is "feeling and exhibiting concern and

empathy toward others" or the act of looking after those unable to maintain their own

health state for themselves, especially the sick, the young, and the elderly (The Free

Dictionary, 2014). Jean Watson's description of human caring adds deliberateness to the

definition: "Human care requires the nurse to possess specific intentions, a will, values,

and a commitment to an ideal of inter-subjective human-to-human care transaction that is

directed toward the preservation of personhood and humanity of both nurse and patient"

(1988, p. 75).

Nurse educators bring to the classroom their considerable years of lived

experience, clinical practice, and areas of expertise (Andrews et al., 2001; Ironside,

2003b; Maccarrick, 2009). Additionally, educators' catastrophic personal experiences can

often serve as catalysts to transform nursing practice (Brown, 2011; Caserta et al., 2009;

Grassman, 1992). It follows then that perhaps nurse educators can translate the lessons of

these transformative events into a curriculum that imparts their lived experiences,

specifically related to undergraduate nurses' caring attitudes and dispositions of empathy

(Brown et al., 2008; Diekelmann, 2001, 2005; Diekelmann & Diekelmann, 2000; Hensel

& Rasco, 1992; Ironside, 2003a; Lee-Hsieh, Kuo, & Tsai, 2004; Lee-Hsieh et al., 2007).

**Significance of the Problem**

In a landmark report, "The Future of Nursing," the Institute of Medicine (IOM;

2010) called for an increase in the number of working baccalaureate-prepared nurses

(BSNs) to 80%, compared to the 50% that then made up the RN workforce. In December

2009, the Bureau of Labor Statistics (BLS) reported more than 581,500 new RNs would

be needed by 2018. If nursing programs continue to produce NNs unprepared to practice at expected levels in technical competency and the core domain of caring and empathy, the current nursing shortage will worsen to one of unprecedented magnitude.

NNs being ill equipped for the reality of practice leads directly to job dissatisfaction, high early career attrition, and poor patient outcomes (Belcher & Jones, 2009; Needleman et al., 2011; Nelson, 2011). The American Association of Colleges of Nursing (AACN) Nursing Shortage Fact Sheet (2011) summarizes the grim impact of the lack of well-trained registered nurses (RNs) on US healthcare now and in the near future. Added to this, 13% of newly-licensed RNs change jobs after one year and over 30% feel ready to change jobs (Kovner, 2007). One study reported that understaffing on nursing units poses a 6% higher mortality risk for patients compared to fully-staffed nursing units (Needleman et al., 2011). These conditions cannot be sustained for the good of society, particularly as they affect the quality of patient care and translate directly to poorer patient outcomes.

## Problem Statement

There are increasing demands to produce 'practice ready' NNs armed with the skills and resources to enable positive, realistic, and satisfying early practice experiences for themselves and those they serve. Crucial elements NNs must master as soon as possible include proficient and competent technical skills, communication skills, and the ability to execute the caritas processes. Yet, according to the AACN's 2010-2011 report on enrollment and graduation in baccalaureate and graduate nursing programs, nearly 70,000 qualified BSN applicants were turned away from US nursing programs in 2010 due to lack of instructors, facilities, preceptors, or program funding.

NNs often lack mastery of the key factors required to build rapport and trusting patient-nurse relationships: communication, confidence, and professionalism (Belcher & Jones, 2009). There is evidence that caring provides a return on investment far beyond that of any other technology or biopharmaceutical. The return on caring in terms of job performance and patient outcomes is yet to be fully identified but strongly suspected to be quite significant (Nelson, 2011).

Every effort must be made to ensure those that are called to care are being equipped to do so throughout their undergraduate nursing programs. This begins with identifying the tools to assess and measure awareness and attitudes of caring and empathy in student nurses. These assessments are necessary to ensure optimal curriculum development for each school of nursing.

## Purpose Statement

The purpose of this project is to identify an optimal instrument or scale to assess awareness and attitudes of caring and empathy among undergraduate baccalaureate students of Point Loma Nazerene University's School of Nursing as an aid to ongoing and future curriculum development.

CHAPTER TWO

**Literature Review**

To identify potential sources of relevant research, it was necessary to search the

literature on variety of diverse topics. Several electronic databases (CINAHL,

MEDLINE, OVID, and PubMed) were searched using keywords: care, caring, empathy,

new nurse, novice nurse, nurse-patient relationship, nursing shortage, caring tools,

empathy tools, caring instuments, assessing caring, measuring caring, and measuring

empathy. Ultimately, 254 sources were reduced to the 71 deemed of highest relevance to

the project.

