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The Perceptions of Nursing Team Caring Behaviors Among Residents of an Assisted Living Facility for Retired Veterans

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The Perceptions of Nursing Team Caring Behaviors Among Residents of an Assisted Living Facility for Retired Veterans

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The dramatic growth in the population of individuals over age 65 and the increase in longevity of life due to advances in technology have resulted in a stunning increase in the number of older adults in the United States. Simultaneous with this change is a decrease in the ability of others to properly sustain this aging population. Assisted Living Facilities (ALFs) have emerged as an option for residential long-term care of this increasing population and promise their residents a sense of autonomy and independence. There is concern that such promises cannot be met as residents with increasingly complex conditions strive to age in place, but are cared for by paraprofessional staff. The impact of caring behaviors has become linked to quality of care and quality of life. It is appropriate to examine the perceptions of residents of ALFs regarding caring behaviors in order to help identify best practices to attempt to fulfill these promises.

The purpose of this study was to identify nursing team caring behaviors as perceived by residents of an ALF for retired veterans and to more fully understand these behaviors by gathering qualitative data to elaborate upon the quantitative findings. This descriptive study utilized Watson's Caring Attending Nurse Model for a framework and methodological triangulation to examine the data. Three tools were used to explore the perceptions of 51 ALF residents over the age of 65 years. The Caring Behaviors Inventory Tool for Elders (CBI-E), (Wolf, 2006), was the quantitative tool and formed the basis for the Focused Interview Guide used to elicit qualitative feedback from 16 residents who agreed to

additional questioning. Descriptive statistics were used to examine demographic data and CBI-E results. Content analysis was utilized to explore the qualitative responses. Two patterns emerged: "The Good Nurse" supported an individual's sense of integrity while "The Non-Attending Nurse" was perceived as lacking an individualized understanding of the person, thus undermining their dignity. This study examined perceptions of caring behaviors within an ALF facility. With a residential base of one million residents and growing, this is a segment of society most deserving of our attention.

This dissertation by Lisa George Jordan fulfills the dissertation requirement for the doctoral degree in Nursing approved by Sister Mary Elizabeth O'Brien, Ph.D., R.N., FAAN, as Director, and by Mary Paterson, Ph.D., R.N., and Janet Merritt, Ph.D., R.N. as Readers.

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Mary Elizabeth O'Brien, Ph.D., R.N., FAAN, Director

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DEDICATION

This work is dedicated to the members of the "Greatest Generation," who have consistently shown us how to give of self, live with dignity, and age with grace. My heartfelt gratitude and sincere thanks go to the residents and those who work at the facility where this research study took place. I am indebted to all of you who were so willing to share your time and thoughts to support a better understanding of the concept of caring within the Assisted Living Environment. It is through your assistance that the advancement of research in this area has been accomplished.

This work is also dedicated to Sister Mary Elizabeth O'Brien, Ph.D., R.N., FAAN, who has taught me a love for research and, through her guidance, has taught an untold number of nurses that we stand on holy ground as we serve others through our mission of caring. Thank you to Sister Marian Brady, S.P., Ph.D., who has oftentimes been an essential part of this journey, with her knowledge of ethics, her devotion to our older population, and her unconditional caring as a teacher and mentor. I express a final thank you to the Little Sisters of the Poor who offer the exemplar for serving our older adults with grace, love and dignity.

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CHAPTER I

Introduction

Caring. The word can evoke myriad thoughts intimately tied to the experience of being human. Caring is an act which when experienced gives sustenance to both the giver and recipient of the caring behavior. As such, caring offers a chance for both recipient and giver to grow and actualize capabilities evolving over time (Meyeroff, 1971).

Watson (2006) views the delivery of caring behaviors as a moral ideal. The preservation of human dignity, support of a sense of integrity and transpersonal connectedness through meaningful relationships are outcomes identified in connection with caring behaviors (2006). The importance of caring behaviors and the resultant impact on health, however, is oftentimes ignored in the current health care delivery system. "Society is in a critical situation today in sustaining human caring ideals and a caring ideology in practice..." (Watson, 2005, p.19).

In fact, today in the United States there is a confluence of circumstances which places our elderly population at risk for a diminishment in receiving caring behaviors. People are living longer in unprecedented numbers. In 1900, the life expectancy was 47 years of age. By the beginning of this century, life expectancy had grown to 77 years. While the overall population of the United States tripled between 1900 and 2000, the increase in the number of older adults was 11 fold. The most dramatic increase is found among those individuals 85 years and older. This cohort has grown 34 times its size since 1900 and will continue to experience dramatic growth as Baby Boomers become Booming Seniors over the next several decades (He, Sengupta, Velkoff & DeBarros, 2005).

The dramatic growth in the population of individuals over 65 years of age combined with the increase in the longevity of life due to advances in knowledge and technology have resulted in a stunning increase in the number of elderly individuals within the population. A reshaping of the life-cycle is becoming increasingly evident. Ironically, the price paid by many who are experiencing increased years of life is an elongated period of debility, dementia and added dependence prior to death (President's Council on Bioethics, 2005).

Synchronized with this seismic demographic shift is a decrease in the ability of others to meet the holistic (physical, psychosocial and spiritual) needs of this elder population through caring behavior, which is individualistic in nature. The present changes of family structure, including marital status and family composition, point to the likelihood of decreased availability of familial support. In addition, the decrease in the number of trained health care personnel is a serious issue which must be examined and addressed to properly sustain the population as it ages (He et al., 2005).

In a report commissioned by the Centers for Disease Control and Prevention (CDC) and the Merck Institute of Aging and Health (MIAH), *The State of Aging and Health in America 2004*, it is suggested that the graying of our population is more than a matter of numbers. While the average 75 year-old has three chronic conditions and may be taking five different prescription drugs, there is an inability to identify how to meet effectively the unique challenges of this frail population. The research cites a sobering lack of understanding of health care providers to meet the specific needs of this growing population. Our society, according to the Alliance for Aging Research (AAR, 2002), is facing a "Geriatrics Gap" in which there is a risk for ignoring the basic human rights of the elderly. This is due to a lack

of formal understanding of the complexities of the caring behaviors necessary to effectively support the health and independence of the elderly population. The workforce is inadequate in both number and expertise to effectively meet the caring needs of elders even with today's demographic picture. This general lack of elder-based knowledge and the grave implications for health care delivery are staggering in scope. The inability to provide the best caring behaviors for older adults due to lack of formal knowledge may, it is feared, result in an undermining and diminishment of the individuality of those who comprise this burgeoning population. In fact, long term care needs are identified as perhaps one of the greatest challenges to those who exhibit long term caring needs (CDC, 2004). An issue brief from the American Health Care Association and National Center for Assisted Living (2008) points out that today's 1.5 million frail elderly Americans who rely on long term care services today will total 12 million by the year 2020**.**

Into this environment, the Assisted Living Facility (ALF) has emerged in response to consumer demand for residential long-term care to meet the physical, psychosocial and spiritual needs of this increasing elder population. Perceived as an alternative to one level of nursing home care, the ALF demonstrated the most rapid growth of all senior housing options throughout the 1990s. ALFs provide a more home-like environment by offering some sense of autonomy and independence to individuals who can no longer manage on their own due to medical need or functional or cognitive decline (Stefanacci & Podrazik, 2005).

The average resident of an ALF is white, female, in her early 80's, and widowed. Approximately three quarters of the residents are cognitively intact or have mild cognitive impairment. Most individuals make the move to an ALF from a personal residence with help

from family. More likely than not, the resident had some control over the decision with the most important characteristic in determining where to move being the availability of a private room with a bath (Hawes, Phillips, & Rose, 2000). However, the determination to relocate to an ALF was likely to have followed a loss of helping relatives or friends (Reinardy & Kane, 2003).

The ALF is difficult to define by structure and function due to great variability across states and among residences (Hawes, Phillips, Rose, Holan & Sherman, 2003). Generally staffed to meet the needs of residents who require some assistance but not the range of around the clock behaviors provided in a nursing home environment, there is no exact definition of what ALFs are in relation to other long term care options. The research which has been done in this area of long-term care demonstrates that there is great variability in regulatory oversight and a lack of standardization in meeting the holistic needs of elderly residents (Stefanacci & Podrazik, 2005; Kissam et al., 2003). Generally regulated on the state level, ALFs can be licensed or unlicensed and are oftentimes staffed by unlicensed personnel (Chen & Cohen, 2002).

In an attempt to define quality of life and the delivery of care within the ALF, Hawes & Phillips (2007) concluded that researchers and policy-makers still know relatively little about this growing industry. This market-driven response to meet the needs of frail elders who require assistance has occurred, for the most part, in a largely unregulated manner. Alarmingly, little is known even concerning the residents who are the recipients of care in these facilities (2007). Most residences are required by the state to have "sufficient staff" to meet the needs of residents, both scheduled and unscheduled, on a 24 hour basis. In an

outcomes study exploring the benefits of Assisted Living, (Zimmerman, Sloane, Eckert, Gruber-Baldini, Morgan, Hebel, Magaziner, Stearns, & Chen, 2005) the researchers found ALFs to generally meet minimal staffing requirements and to be understaffed. This situation is compounded by a rapidly growing resident population with increasingly complex medical and physical problems (2005). For instance, the average resident takes six medications per day and almost 25% of residents take nine or more medications daily (Mezey & Kovner, 2003). These data demonstrate that ALF residents receive a higher number of medications, including psychotropic agents, than nursing home residents (2003). Meeting minimal staffing requirements translates into the stark realization that these medications are often administered by a certified medication aide, not by a registered nurse (Zimmerman et al., 2005).

Concerns at the national level about safety and the potential need for federal regulation have been addressed (Breaux, 2002). In a review of the literature from 1989 to May of 2004, Kane, Chan and Kane (2007) report that despite the rapid growth, research is both underdeveloped and without consensus in defining the ALF or its population. Topics of importance such as selection of an ALF, pricing, admission and retention practices, and even the role of resident preferences, are viewed as areas which are unstudied (Hernandez & Newcomer, 2007). There is a growing call for data concerning the costs and benefits of assisted living to the consumer (Wilson, 2007). At the same time, there is concern that increasing regulations could make it difficult for smaller facilities capable of offering good care to remain in business (Zimmerman et al., 2005). Data suggest, however, that assessment

of performance measures which could target modifiable deficits could prolong independence and support healthy aging.

While the increased complexity of elder needs in relation to those of other age groups is well documented (AAR, 2002; Kovner, Mezey & Harrington, 2002), little is known concerning how elders in ALFs truly fare in relation to caring behaviors due to a dearth of research about the individuals who choose this option of long term care delivery (Burdick et al., 2005). With a burgeoning population of frail elderly residing in ALFs, however, it is incumbent upon nurse researchers to examine the issue of caring behaviors within the ALF milieu.

Caring behaviors, perceived as interventions necessary to supporting the holism of the individual, should be promoted as primary activities, rather than actions considered when a provider has extra time (Meyer, Cecka & Turkovich, 2006). With the identified need for behaviors which are knowledge-based to effectively meet the needs of a growing frail elderly population, it is appropriate to examine the perceptions of elders concerning nurse caring behaviors. The question concerning the perceptions of nursing staff caring behaviors among residents of ALFs is justified as there is a considerable gap in the literature regarding this important information.

Statement of the Problem

Assisted Living Facilities have emerged as an option for residential living as the number of older adults with disabilities grows and the number of family caregivers decreases. Displaying great variability, these environments are socially based, and may have limited influence from professional nursing with much of the direct care delivered by para-

professional staff. While nursing team caring behaviors are believed to preserve human dignity and support the health of mind, body and spirit; the perceptions of nursing team caring behaviors among ALF residents is unknown.

Statement of the Purpose

The purpose of this study is twofold:

1. To identify nursing team caring behaviors as perceived by residents of an Assisted Living Facility for Retired Veterans.
2. To more fully understand the nursing team caring behaviors by gathering qualitative data to elaborate upon the quantitative findings.

Theoretical Framework

The Theory of Human Care (Watson, 1979) forms the theoretical structure for this study. In her seminal work on caring in nursing, *The Philosophy and Science of Caring*, Watson (1979) proposes that the premises for a science of nursing with a construct of "caring" are both broad and complex and constitute the basis for the science of caring. The focus of Watson's work revolves around what is identified as the "core" of nursing. This core, reflecting nurse caring behaviors, refers to the processes which effect positive health changes from practices intrinsic to the nurse-patient relationship. The Science of Caring forms a union between the quantitative aspects of science and the qualitative aspects of humanism. This caring behavioral approach allows the nurse to merge scientifically based practice under an umbrella of humanistic values. The result is a marriage of humanism and science, the foundation for the science of caring, which incorporates the four concepts of the

nursing metaparadigm; person, environment, health and nursing at a level perceived as more humanistic in nature (1979).

The carative factors form the guide for practice and have evolved over several revisions of Watson's work (1988b, 1996, 1999, 2002). The term "carative" is in stark contrast to medicine's curative approach. Guided by the clinical caritas processes of Watson's work, one finds a blueprint for a measured intentional approach to caring with supports the dignity and self esteem of the of all involved in the caring process.