**Caring and Empathy**

Intentionality is a key concept that separates nurse caring from other caring

(Roach, 2008). Caring is noted to be the central domain of nursing and differentiates

nurses from other healthcare providers in a holistic approach where science and art

intersect; it is translated through actions that incorporate knowledge and skills with heart

or emotions (Como, 2007; DiNapoli et al., 2010; Touhy & Boykin, 2008). But more than

philosophy and action, caring requires authentic presence, persistence, and quiet "being

there" (Como, 2007; Roach, 2008).

**Measuring Caring and Empathy**

Based on Watson's theories, specifically the Caritas Processes (CP), two

instruments to measure caring and empathy are the 20-item Caring Factor Survey (CFS

20) and the subsequent 10-item Caring Factor Survey (CFS 10) created by Karen

Drenkard, John Nelson, Gene Rigotti and Jean Watson. Their brevity make them

attractive from a practical and financial standpoint, as they do not fatigue the individuals

taking the survey and cost less to administer and evaluate than longer surveys. The drawback of these CFS tools is that they require patients to complete surveys as an evaluation of the nurse. Criterion validity was established using Pearson's correlation between CFS and CAT-II (Duffy, 2002), a caring tool determined to be closest in similarity. There was a correlation of .69, signifigant at the .10 level (p=0.6; Watson, 2009). Since the two authors of the CFS are considered experts in the caritas process, after nine revisions they confirmed content validity that each of the 20 statements accurately reflected caritas processes (Watson, 2008). While this provides a high level of validity, it is far less feasible to execute in the case of BSNs, requiring Institutional Review Board (IRB) approval at each clinical facility.

The Caring Behavior Measurement (CBM) is a 26-item instrument that adds measures of sincerity, respect, and empathy (Lee-Hsieh et al., 2004). The Caring Behaviors Scale (CBS) has 56 items that have been validated in students but lacks a specific theory (Lin, 2002). The 28 items of the Caring Behaviors Inventory for Elders (CBI-E) address Watson's theory of caring (Wolf et al., 2004), but the instrument is directed at a narrow patient population and has only been validated in elder patients and nurses, resulting in overall combined elder and caregiver Cronbach's internal consistancy reliability coefficient of alpha=0.936; Wolf et al., 2006).

The Caring Nurse-Patient Interaction Long Scale (CNPI-70) has theoretical grounding in Watson's carative factors and was validated in nursing students (Cossette et al., 2008). One slight disadvantage is that it is a 70-item survey; however, its theoretical grounding and validation may make it the ideal choice for this project. In 2008 Cossette et al. reviewed all available caring scales (totaling 12) utilizing factor analysis. These

scales were reviewed and exploratory factor analysis applied to the researchers' 70-item

CNPI-L to reduce the tool to a more manageable four-dimensional, 23-item Caring

Nurse-Patient Interaction Short Scale (CNPI-S) covering the caring domains of

humanistic, relational, clinical, and comforting care validated in 531 nursing students.

Construct validity of the four domains found Cronbach's alpha coeffients ranging from

0.91 to 0.95 (Cossette et al., 2008).

## Nursing Education Curriculum

Current learning outcomes of nursing education have evolved from traditional

care planning methods to developing critical thinking skills (Maneval, Filburn, Deringer,

& Lum, 2008). In the nursing classroom, instruction has moved away from historical

teacher-centered lectures toward more student-teacher co-learning transformative

approaches (Diekelmann, 2005; Ironside, 2003b; Nehls, 1995). None of these reforms

abandon completely the importance of care plans, lecture demonstration, and critical

thinking, but rather augment them in a more engaging format with a focus on reflection

and shared lived experiences (Story & Butts, 2010).

## Novice Nurses

Much work has been undertaken to identify and bridge the gap between education

and practice. Many studies note critical thinking among the weaknesses of novices

nurses, specifically difficulty prioritizing, an inability to administer and give rationale for

nursing actions, lack of insight to gather complete pertinent data and/or laboratory values

(Burns & Poster, 2008). Additionally, NNs tend to lack confidence, have poor awareness

of the level of responsibility required of them, and need multiple interactions sharing

experiences with expert nurses to evolve on the continuum of beginning practitioner learning to "think like a nurse" (Etheridge, 2007).

Communication has also been noted as a skill deficit in the NN (Belcher & Jones, 2009). There are more and more studies advocating nursing residency for NNs as a means of increasing retention, confidence and competency in ther early careers (Goode et al., 2009; Ulrich et al., 2010).

There are many definitions of competency for new nurses. Ramritu and Barnard (2001) identify six areas new graduate RNs reported as necessary to evolved competent practice: knowledge, limited independence, accessing and utilizing resources, time and workload management, ethical practice, and clinical skills performance. There is no mention of NNs' abilities with regards to caring and empathy, which is odd considering that caring and empathy are at the core of nursing, as noted earlier in this chapter. Equally baffling is that despite decades of research identifying the gap between education and practice and the poor experiences of NNs, little has changed while the same themes are currently reported (Morrow, 2009).