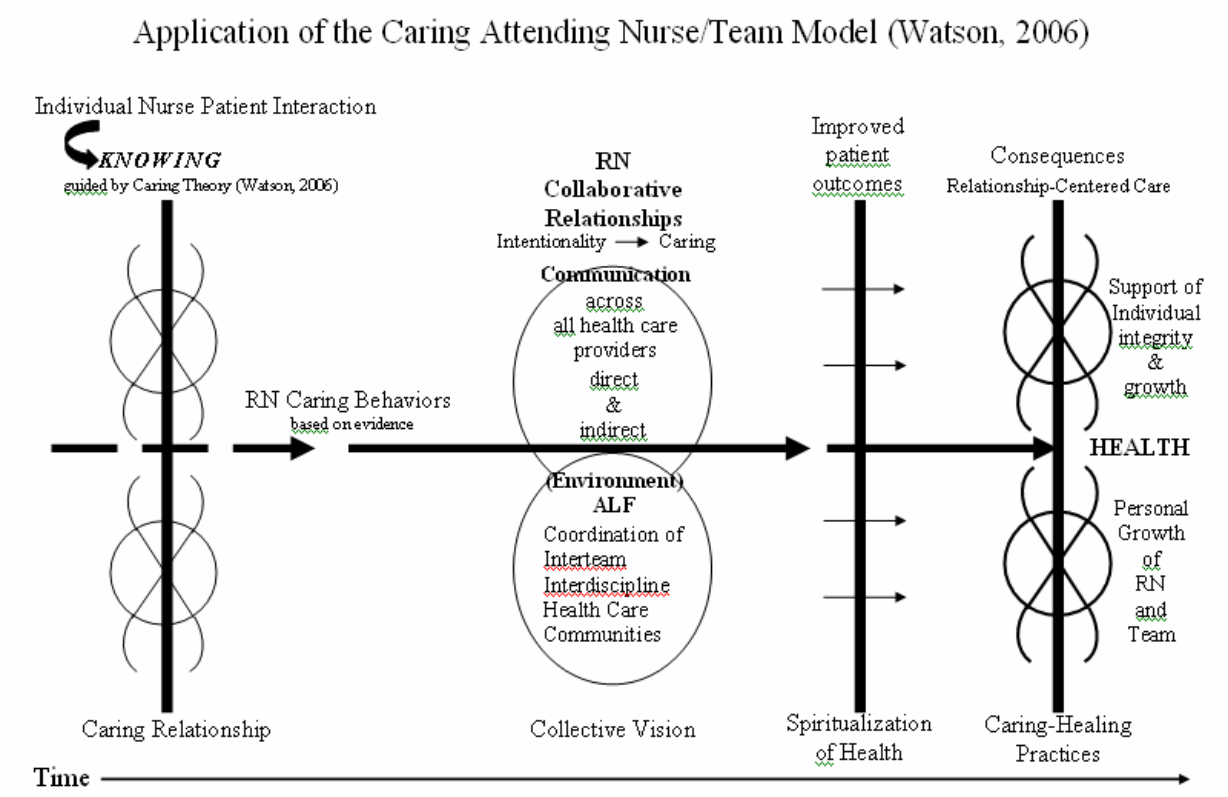
The practice of loving kindness, the actions engaged by being authentically present for the recipient of care, the cultivation in one's own self awareness, the work of sustaining helping-trusting relationships for caring and the focus of being present for a deeper understanding of oneself and for the one being cared for, are essential components of this course of action. In addition, the creative use of self to support caring, the engagement in a genuine teaching-learning experience to best understand the other's frame of reference, the creation of an environment based on a foundation of healing, the assistance with basic needs with intentional consciousness, and the focus on attending to the spiritual dimensions of both one-self and the one being cared for are all fundamental to the effective clinical caritas process (Watson, 2002).

Utilization of these elements refocuses attention of nursing behaviors to attend to the subjective experiences of patients. In addition to the carative factors, Watson built the theory on specific caring assumptions. These assumptions include the belief that caring can be demonstrated and, when based on the clinical caritas processes, can help to fulfill the needs of those served. As such, these caring behaviors support the client in achieving the

developmental task of older adulthood, integrity (Erickson, 1994). In contrast, the absence of such an individualistic approach can lead to the thwarting of this developmental goal and lead to maladjustment and psychopathology, according to Maslow (1962).

The theory submits that an environment which is caring in nature supports the development of potential which, in turn, offers a person a sense of autonomy to make informed choices in regard to health. Inherent to the theory are the assumptions that caring is equal in importance to curing and that the practice of caring is central to nursing. These caring behaviors are intrinsically responsive to the support of individual health (1979). Watson (2003) recognizes that today's health care delivery system places nurses in a situation torn between the task-oriented biomedical model of practice and the caring ideal that attracted them to nursing. The ability to resolve the conflicts which emerge between *what nursing is* and *what nurses do* may in the end dictate the survival of the profession in this new millennium (p. 361). In response to this situation, Watson offers a solution to renewal of the nursing profession. At a pivotal time of shortages, concerns about safety, which includes direct care delivery primarily from para-professionals on the nursing team, and need for health reform, Watson offers *The Caring Attending Nurse/Team Model* ®, (2006) (see Figure 1). Expounding on the Watson Caring Theory (2003), this approach further strengthens the goal of spiritualizing the human experience fostering unity of mind, body and spirit through the work of the Caring Attending Nurse.

Figure 1.



The responsibilities of the Caring Attending Nurse (CAN) within this team model approach are essential to the overall achievement of an individualistic caring response, which has at its core, the holistic support of the health of the individual. The CAN guides and sustains continuous caring relationships with patients and families across the entire interprofessional team including para-professionals of the nursing staff. This coordination of care is achieved by assessing caring needs from the patient's frame of reference and co-creating, with the patient and family, a plan for caring and healing that intersects with the medical care plan. This approach helps to assure comprehensive care planning among team members even when direct care is not administered by the CAN.

Watson (2006) suggests we look with a new perspective at how we are connected to each other. She underscores the importance of environment beginning with the historical perspective of its place as an essential concept of Florence Nightingale's (1859) paradigm for health. Watson proposes that we must *belong* as well as *become* the environment for clients, colleagues, ourselves and our communities (2005, p.96). While acknowledging that caring is not to be bought and sold like a commodity, Watson points out neither is caring the antithesis of good economics. Suggesting that human caring is an essential human resource she promotes this caring model which incorporates a moral foundation and a focused return of the human spirit back into the workplace under the coordination of the professional nurse (Watson, 2006).

The purpose of this study, to understand the perceptions of nursing team caring behaviors among residents of an ALF, can be accomplished through the framework of Watson's Science of Caring. Intentional caring behaviors within the assisted living environment can be described and measured through the quantitative and qualitative exploration of the perceptions of the ALF recipients of such caring behaviors.

Definition of Terms

Assisted Living Facility

Theoretical Definition: An assisted living facility is theoretically defined as a non-medical community based residential setting which provides housing, food and some personal services and oversight to frail elders who for their own safety cannot live alone (Aud & Rantz, 2004).

Operational Definition: An assisted living facility is operationally defined for this study as an Assisted Living Facility for Retired Veterans located within the Mid-Atlantic region of the United States which provides housing, food and some personal services and oversight to retired military personnel who for their own safety cannot live alone.

Elderly

Theoretical Definition:

The United States Census Bureau (1996) differentiated the elderly into three categories:

The young-old category is theoretically defined as the population between the ages of 65 to 74 years.

The middle-old category is theoretically defined as the population between the ages 75 to 84 years.

The oldest-old category is theoretically defined as the population which is 85 years of age and older (McInnis-Dittrich, 2005).

Operational definition of Residents in an Assisted Living Facility for Retired Veterans: The operational definition of Residents in an Assisted Living Facility for Retired Veterans for this study includes all residents of an ALF for Retired Veterans who are over the age of 65 years and have resided within the identified ALF for a minimum of two months at the time of the study and who can speak English, respond to interview questions in a clear manner and demonstrate orientation to person, place and time.

Theoretical definition of nursing staff in ALFs: The theoretical definition of nursing staff in ALFs is those staff members both licensed and unlicensed who provide health and personal services under individual state regulation to meet residents' service requirements. These

workers may include registered nurses, licensed practical nurses, certified nursing assistants, personal care workers and medication aides (The Assisted Living Sourcebook, National Center for Assisted Living (NACL), 2001).

Operational definition of nursing staff in ALFs: The operational definition of nursing staff in an ALF for Retired Veterans for this study will include all those personnel who work under the auspices of the RN within the identified ALF, and who offer health and personal care services to the residents.

Perceptions of nursing staff caring behaviors

Theoretical Definition: Perceptions of nursing staff caring behaviors are defined for this study as those behaviors occurring during caring moments when nurses respond to patients in caring situations (Watson, 2002).

Operational Definition: Perceptions of nursing staff caring behaviors among elderly residents of assisted living facilities will be operationally defined for this study as:

1. The total score obtained on the Caring Behaviors Inventory for Elders Tool (CBI-E) (Wolf, Zuzelo, Costello, Cattilico, Cooper, Crothers & Karbach, 2004).
2. Responses to the investigator developed Caring Behavior Focused Interview Guide (CBFIG).

Assumptions

The study is conducted with the following assumptions:

1. The essence of nursing is caring
2. Perceptions of caring behaviors can be measured.
3. Respondents will be truthful and accurate in their statements.

4. Older adults strive to achieve integrity in their lives
5. People expect that caring behaviors administered to elderly are knowledge based.

Limitations

The following is considered a limitation of the study:

1. Findings from the combined quantitative and qualitative investigational approach may offer new insight into the practice of nursing care with the elderly but are limited to the participants of the study and, as such, can be extended only with caution to similar settings and samples.

Implications for Nursing

The issue of long term care delivery to the growing population of individuals over the age of 65 years is pervasive throughout all aspects of society and has been identified as one of the greatest challenges facing policymakers, families, health care providers and businesses today (FIFARS, 2006). Research demonstrates that the protective role afforded by psychosocial resources can strengthen the link between physical and mental health and can support the integrity of the older individual as it helps to foster a more positive attitude toward the aging process (Jang, Bergman, Schonfeld & Molinari, 2006). The authors of this research suggest the notion that such supportive behaviors have implications for designing effective strategies to support the mental health of residents of ALFs (2006). Yet the scarcity of research regarding this aging population undercuts such support (CDC & MIAH, 2004).

As the burgeoning number of frail elderly select ALFs to help them meet their needs, the utilization of Watson's Theory of Human Caring offers an effective strategy to utilize patient and family perceptions to guide the team of staff members who offer nurse caring behaviors and implement strategies to support integrity and health. Engagement through the CAN/Team is one in which the Caring Attending Nurse (CAN) employs a collaborative approach grounded by effective communication across all interprofessional health care providers.

Utilization of holistic knowledge of the patient and the environment offers the nurse the opportunity to affect caring behaviors even when not in a position to deliver such behaviors directly. Consequences born of such caring are believed to comprise an essential component of how one manages living. Believed to be necessary for survival, these actions offer meaningful support throughout life, and may even impact how one approaches death (Leininger, 1984). Such caring actions are the essence of nursing (Watson, 1979; Leininger, 1981; O'Brien, 2003; Brilowski & Wendler, 2005). Understanding an individual's deficits and targeting interventions to support independence support the ability to age in place, an important component of the ALF philosophy (Giuliani et al., 2008).

The significance of a study of this type has implications on several levels. While such a study cannot generalize outside of the specific ALF in which the data were collected, it offers a unique insight into the perceptions of the elderly population so ignored in the literature to date. Moreover, in examining the perceptions of residents of an ALF for retired veterans, the study supplies perceptions of the elderly male, consistently overlooked in research.

Nursing, with sound clinical insight and knowledge of family systems, is positioned to address the challenges facing residents of ALFs. Data describing the perceptions of caring behaviors from elderly residents of ALFs may begin to supply important information supporting policy and practice in meeting the needs of this expanding and vulnerable population (Lowe, Lucas, Castle, Robinson, & Crystal, 2003).

Summary

Approximately one million elderly persons reside in ALFs which are residential long-term options for the rapidly increasing number of older adults who need some support with activities of daily living. Great variability exists among these facilities raising question concerning safety and maintenance of health. More research is needed to define the variable characteristics of the residents and to explore how this long term care option meets their needs. Nursing, with a comprehensive understanding of the needs of the elderly population, is poised to explore and produce evidenced based data which can effectively shape policy regarding the best practices to guide care within the Assisted Living Facility environment. Exploring the perceptions of ALF residents within the framework of Watson's Theory of Human Care and the CAN/Team Model could provide important information guiding nursing staff behaviors viewed as caring and effective. Increased knowledge based on resident feedback could begin to develop a strong foundation for the role of the CAN in promotion of health and the prevention of illness during this important but generally ignored developmental period of the older adult who resides within the ALF environment.

CHAPTER II

Review of the Literature

The purpose of this chapter is to further explore the concept of caring in a manner which offers more detail and understanding of the importance of this concept to nursing and to the health of older adults who reside in Assisted Living Facilities. The ontology of the concept and its impact on nursing will be presented along with the growth of this concept to its current and evolving state as theory put into action. The demographics of the burgeoning elderly population will be examined. In addition, the ramifications of the growth of this emerging cohort in relation to caring behaviors available to them will be explored. The emergence of the Assisted Living Facility as a market driven response for individuals no longer able to manage personal needs without assistance will be addressed. The issues of caring specific to the cohort of individuals 65 years of age and older and the impact of residency within the ALF will be investigated. The paucity of data concerning elderly residents in these ALFs will be discussed. Finally, the potential impact of nurse caring behaviors within the ALF environment and the subsequent significance for nursing will be presented.

Caring

Described by the philosopher, Milton Meyeroff (1971) as a way of being, caring is inherent in the process of day to day existence. Leininger (1976) identified caring as a universal human need crossing all cultures postulating that it is an essential element for realizing full potential in human development and for maintenance of health. Careful to clarify the distinction between “care” and “caring” Leininger (1984) defined the concept of

care in a generic manner as supportive actions toward another with the intent to improve a human condition. Caring on the other hand, denotes skillful activities focused on assisting others with interventions which are knowledge based and goal directed (1984). Swanson (1991) defines caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 162). In the literary meta-analysis concerning caring in nursing science performed by Swanson (1999) she refrains from including either, "the philosophical underpinnings or importance of caring to the discipline" (p. 32), stating that the importance of both are assumed at this point in time. Indeed, the concept of care and the impact of caring behaviors on health are issues which have been embedded in the practice of nursing since recorded time (O'Brien, 2006).

Since the 1970's, Watson has worked on the theory of human care advocating the message that caring behaviors are capable of preserving human dignity and transforming healthcare. Unwilling to allow caring to be restricted to "outer curing" she has championed the need for interconnectedness of mind, body and spirit through transpersonal human to human caring and intentionality on the part of the nurse (2006). By the inclusion of intentional caring and love into professional nursing care, Watson (2005) affirms that nurses approach the patient in a manner which is much more than a scientifically-based "cure" endeavor. The caritas processes, those factors which form a structure for understanding human need fulfillment, lead to a fuller engagement with the patient to promote comfort and healing. The nurse-patient transaction emerges as both a life-giving and life receiving endeavor which supports the humanity of all involved (2005).

Caring behavior is a process which creates understanding between the individuals involved in the transaction. It defines and is depicted by the transpersonal nature of the process. When directed toward the good of the patient, the caring process demonstrates a moral commitment to the person while reflecting the vulnerability of both parties sharing in the human caring experience (Wolf, Zuzelo, Costello, Cattilico, Cooper, Crothers & Karbach, 2004).