Additionally, many studies seek to assess and report the early experiences of newly graduated or novice nurses (Burns & Poster, 2008; Etheridge, 2007; Goode et al., 2009; Hengstberger-Sims et al., 2008). Themes repeatedly identified are gaps between education and readiness for autonomous practice, the importance of role modeling by a more expert nurse, and high rates of dissatisfaction and attrition. These factors contribute to poor retention of NNs, which only deepens the overall nursing shortage.

**Conceptual Framework**

A number of conceptual frameworks exist on caring with clearer definitions of measurable processes or outcomes (DiNapoli et al., 2010), one of which is Jean Watson's theory of caring, specifically the Caritas Process (CP). CP defines ten carative factors that enable nurses to respond to clients with a level of caring that exhibits the lovingkindness nurses are called to (Watson, 1988).

Dr. Watson's theory is multi-dimensional, complex, and requires a willingness to think deeply, reflectively, and existentially at times. There are four major concepts within Watson's theory and an overall commitment to seek authentic connections and caring-healing relationships with self and others (see Appendix A). The CP is a construct of seven assumptions and ten elements. Caritas One, "embrace altruistic values and practice loving kindness with self and others," illuminates Watson's belief about the responsibility of caring. It represents a holistic approach to caring and the role of the nurse (Watson, 1988).

Watson's theory is broken down by the individual steps of the caritas process, lending itself useful to development of tools and instruments to measure nursing students' attitudes and efficacy related to caring and empathy (Cossette et al., 2008; DiNapoli et al., 2010).

**Summary**

Given the projected increasing shortage of well-prepared nurses, particularly at the baccalaureate level, the climate of limited resources for adequate RN training, and high attrition rates among NNs, it is imperative every effort is made to effectively prepare actively enrolled BSN students to care. To this end, nurse educators need to be armed

with tools and instruments that accurately assess awareness and attitudes of caring and

empathy among BSNs as a critical element of curriculum content and development.

CHAPTER THREE

**Methods**

Caring is a central domain of nursing and is an area demanding competencies equally as important as technical skills, communication, and critical thinking. Without instruments to measure and assess awareness and attitudes about caring and empathy, little headway can be made in assuring a nursing school's curriculum is on target to producing NNs called and prepared to care.

**Scope of Project**

The merits and limitations of available instruments to measure caring and empathy among BSNs will be compared and contrasted in an effort to identify an optimal instrument or scale to assess current and ongoing awareness and attitudes of caring and empathy among undergraduate baccalaureate students of Point Loma Nazerene University's School of Nursing to serve as an aid for ongoing and future curriculum development. Consideration will be given to the instruments' alignment with the  School of Nursing's student objectives, curriculum content and adopted frameworks of caring theory. Care will also be give to scientific merit and feasibility of utilization before a recommendation is made.

**The Caring Behavior Inventory (CBI-24)**

The Caring Behavior Inventory (CBI-24) was one of the earlier care-measuring instruments to surface in nursing literature. It was developed by Dr. Zane Wolf in 1986 as a 75-item, 4-point Likert scale inventory designed to allow patients to assess caring behaviors of nurses by responding to a series of caring words and phrases. The theoretical framework of the instrument is strongly influenced by Watson's theories of caring. It was

paired down from the original 75 items to 43 and then eventually to a 42-item 6-point Likert scale inventory (Beck, 2001; Kyle, 1995; Wolf et al., 1998) and has been revised and adapted for specific populations, such as adult primary care practices and the elderly. It was deemed that most of the variances could be reduced to six areas or concepts and further modifications were made to create the 6-item CBI-6 (Coulombe et al,. 2002), the 5-item CBI-5 (Yavinsky et al.,2006), and the 24-item CBI-24 versions (Wu, Larrabee, & Putman, 2006). Additional testing and modifications yielded the 28-item, 3-point Likert scale Caring Behaviors Inventory for Elders (CBI-E; Wolf et al., 2004, 2006).

### Caring Ability Inventory (CAI)

The Caring Ability Inventory (CAI) is a self-administered 37-item, 7-point Likert scale designed by Nkongho (1990) to assess the caring abilities of college students in relationships with others from a variety of majors. The initial 80-item scale (36 positive and 46 negative) was reduced to 37 items and content validity was established (Waltz, Strickland, & Lenz,1984). This scale is not based on one theorist, but rather a general literature review of caring theory in 1990 and conceptual framework of Mayeroff's view of caring (1971). Due to its generalist nature it can be utilized in many populations of students and/or professionals. But subscales were used to rate nurses and colleges as high, medium, or low in their capacities for knowing, courage, and patience. It is a self-reporting measure, which increases ease of administration.