While no universal definition of caring exists, Watson's Theory of Human Caring (1999) and Leininger's Transcultural Care Theory (1994) have laid a foundation from which it is viewed as a central domain within the field of nursing (Digman, Williams, Fosbinder & Warnick, 1999). Not to be perceived as some basic action which can be directly accomplished, caring is a mediated response emerging as a result of various activities. These intentional behaviors demonstrate competency in caring through goal achievement (Gaut, 1983). It is clear that in caring, good intentions are not enough Meyeroff (1971). On the contrary, the act of *knowing* is an essential aspect of caring. Embedded within this understanding must be a true cognitive sense of the recipient of the care, what needs must be met, how to most effectively intervene for the welfare of the recipient, and an understanding of one's own personal limitations (1971).

Boykin and Schoenhofer (2001) propose in the theory of *Nursing as Caring* that all persons are caring by virtue of their human state. While the act of caring is not unique to nursing, the purposeful expression and focus of caring by the nurse defines how it is uniquely expressed within the discipline. Through the *nursing situation*, the interaction of the nurse and the one who is the recipient of the nurse caring behavior, the caring process is actualized.

The result of this situation is that supportive nursing caring actions are delivered. Referring to the process as intentional and authentic, caring becomes much more focused requiring the nurse to have understanding to do more than meet individual needs. Inherent in the caring situation is the ability to meet these needs in a knowledge-based manner (2001).

Identifying caring as the "starting point" from where nursing strategies emerge, Benner (1984) outlines an approach to caring behavior which is actualized at the location of the patient wherever the caring interaction takes place. Referring to caring as a basic way of being in the world, caring is the point from which the nurse can effectively perceive the stress, explore the coping mechanisms and respond through formulation of individualized caring behaviors to intervene. Building on the four patterns of knowing, (Carper, 1978) Benner (1984) identifies the knowledge base needed for expertise in caring. The nurse grows from novice to expert through the accumulation of knowledge built upon the experiences born of the personal, ethical, empirical and aesthetic ways of knowing. In this utilization of knowledge learned, caring becomes the tool by which the nurse crafts the art and science of the therapeutic response, the nursing process (Watson, 2006).

Sister M. Simone Roach (1987) in her discussion on the importance of caring as a major concept called for a systematic study of caring while identifying its role as central to the profession of nursing. Referring to caring as an expression of humanness and essential to continued development, she noted that it is the lack of caring which highlights its very importance to humanity. Roach attests to the fact that while not unique to nursing as a profession, "… caring is, unique in nursing as the concept which subsumes all the attributes descriptive of nursing as a human, helping discipline" (p. 9). Roach categorizes caring by the

following descriptors: compassion, competence, confidence, conscience and commitment. Identifying these as the *five C's,* these descriptors demonstrate a similarity to the knowledge needed for the expert nurse to function effectively.

Consistently the previous discussion has demonstrated that good intentions are not enough to support health. On the contrary, this discussion clearly demonstrates the belief that caring is intentional, relationship centered, and knowledge based (Meyeroff, 1971; Carper, 1978; Leininger, 1984; Gaut, 1983; Benner, 1989; Watson, 1999; Boykin & Schoenhofer, 2001).

Building on the belief that, as a profession, nursing is informed caring with the well-being of those served as its goal, Swanson (1999) performed a literary meta-analysis to examine how far the concept of caring in nursing had evolved and integrate the findings into a framework. Over 130 publications were studied and a hierarchy of five categories of caring emerged. The hierarchical levels are: capacities (for caring), commitment or concerns (which are the foundation for the caring), conditions (which affect the likelihood caring transactions will take place), caring actions (the actual interventions), and the (intentional and unintentional) consequences of caring. The construction of a framework to classify caring actions was a direct result of this work. "Nurse researchers working in a clinical arena need to expand (some say constrict) their thinking to consider caring as a commodity that may be measured, rigorously applied, and tested for its effectiveness in promoting healing, recovery, or optimal well-being (p. 55, 1999). It could easily be argued that the ALF is not included as a "clinical arena." Few studies have examined how our elders fare in relation to nursing care

in this environment. Even the aforementioned call for serious study by a noted nurse researcher leaves the inclusion of such an environment questionable.

In point of fact, when combining the terms caring, elderly, and assisted living facility, as parameters for a literature search, few studies emerge. While seen as a popular residential option for older adults, there has been little research done on the individuals who have chosen this option (Burdick et al., 2005). The vastly growing number of frail elderly, who by definition need assistance with living, suggests the need to champion the expansion of the focus of the clinical arena to include the ALF. "No matter our place in the world, we are "in place" by having our lives ordered by inclusive caring" (Meyeroff, 1971, p. 39). There is justification for such a study to both describe how nurse caring behaviors are perceived by this cohort and to begin a dialogue surrounding nurse caring behaviors which might better support the dignity, integrity and health of this population.

Demographics of the Elderly

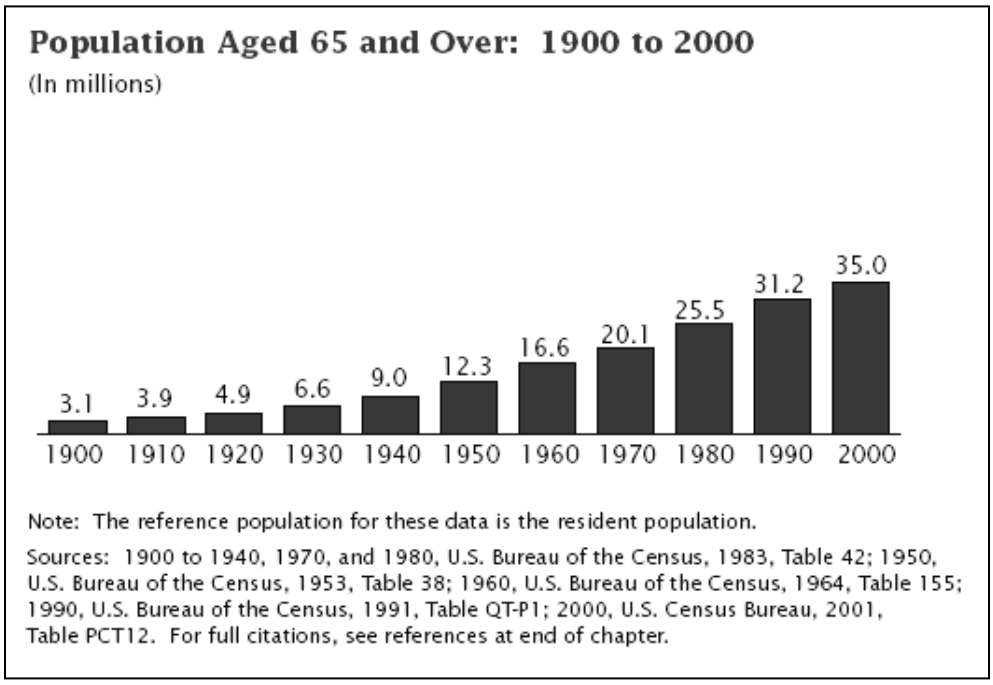
In the report, *65+ in the United States: 2005* (He, Sengupta, Velkoff & DeBarros, 2005) which was compiled from the data of the U. S. Census Bureau, the following is stated: "Population aging is one of the most important demographic dynamics affecting families and societies throughout the world. The growth of the population aged 65 and over is challenging policy makers, families, businesses, and health care providers, among others, to meet the needs of aging individuals" (p.5, 2005). The occurrence of this population shift can be clearly seen over the past century. In 1900, the cohort of individuals aged 65 years and older numbered 3.1 million. This number grew to 35 million by 2000 (2005).