### Caring Efficacy Scale (CES)

The Caring Efficacy Scale (CES) is a 30-item, 6-point Likert scale originally designed to assess nurses' or nursing students' beliefs about their ability to express caring or form caring relationships with patients in a clinical setting (Coates, 1996). It is

grounded in the theories of Bandura's social psychology and self-efficacy and Watson's

caring. The first version had 46 items measured by a 6-point Likert scale and was a self-

report model tested on 47 novice nurses with good reliability and validity. From there, it

has been revised and tested multiple times to produce the current 30-item self-report scale

balanced for positive and negative items. Content was validated specifically in terms of

Watson's carative factors (Coates, 1996).

### Caring Dimensions Inventory (CDI)

The Caring Dimensions Inventory (CDI) is a 25-item, 5-point Likert scale

designed to sample perceptions of caring from a large number of nurses and student

nurses and is not based on any one theory of nursing (Watson & Lea, 1997). Sixty-three

articles were reviewed that used *care* or *caring* as a keyword and then analyzed to

produce 14 emerging themes. The general categories of care were developed based on

this review and produced the 25 core items of the CDI. The CDI was administered to

1,452 nurses and student nurses between 1994 and 1995 (Watson & Lea, 1997).

### Caring Factor Surveys (CFS 20)

The Caring Factor Surveys (CFS 20) is a 20-item, 7-point Likert scale designed

by Watson et al. in 2006 and published in 2008 to assess 10 caritas behaviors of effective

nurses, with two items dedicated to each of the 10 behaviors. The instrument was

designed to be completed by patients or their family members to assess the nursing care

they received. In 2010 DiNapoli et al reduced the tool to 10 positively phrased statements

using a 7-point Likert scale (one for each of the 10 carative processes) intended to be

answered by the patient and/or their family members.

CHAPTER FOUR

**Results**

Each of the five tools or scales evaluated here are effective measures of caring

and empathy with a variety of strengths and disadvantages for assessing awareness and

attitudes of caring and empathy among undergraduate baccalaureate students of Point

Loma Nazerene University's School of Nursing (see Table 1).

Table 1

*Comparison Of Five Caring Tools*

| Instrument | Description of Scale | Participants Aimed at | Designed to Assess | Theoretical Basis | Comments |
|---|---|---|---|---|---|
| The Caring Behavior Inventory **(CBI-24)** | 24 Items 6-point Likert | Patients | Caring behaviors of nurses | Watson's Caring influenced | Revised for Adult Primary Care & Elderly |
| Caring Ability Inventory **(CAI)** | 37 Items 7-point Likert | College Students (Any Major) | Caring abilities of college students | Generalist view of caring | Rates only capacities of Knowing, Courage, & Patience |
| Caring Efficacy Scale **(CES)** | 30 Items 6-point Likert | Nurses and/or Nursing Students | RN students beliefs about ability to express caring | Bandura, Self-Efficacy, & Watson's Caring, | Validated specifically in Watson's Carative Factors |
| Caring Dimensions Inventory **(CDI)** | 25 Items 5-point Likert | Nurses and/or Nursing Students | Perception of caring | Metanalysis of popular themes of caring | Not based on any specific Theory |
| Caring Factors Surveys **(CFS-10)** | 10 Items 7-point Likert | Patients and/or Patient's Family | 10 caritas behaviors of effective nurses | Watson's Caritas Process | Patient and/or family centered |

**The Caring Behavior Inventory (CBI-24)**

The Caring Behavior Inventory (CBI-24) is a 24-item, 6-point Likert scale inventory that allows patients to assess caring behaviors of nurses by responding to a series of caring words and phrases. Wu, Larrabee, and Putman (2006) administered the CBI-24 to 362 hospitalized patients and 90 registered nurses and identified four subscales in their published results: assurance, knowledge and skill, respectfulness, and connectedness (Wu et al., 2006). Validity and reliability were reported as Cronbach's alpha 0.98 for the 24 items, for 24 items, 0.95 for patients, and 0.96 for nurses, and test-retest reliability of r =0.88 in patients and r =0.82 in nurses. Because this tool was designed to be taken by patients receiving care, it has a low risk of positive or negative self bias and is an excellent tool to measure patients' actual perceptions of the care given by student nurses or NNs. However, utilization of the instrument would require IRB approval at every hospital site hosting clinical rotations and would need to be administered at these sites as well, making it logistically challenging.