It is estimated that by 2012, approximately 10,000 people a day in the United States will turn 65 years old and that by 2030, one out of every four Americans will be over age 65 years (AAR, 2004). Concurrently, life expectancy continues to increase, adding to the graying of the US population. The number of individuals over the age of 85, identified by the U.S. Bureau of the Census to be the old-old, is projected to increase from 3.7 million in 1996 to 6 million in 2010. This demographic change in the population coincides with the 75 million babies of the post World War II Baby Boom generation turning age 65. This confluence of circumstances produces a "perfect storm" increasing the numbers of elderly to a magnitude and proportion heretofore unseen in human history (2004).

The ratio of people aged 85 to those aged 50 to 64, usually the caregivers of their elders, tripled during the second half of the 20th century. It is expected that the ratio may triple again during the first half of this century (Barton, 1997). To more fully appreciate the enormity of these data, a different frame of reference gives additional insight concerning this shift in the population. From 1900 to 2000, those individuals 85 years of age and older grew to a number 34 times its size over the century. During the same time period, those aged 65 to 84 years of age grew only 10 times as large (He, Sengupta, Velkoff & DeBarros, 2005) (see Figure 2).

Figure 2.

U.S. Census Bureau, 2005



When discussing the aging of the population, in addition to the changes in family structure and family composition decreasing availability of familiar support (He et al., 2005), another essential factor which should be examined is the decline in fertility since 1900. This trend, especially pronounced since the 1970s, has resulted in a decline in the size of the birth cohorts as well as a corresponding increase in the proportion of the older to younger population ratio (He et al., 2005).

Marital status is identified as a key indicator of emotional and economic well-being according to the *Older Americans Update 2006 (*FIFARS, 2006). This report offers insight into important data in regard to age and gender. Across all three age groupings: 65-74years, 75-84 years and 85 years and older, married men significantly outnumber married women.

The most striking difference is seen in the over 85 year age group in which over 58 percent of men are married compared to 15 percent of women. In the 65-75 age group category, widowed women outnumber widowed men nearly four to one. This statistic in the 85 and older category points out the fact that 77 percent of women are widowed compared to 35 percent of men (2006). Currently, 50% of women over age 75 live alone. This number is double that of men in the same category. These data are important because both marital status and living arrangements are indicators which are intrinsically linked to emotional well-being, income, health status and availability of caregivers (FIFARS, 2006). In addition, It must be noted that while increasing numbers of people are living into their 80's, an accident, disease or a progressive decline in functional capacity can abruptly propel one from independent living into a dependent living arrangement (Reinardy & Kane, 2003; Barton, 1997).

Elderly and Caring Needs

The achievements in modern medicine throughout the second half of the 20th century have resulted in life-saving measures and have increased the years of life to individuals in numbers previously unseen in the history of mankind. This extended life experience has also had an impact on the manner in which people live out their final years. As many elders live well into the eighth decade and beyond, there is a concurrent increase in years of disability and infirmity, leaving many of them dependent on the caring behaviors of others for extended periods of old age (President's Council on Bioethics, 2005). The issue of caring for our elderly is one of grave concern. According to the Merck Institute of Aging & Health (2004) in their research commissioned by the CDC, a knowledge gap related to expert based care for older individuals exists. It reports that by 2030 the United States will need more

than 35,000 geriatricians and will fall short by 25,000. These data reflect serious concerns about how capable the caregivers of this population will be and the type of caring behaviors these frail members of society will receive. Assessments of this population are oftentimes interdisciplinary in nature including physicians, nurses and other health care team members. This study stresses that care must be coordinated and guided by those trained in the care of older people to monitor health and prevent physical and mental decline in every aspect of care. It warns however, that precious few dollars are being spent in schools of medicine and nursing to integrate the study of geriatrics into the curriculum and calls for leadership across all areas of academia in addressing and correcting this problem (CDC & MIAH, 2004; AAR, 2002).

Identifying factors such as the marginalization of the elderly, lack of research of the aging process, and clinical trials which do not include the aged, concerns are raised that while the benefits of improving the health of the elderly are obvious, as a nation we are woefully unprepared for the geriatric disparity in care that will continue to widen with the coming older adult population age boom. This lack of knowledge both undercuts the health and independence of the elderly and increases the cost of their care as a result (CDC & MIAH, 2004). Addressing the staggering impact that the graying of our population will have on all segments of society, McInnis-Dittrich (2005) identifies this confluence of circumstances as one of the greatest challenges we face in the twenty-first century. It is imperative that society provide caring behaviors based on proper knowledge to support the dignity of the elderly if elders are to live out their extended years of life with some semblance of integrity (2005).

The emergence of this aging population demands new strategies to adequately address concerns and enhance patient satisfaction. The impact of caring on health has become linked to quality of care and quality of life (Watson, 2006). Understanding the significance of loss resulting from diminishment of the bodily systems that accompany the natural process of aging, O'Brien (2006) supports exploration to gain insight into the meaning of such losses. This holistic approach can assist the elder individual to better gain understanding and meaning to deal with such change. Insight concerning the perceptions of caring needs among the elderly may help to identify how these needs are met. Personalized interventions based on knowledge and skill are what elders expect (Wolf, Zuzelo, Goldberg, Crothers, & Jacobson, 2006).

As this frail population increases, Flesner (2004) stresses that a more thorough understanding of the individual needs of elderly persons by health care providers is essential to their well-being and to competent caring interventions. Counting the number of residents who live within the ALF environment as approximately 1 million, Chen and Cohen (2002) bring the typical resident into focus. The researchers identify this person as an 83 year old female with approximately three limitations in activities of daily living. Understanding the magnitude of such a number and the variability which can result form such limitations, understanding individual needs through exploration of the perceptions of the residents themselves, could help guide approaches to ensure that caring needs in long term care living environments such as ALFs are being met (Hawes & Phillips, 2007).

Assisted Living Facilities

The Assisted Living Facility (ALF) is one option that has emerged to address the rising need for assistance to elders with some cognitive or physical impairment who are no longer able to mange on their own. Based on a social rather than a medical model for delivery of care, it is referred to as arguably the most positive development in long-term care delivery in decades (Polivka & Salmon, 2006). Purporting such values as respect for autonomy, privacy, and choice, the mission is to facilitate the ability of residents to age in place in a homelike environment (Chen & Cohen, 2002). There is concern however that such promises cannot be met due to the sizable differences regarding the quality and safety standards under which these state regulated long-term care facilities operate. A recent report which examines the ALF industry and issues of quality of care, refers to the marriage of resident autonomy to bridging the needs gap as an "awkward union" (Zimmerman et al. 2005).

In 2000, a report was issued by the U.S. Department of Health and Human Services following the examination of approximately 500 assisted living facilities (Hawes, Phillips, & Rose, 2000). Underscoring the data was the stark reality that the term "assisted living" referred to a vast array of residential settings with dramatic variation among them. Policy makers were left with many questions regarding policy formation, regulation and reimbursement structure regarding these long term care facilities (Hawes, Phillips, & Rose, 2000). Prior to this report, The Assisted Living Quality Coalition (ALQC), a group of six major organizations interested in supporting the needs of the elderly, produced a document in 1998 which was the culmination of two years of study regarding the issue of quality. The

goal of this study had been the establishment of a framework to delineate guidelines and set minimum standards to support the structure of programs representing such enormous diversity. The National Assisted Living Quality Organization (NALQ) was formed for this purpose. This independent group was established to effectively monitor, review and implement policies to help ensure consistency and enhance collaboration between consumers and providers. The focus was on performance outcomes and, promoting the highest possible quality of life for the population served by such facilities.

During a hearing before the Special Committee on Aging of the United States Senate of the One Hundred Seventh Congress on April 26, 2001 (107 Senate Hearing from the U. S. Government Printing Office via GPO Access), Senator Breaux recalled that twenty five years earlier the Nursing Home Industry grew with little consumer advocacy in its structure. To prevent such a reoccurrence, the Assisted Living Work Group (ALWG) was commissioned. This coalition included consumers, industry leaders, state level health department representatives, researchers and gerontologists to combine resources and create model standards for the assisted living care industry. The focus of this work was to provide care which would not simply extend one's life, but would make one's existence more fulfilling. Quality of life was the overriding philosophy yet the broader scope of the problem, including lack of consumer information and the shortage of personnel, had to be addressed.

The re-examination of the issues came on October 2, 2002 when the Special Committee on Aging in the Senate once again addressed quality of care and consumer protection involving assisted living facilities (Piotrowski, 2003). The Assisted Living Workgroup (ALW), formed at the April 2001 Senate Hearing, reported on the progress made

up to that point. Qualifying the work as ongoing, the committee reported that achieving a national consensus on the definition of assisted living and its derivations would establish benchmarks on which states could measure themselves but concluded that the model was a work in progress. All who testified urged that the regulation of ALFs remain at the state level. It was argued that the potential for change would be close to the consumer and specific to the needs of the situation in this manner. Admitting that there were as many ways to regulate these facilities as there are states in the union, members of the ALG reiterated their commitment to continue the work to achieve consensus across the country in regard to this issue (Piotrowski, 2003).

The committee had grown from 20 organizations in 2001 to more than 50 organizations at the time of the hearing. Testimony from the various groups represented thousands of facilities nationwide committed to proper oversight of the facilities and promotion of consistent quality based care for the hundreds of thousands of consumers they represented. The working definition of Assisted Living, reported to the committee on April 16, 2002, follows:

> "A congregate residential setting that provides or coordinates personal services and care, 24-hour on-site support and assistance (scheduled and unscheduled), activities and health-related services by qualified individuals. It is designed to: minimize the need to move (as disclosed); accommodate individual resident's changing needs and preferences; protect resident's rights; maximize resident's dignity, autonomy, privacy, independence, choice, safety, quality of life,

and quality of care; and encourage family and community involvement" (107 Senate Hearing form the U. S. Government Printing Office via GPO Access).

From the hearing, two points were highlighted as breakthroughs based on the testimony offered to the committee. Praised were the plans that consumer protection information and specific information concerning the quality of any facility would be available on the web to inform families in advance of their selection of an ALF to help ensure a proper fit to better meet the needs of the consumer. In its final report to the US Senate Special Committee on Aging in April 2003, the ALW Steering Committee, comprised of eight major group representatives, supplied testimony for the more than 50 stakeholders representing providers, consumers professionals, accrediting bodies and regulators presented the core principles which were addressed by all participating groups which included: quality indicators, outcome measures, dementia care, facility size, outcome measures, accountability, regulations, legislation, research, best practices and affordability (American Association of Homes and Services for the Aging, 2003).

The three hundred eighty one page report offered 110 recommendations and identified affordability as a paramount concern. Piotrowski (2003) summarized the work of the committee and its focus on improvements to staff training and medication management. The report was identified as a valuable first step and just the beginning of work which needs to be accomplished.

In a descriptive study on consumer satisfaction which comprised a survey of state initiatives of all 50 states, Lowe and colleagues (2003) concluded that such measurement is

in an early stage of development with little consensus on how to best quantify consumer satisfaction. While the response rate in this study was 100% across the states, the limited number of states which actually elicit information on resident satisfaction was embarrassing small. The study was presented as a first step in addressing the process of such a measurement and calls for the development of a standardized data collection tool and techniques to achieve results which could be used to compare facilities within states and across the country in the future.

Concerning the issue of quality among ALFs, Aud & Rantz (2004) demonstrated that differences among states continued to be a source of concern. Data suggest that there remains the same variability apparent from the first senate hearing in 1999. Even the names used to refer to these long term care facilities continued to exhibit a lack of consistency. Concerns over quality remain due to a lack of a national standard for assessment and care planning for residents and an absence of nationally recognized quality indicators for evaluative purposes. Included as additional concerns were the limited amounts of research regarding both ALFs and their consumers and the limited involvement of registered nurses operating as stakeholders throughout spectrum of care delivery (2004).

Attesting to the fact that the situation is begging for greater enforcement, McCoy (2004) in an article in USA Today pointed out that while it takes someone over 300 hours to become properly trained to be a manicurist, it takes only a few hours for someone over 18 years of age to become an assisted living facility staffer. Policy issues which were addressed in 1999 still remain as concerns today.

Due to the rapid growth in the ALF industry, one-third of all residences have been operating less than five years and approximately 60% of ALFs have been operating less than 10 years according to Aud, Rantz, Zwygart-Stauffacher and Manion (2004). This fact, along with the lack of consistency in definition, size of facility, admission policies, and resident and staff characteristics all combine to point to the need for a tool to help the consumer measure the quality of an ALF. With an emphasis on autonomy and resident choice of facility, the article describes the process under which such a tool was tested, revised and validated. The authors offer hope for its utilization in the future where consumer choice could reflect a decision to move into a facility based on quality of care rather than simply proximity which is currently often the case (2004).

The American Geriatrics Society (AGS) position paper (2005) identifies the move to an ALF as a critical transition in the life of an individual and calls for ALFs to provide complete information to prospective consumers and offer a comprehensive review of each resident within the first month of the admission to an ALF. Other positions from the paper include staffing practices which reflect individuals sufficient in numbers and knowledgeable in approach to meet the caring needs of aging residents calling for primary care providers including geriatric nurse practitioners and physicians experienced in geriatrics to direct the staff and coordinate care to help ensure optimal outcomes for the residents. The caring attending nurse team model (Watson, 2006) supports this delivery framework but only 55% of ALFs have a registered nurse full or part time on staff (AGS, 2005).

In an effort to research the availability of information obtained from ALFs regarding important consumer information such as cost, details of different levels of care, medication

policies and the contract, Consumer Reports (2005), made 30 calls to at least three locations of the 10 largest ALFs requesting the identified information. While many glossy brochures concerning menus and activities resulted from the endeavor, data from the study showed that none of the facilities responded with all the requested information.

It is apparent that the ALF is positioned to bridge the gap between independent living and nursing home care. In a recent survey by MetLife Mature Market Institute and LifePlans, Inc., on Nursing Home and Assisted Living Costs (2009), the national average of a private pay monthly base rate was approximately $3,100 with additional fees increasing the cost to individuals who have a need for Alzheimer's and dementia care. Consistent with its history, much variability in both physical style and cost were observed among the types of ALFs. The study demonstrated that while less expensive than nursing homes, costs might be reflective of the community size as some AFL communities offered multiple levels of care and might charge an additional entrance fee to join.