**Caring Ability Inventory (CAI)**

The Caring Ability Inventory (CAI) is a self-administered 37 item 7-point Likert scale designed to assess the caring abilities of college students in relationships with others. It has been tested in 462 college students from a variety of majors with a Chronbach's alpha for each factor ranging from 0.71 to 0.84. As it is self-administered and applies to many populations of students and/or professionals, it is fitting to assess awareness and attitudes of caring and empathy among undergraduate baccalaureate students. But it is derived from a more generalist view of caring and rates students as high, medium, or low in knowing, courage, and patience rather than caring and empathy

as viewed through Watson's framework and the caritas factors taught Point Loma

Nazarene University's School of Nursing.

## Caring Efficacy Scale (CES)

The Caring Efficacy Scale (CES) is a 30-item, 6-point Likert scale that assesses

nurses or nursing students' beliefs about their ability to express caring or form caring

relationships with patients in a clinical setting (Coates, 1996). CES is also used with

permission in many US schools of nursing as a measure of student outcomes. Content has

been validated specifically in terms of Watson's carative factors and the instrument has

been tested on 110 graduating nursing students, yielding a Cronbach's alpha of 0.88. It is

a self test that can be easily administered in less than an hour in a classroom setting.

There is also a version for clinical administrators/supervisors with alphas of 0.84 (Coates,

1996).

## Caring Dimensions Inventory (CDI)

The Caring Dimensions Inventory (CDI) is a 25-item, 5-point Likert scale

measuring perceptions of caring from a large number of nurses and student nurses

(Watson & Lea, 1997). The CDI was administered to 1,452 nurses and student nurses

between 1994 and 1995 and reports a Cronbach's alpha of 0.91 (Watson & Lea, 1997).

Its simplicity and self administered nature make it an appealing tool; however, the CDI is

not based on any one caring theory and does not specifically measure caritas factors of

Watson's caring theory. Therefore, it may not be as pertinent to the scope of this research

as other tools evaluated here.

**Caring Factor Surveys (CFS 10)**

The Caring Factor Surveys (CFS 10) is a 10-item 7-point Likert scale survey taken by patients or their family members to assess their nursing care, specifically 10 caritas behaviors of effective nurses. Reliability is high with Cronbach's alpha 0.97-0.98 and content has been validated by a panel of experts (Persky et al., 2008). Of the tools evaluated, the CFS 10 is most strongly based on Watson's theories of caring and is not time-consuming to administer; however, it is patient/family-centered and may not be the best tool to measure an individual without the influence of patient or family bias from circumstances and potential crisis mode dynamics. It also requires multiple IRB approvals at each clinical site and must be administered in a variety of locations and settings, which adds extreme challenges to effective execution.

CHAPTER FIVE

**Discussion**

The purpose of this project is to identify an optimal instrument or scale to assess current and ongoing awareness and attitudes of caring and empathy among undergraduate baccalaureate students of Point Loma Nazerene University's School of Nursing as an aid to ongoing and future curriculum development. The University's School of Nursing derives much of its curriculum on Watson's theories of caring and the ten caritative factors.

Each of the tools evaluated in this research have merit. The CAI and CDI have been tested and validated in large student populations; however, both are based on general empirical ideas of caring rather than on one or two frameworks or conceptual theories of care. Both the CBI and CFS have strong grounding in Watson's theroies of caring and specifically the ten carative factors. They both also require administration to patients and/or the patient families being cared for by the student nurse being evaluated as opposed to the self-administered CAI, CES, or CDI. This represents a logistical challenge and shows great vulnerability to numerous uncontrolled variables as the scale must be administered in multiple locations and settings, each requiring individual IRB approvals in addition to PLNU IRB approval versus one classroom and one IRB approval. At 10 items and 25 items respectively, the CFS and CDI are shorter and are likely the least time-consuming compared to the CBI (28 items), CES (30 items), or CAI (37 items).

**Limitations**

There are a number of limitations to identifying an optimal tool to assess the awareness and attitudes of caring and empathy among baccalaureate students. One significant limitation is that the tool must be practical from both a time and resource point of veiw. While tools that are administered to patients to rate their student nurses' caring and empathy eliminate bias and may offer a higher degree of accurate valuable feedback than the self-administered student nurse tools, the financial and administrative burden of seeking, obtaining, and maintaining IRB approval at all PLNU clinical sites would be very difficult to sustain. The time required to administer and take even self-evaluations must be considered within curriculum design, as it will take away from clinical or instructual time.

**Recommendations**

Of the five instruments compared here, it is the opinion of this author that the best balance of resources and ability to measure awareness and attitudes of caring and empathy among baccalaureate students in PLNU's School of Nursing are found in Coates' Caring Efficacy Scale (CES; Appendix B). A student self-administered tool that can be completed in less than an hour and has already been validated specifically in Watson's carative factors and tested in student nurses is very appealing for use in this population. A pre-test post-test design including elements of caring and empathy could be incorporated into online class requirements to help guide current and future students' self reflection. Permission to utilize this instrument has been granted to other US nursing schools and is likely attainable for PLNU.

References

Adamski, M., Parsons, V., & Hooper, C. (2009). Internalizing the concept of caring: An examination of student perceptions when nurses share their stories. *Nursing Education Perspectives, 30*(6), 358-361.

American Association of Colleges of Nursing (2011). Nursing shortage fact sheet. Retrieved from www.aacn.nche.edu

Andrews, C. A., Ironside, P. M., Nosek, C., Sims, S. L., Swenson, M. M., Yeomans, C., ... Diekelmann, N. (2001). Enacting narrative pedagogy. The lived experiences of students and teachers. *Nursing and Health Care Perspectives, 22*(5), 252-259.

Beck, C. T. (2001). Caring within nursing education: a metasynthesis. *Journal of Nursing Education, 40*(3), 101-109.

Belcher, M., & Jones, L. K. (2009). Graduate nurses' experiences of developing trust in the nurse-patient relationship. *Contemporary Nurse, 31*(2), 142-152.

Benner, P. (1982). From novice to expert. *The American Journal of Nursing, 82*(3), 402-407.

Benner, P., & Wrubel, J. (1982a). Skilled clinical knowledge: The value of perceptual awareness, part 1. *The Journal of Nursing Administration, 12*(5), 11-14.

Benner, P., & Wrubel, J. (1982b). Skilled clinical knowledge: The value of perceptual awareness, Part 2. *The Journal of Nursing Administration, 12*(6), 28-33.

Benner, P. E., Tanner, C. A., & Chesla, C. A. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer.

Benner, P. E., Tanner, C. A., & Chesla, C. A. (2009). *Expertise in nursing practice: Caring, clinical judgment & ethics* (2nd ed.). New York: Springer.

Blum, C. A., Hickman, C., Parcells, D. A., & Locsin, R. (2010). Teaching caring nursing
to RN-BSN students using simulation technology. *International Journal for
Human Caring, 14*(2), 41-50.

Brown, L. P. (2011). From the other side of the curtain: The nurse as patient. *The ABNF
Journal: Official Journal of the Association of Black Nursing Faculty in Higher
Education, Inc., 22*(1), 13-14.

Brown, S. T., Kirkpatrick, M. K., Mangum, D., & Avery, J. (2008). A review of narrative
pedagogy strategies to transform traditional nursing education. *The Journal of
Nursing Education, 47*(6), 283-286.

Burns, P., & Poster, E. C. (2008). Competency development in new registered nurse
graduates: Closing the gap between education and practice. *Journal of Continuing
Education in Nursing, 39*(2), 67-73.

Caserta, M., Lund, D., Utz, R., & de Vries, B. (2009). Stress-related growth among the
recently bereaved. *Aging & Mental Health, 13*(3), 463-476. doi:
10.1080/13607860802534641

Chan, E. A. (2008). Evaluating narrative pedagogy in nursing education in Hong Kong.
*Nursing Science Quarterly, 21*(3), 261-267. doi: 10.1177/0894318408319608

Coates, C. J. (1996). *Development of the caring efficacy scale: self-report and
supervisor versions*. Unpublished manuscript. Denver: University of Colorado
Health Sciences Center.

Como, J. M. (2007). Care and caring: A look at history, ethics and theory. *International
Journal for Human Caring, 11*(4), 37-45.

Cossette, S., Pepin, J., Cote, J. K., & de Courval, F. P. (2008). The multidimensionality

of caring: A confirmatory factor analysis of the caring nurse-patient interaction

short scale. *Journal of Advanced Nursing, 61*(6), 699-710. doi: 10.1111/j.1365-

2648.2007.04566.x

Coulombe, K. H., Yeakel, S., Maljanian, R., & Bohannon, R.W. (2002). Caring behaviors

interventory: analysis of responses by hospitalized surgical patients. *Outcomes

Management, 6*(3), 138-141.

Diekelmann, N. (2001). Narrative pedagogy: Heideggerian hermeneutical analyses of

lived experiences of students, teachers, and clinicians. *Advances in Nursing

Science, 23*(3), 53-71.

Diekelmann, N. (2005). Engaging the students and the teacher: Co-creating substantive

reform with narrative pedagogy. *The Journal of Nursing Education, 44*(6), 249-

252.

Diekelmann, N., & Diekelmann, J. (2000). Learning ethics in nursing and genetics:

Narrative pedagogy and the grounding of values. *Journal of Pediatric Nursing,

15*(4), 226-231. doi: 10.1053/jpdn.2000.8040

DiNapoli, P., Nelson, J., Turkel, M., & Watson, J. (2010). Measuring the caritas

processes: Caring factor survey. *International Journal for Human Caring, 14*(3),

Duffy, J. (2002). Caring assessment tools. In J. Watson (Ed), *Instruments for assessing

and measuring caring in nursing and health sciences, (pp. 120-150).* New York:

Springer Publishing.

Etheridge, S. A. (2007). Learning to think like a nurse: Stories from new nurse graduates.

*Journal of Continuing Education in Nursing, 38*(1), 24-30.

Evans, B. C., & Bendel, R. (2004). Cognitive and ethical maturity in baccalaureate

    nursing students: Did a class using narrative pedagogy make a difference?

    *Nursing Education Perspectives, 25*(4), 188-195.

Free Dictionary (2014). Caring. Retrieved from www.thefreedictionary.com

Galvin, K. T. (2010). Revisiting caring science: Some integrative ideas for the 'head,

    hand and heart' of critical care nursing practice. *Nursing in Critical Care, 15*(4),

    168-175. doi: 10.1111/j.1478-5153.2010.00394.x

Goode, C. J., Lynn, M. R., Krsek, C., & Bednash, G. D. (2009). Nurse residency

    programs: An essential requirement for nursing. *Nursing Economic$, 27*(3), 142-

    147, 159; quiz 148.

Grassman, D. (1992). Turning personal grief into personal growth. [Case Reports].

    *Nursing, 22*(4), 43-47.

Hengstberger-Sims, C., Cowin, L. S., Eagar, S. C., Gregory, L., Andrew, S., & Rolley, J.

    (2008). Relating new graduate nurse competence to frequency of use. *Collegian,*

    *15*(2), 69-76.

Hensel, W. A., & Rasco, T. L. (1992). Storytelling as a method for teaching values and

    attitudes. *Academic Medicine: Journal of the Association of American Medical*

    *Colleges, 67*(8), 500-504.

Institute of Medicine (IOM). (2010). *The future of nursing: Leading change, advancing*

    *health.* Washington, DC: National Academy of Sciences.

Ironside, P. M. (2003a). New pedagogies for teaching thinking: The lived experiences of

    students and teachers enacting narrative pedagogy. *The Journal of Nursing*

    *Education, 42*(11), 509-516.

Ironside, P. M. (2003b). Trying something new: Implementing and evaluating narrative

      pedagogy using a multimethod approach. *Nursing Education Perspectives, 24*(3),

      122-128.

Kovner, C. T., Brewer, C. S., Fairchild, S., Poornima, S., Kim, H., & Djukic, M. (2007).

      Newly licenced RN's characteristics, work attitudes, and intentions to work. *AJN,*

      *American Journal of Nursing, 107*(9), 58-70. doi: 10.1097/01.NAJ.0000287512.

      31006.66

Kyle, T. V. (1995). The concepts of caring: A review of the literature. *Journal of*

      *Advanced Nursing, 21*, 506-514.

Lee-Hsieh, J., Kuo, C. L., & Tsai, Y. H. (2004). An action research on the development

      of a caring curriculum in Taiwan. *The Journal of Nursing Education, 43*(9), 391-

      400.

Lee-Hsieh, J., Kuo, C. L., Turton, M. A., Hsu, C. L., & Chu, H. C. (2007). Action

      research on the development of a caring curriculum in Taiwan: Part II. *The*

      *Journal of Nursing Education, 46*(12), 553-561.

Lin, P. F. (2002). The measurement of caring. *The Journal of Health Science, 4*(2), 178-

      192.

Maccarrick, G. (2009). Curriculum reform: A narrated journey. *Medical Education,*

      *43*(10), 979-988. doi: 10.1111/j.1365-2923.2009.03457.x

Mayeroff, M. (1971). *On caring.* New York: Harper & Row

McAllister, M., John, T., Gray, M., Williams, L., Barnes, M., Allan, J., & Rowe, J.

      (2009). Adopting narrative pedagogy to improve the student learning experience

in a regional Australian university. *Contemporary Nurse: A Journal for the*

*Australian Nursing Profession, 32*(1-2), 156-165.

Morrow, S. (2009). New graduate transitions: Leaving the nest, joining the flight. *Journal*

*of Nursing Management, 17*(3), 278-287.

Needleman, J., Buerhaus, P., Pankratz, V. S., Leibson, C. L., Stevens, S. R., & Harris, M.

(2011). Nurse staffing and inpatient hospital mortality. *The New England Journal*

*of Medicine, 364*(11), 1037-1045. doi: 10.1056/NEJMsa1001025

Nehls, N. (1995). Narrative pedagogy: Rethinking nursing education. [*The Journal of*

*Nursing Education, 34*(5), 204-210.

Nelms, T. P., Jones, J. M., & Gray, D. P. (1993). Role modeling: A method for teaching

caring in nursing education. *The Journal of Nursing Education, 32*(1), 18-23.

Nelson, J. W. (2011). Measuring caring: The next frontier in understanding workforce

performance and patient outcomes. *Nursing Economic$, 29*(4), 215-219.

Panosky, D., & Diaz, D. (2009). Teaching caring and empathy through simulation.

*International Journal for Human Caring, 13*(3), 44-46.

Persky, G., Nelson, J., Watson, J., & Bent, K. (2008). Creating a profile of a nurse

effective in caring. *Nursing Administrative Quarterly*, 32(1), 15-20.

Ramritu, P. L., & Barnard, A. (2001). New nurse graduates' understanding of

competence. *International Nursing Review, 48*(1), 47-57.

Roach, M. (2008). Caring scholar response to caring as the central domain in nursing

education. *International Journal for Human Caring 12*(8), 16-18.

Smith, P., & Allan, T. H. (2010). "We should be able to bear our patients in our teaching

in some way": Theoretical perspectives on how nurse teachers manage their

emotions to negotiate the split between education and caring practice. *Nurse*

*Education Today, 30*(3), 218-223. doi: 10.1016/j.nedt.2009.12.015

Story, L., & Butts, J. B. (2010). Compelling teaching with the four Cs: Caring, comedy,

creativity, and challenging. *The Journal of Nursing Education, 49*(5), 291-294.

doi: 10.3928/01484834-20100115-08

Touhy, T., & Boykin, A. (2008). Caring as the central domain in nursing education.

*International Journal for Human Caring, 12*(2), 8-15.

Ulrich, B., Krozek, C., Early, S., Ashlock, C. H., Africa, L. M., & Carman, M. L. (2010).

Improving retention, confidence, and competence of new graduate nurses: Results

from a 10-year longitudinal database. *Nursing Economic$, 28*(6), 363-376.

Waltz, C. F., Strickland, O. L., & Lenz, E. R. (1984). *Measurement in nursing research.*

Philadephia, PA: F. A. Davis

Watson, J. (1988). *Nursing. Human science and human care. A theory of nursing.* New

York, PA: National League for Nursing

Watson, J. (2008). *Nursing. The philosophy and science of caring (2<sup>nd</sup> ed.).* Boulder:

University Press of Colorado.

Watson, R., & Lea, A. (1997). The caring dimensions inventory (CDI): Content validity,

reliability, and scaling. *Journal of Advanced Nursing, 25*, 87-94.

Wolf, Z. R., Colahan, M., Costello, A., Warwick, F., Ambrose, M. S., & Giardino, E. R.

(1998). Relationship between nurse caring and patient satisfaction. *MEDSURG*

*Nursing, 7*(2), 99-110.

Wolf, Z. R., Zuzelo, P. R., Costello, R., Cattilico, D., Collaretti, K., Crothers, R., et al.

    (2004). Development of the caring behaviors inventory for elders. *International*

    *Journal for Human Caring, 8*(1), 48-54.

Wolf, Z. R., Zuzelo, P. R., Goldberg, E., Crothers, R., Cattilico, D., & Jacobson, N.

    (2006). The caring behaviors inventory for elders: Development and psychometric

    characteristics. *International Journal for Human Caring, 10*(1), 49-59.

Wu, Y., Larrabee, J., & Putman, H. (2006). Caring behaviors inventory: A reduction of

    the 42-item instrument. *Nursing Research, 55*(1), 18-25.

Appendix A

**Watson's Human Caring Theory***

**Ten Caritas Processes:**

1. Embrace altruistic values and practice loving kindness with self and others.

2. Instill faith and hope and honor others.

3. Be sensitive to self and others by nurturing individual beliefs and practices.

4. Develop helping—trusting—caring relationships.

5. Promote and accept positive and negative feelings as you authentically listen to another's story.

6. Use creative scientific problem-solving methods for caring decision making.

7. Share teaching and learning that addresses the individual needs and comprehension styles.

8. Create a healing environment for the physical and spiritual self, which respects human dignity.

9. Assist with basic physical, emotional, and spiritual human needs.

10. Open to mystery and allow miracles to enter.

*Caritas Processes refined from Inova Health (Jean Watson, 2007)

Appendix B

**Caring Efficacy Scale** (**CES**; Coates 1995, 1997, 1999)

Instructions: When you are completing these items, think of your recent work with patients/clients in clinical settings. 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 client/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 caregiving. | -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 shocked. | -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 |
| 9. I can walk into a room with 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 client/patients from backgrounds different from my own. | -3 | -2 | -1 | +1 | +2 | +3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13. I feel like 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 am 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 my 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 patients/clients when I need to. | -3 | -2 | -1 | +1 | +2 | +3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 clints/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 |