Kane, Wilson and Spector (2007), have called for increased research in such areas of consumer preferences, cost and financial assistance, areas of decision-making, attention to developing quality measures, and resident outcomes. The continued failure to study ALFs using standardized definitions or measurements are considered by the authors the major barriers to building an empirical data base to enhance ALF knowledge.

Residents of Assisted Living Facilities

While approximately 80% of the care received by elders within the United States today is provided by family members (Crist, 2005), demographic data regarding the aging of the population and the changing family composition suggests this situation will increasingly

prove not to be the case. "As more elders with fewer family carers [sic] are predicted, nursing's insight into the family care phenomenon becomes even more important" (p 485). Elders usually choose to move to ALFs due to some cognitive or physical impairment giving up prized possessions and much of their savings to finance such a decision (Black, 2006). Inherent in this situation is a crisis in identity. As a result of the potentially staggering change in terms of social structure and the new living environment, this event is identified as a critical transition in the life of the individual (Black, 2006; AGS, 2005).

Based on the premise that many older adults will benefit from residence in an ALF as a result of declining health, a qualitative study was done to better understand the experience of such a change in the decision-making process of four older adults (Kennedy, Sylvia, Bani-Issa, Khater, & Forbes-Thompson, 2005). The results of the study pointed out the heterogeneity of the cohort of older adults regarding physical functioning, life-history and decision-making style. Reinforced by the data was the importance of the active participation of the resident in the decision making process. The authors stress the need to understand personal preferences and the development of personalized care plans to insure a fit that is comfortable and ease the transition into the culture of the ALF (2005).

A longitudinal study was conducted to examine perspectives, needs and expectations of both residents of ALFs and their family members (Iwasiw, Goldenberg, Bol & MacMaster, 2003). The year long qualitative study viewed moving into an ALF as a major life altering event and sought to use the perspectives of the individuals who participated in the study to help improve approaches to care for other residents in this situation. Listening to the residents and their families recount their stories was found to be beneficial for the

residents, improving their lives through the validation of the uniqueness of their experience. While small in size, N=3, this study too points to the need for greater understanding of the process of transition.

As more attention is drawn to how best meet the needs of this vastly diverse population, quantitative approaches to understanding satisfaction have been employed. A recent survey of ALF residents commissioned by the Ohio Department of Aging was performed to explore how satisfied residents were with the facility and services it provided. In a news release dated February 15, 2008, Barbara Riley, Director of the Department of Aging reported that the results of the survey demonstrated that most of the ALFs in the state were meeting the desires of their residents for high quality care. The survey covered areas of activity, choice, care and services, employee relations and employee responsiveness. Under the subject of activities, the residents were asked questions regarding whether they had enough to do at the facility. Questions regarding choice reflected the freedom of the resident to decide on activities such as going to bed when it pleased them to do so. Care and services questions covered areas including being able to get snacks and medications on time. In addition, questions referenced if the employees knew the residents preferences and explained the care offered to the resident. Areas surrounding employee behavior reflected friendliness, courtesy and respect. Questions regarding responsiveness dealt with whether help could be expected when needed at various times and if the employee knew how to do their job. The statewide average was a score of over 90% of those facilities who participated in the study which included 9,200 ALF residents.

While limited in scope since many facilities that did not respond or were not eligible to be part of the survey, such an undertaking is very important. This survey, identified as the first in the nation to question ALF residents regarding quality of care issues, demonstrates a new willingness of state regulators to validate the resident's experiences while offering consumers and providers important information. The facility scores along with a long-term consumer guide are available on the web through the state and, as such, can be easily obtained by a potential resident or family member seeking such information.

This study is a long awaited positive response to the GAO report (GAO-04-684, 2004) which outlined the need for better information for consumers in selecting an ALF. The report stressed the need for full and more accurate disclosure of information to consumers as well as state assistance to ALF providers to meet regulatory requirements and improved procedures to address consumer complaints. While a first step, it represents a paradigm shift in responding to the needs of the prospective ALF resident.

The efforts of Aud, Rantz, Zwygart-Stauffacher and Flesner (2007) have also supplied needed feedback to consumers, providers and researchers in the long term care industry. Stating that ALFs now outnumber nursing homes and that quality of care is an issue in both, the authors have adapted a tool originally constructed for the nursing home environment to support improved long-term caring behaviors for ALFs. The tool offers data from the observer's point of view. This work represents an additional attempt to empirically validate quality indicators for an industry which provides care to an incredibly varied and rapidly growing population.

There is immense diversity across facility style and resident characteristics within each state and throughout the country. Yet, there is a lack of data to adequately describe specific phenomena concerning even the most basic indicators to describe this cohort. The inability to define such variables as the physical type of facility, staffing patterns, occupancy, and types of medications taken by the residents, highlights the lack of data regarding this long term care option. This great variability can negatively impact the ability to adequately meet the needs of this diverse population. The great irony however is evident as it is the uniqueness of the individual long term care system and the unique needs of the particular resident which must be taken into consideration if the philosophy of the ALF living environment is to be achieved.

There is an apparent growth in the willingness of various stakeholders in society to begin to address the impending demographic shift with specific action. While nursing is represented in the collection of professionals, the issue of nurse caring behaviors is noticeably absent. The presence of nursing within this milieu is still an indicator of great variability, Mitty (2003), believes that "Nurses have a significant opportunity - as well as a professional obligation - to help develop appropriate policies for assisted living and to shape the role of nursing, the delegation of responsibilities, and accountability in the care of residents" (p 35).

Feedback from residents of Assisted Living Facilities regarding their perceptions of nurse caring behaviors could help increase understanding of this population and their needs within this environment. These data could offer insight concerning how effectively ALFs

meet the caring needs of this frail population and in turn support their health through assisting with the transition (Kennedy et al. 2005).

Larry Polivka, (2006) Director of the Florida policy Exchange Center on Aging, discusses the importance of a commitment to the set of core values of the ALF philosophy. Polivka and Salmon (2004) affirm that research supports that ALFs with regulations which support the goals of autonomy, privacy and the ability of residents to age in place in an affordable setting, are indeed achievable. Additionally, the authors point out the fact that when ALFs have a registered nurse on staff, residents are able to remain within the ALF for longer periods and are hospitalized less often. Watson (2006) places great value on the need for such intentional behavior to support the dignity and health of each individual. This is no less true in the ALF environment where individualized care delivered through the collaborative approach guided by the CAN/Team Model could support health and quality of life through relationship-centered caring behaviors.

The CAN guides and sustains continuous caring relationships with patients and families across the entire interprofessional team including para-professionals of the nursing staff. Understanding needs from the patient's perspective and coordinating care to intersect with the medical plan of care helps to assure comprehensive care planning among team members even when direct care is not administered by the CAN. Within the ALF environment, the responsibilities of the Caring Attending Nurse (CAN) could be essential to the overall achievement of an individualistic caring response, which has at its core, the holistic support of the health of the individual.

Nurse Caring and Assisted Living Facilities

The Assisted Living Facility is an environment in which relationships based on nurse caring behaviors may be limited by the organizational structure from which the majority of these facilities have emerged. Aud & Rantz (2004) caution that the limited involvement of professional nurses within the ALF, "deprives residents of nursing knowledge and skills in assessment, coordination of care, medication management, and health promotion" (p 9). Indeed, in a report commissioned by the U.S. Department of Health and Human Services (2002) enumerating reasons for residents leaving Assisted Living Facilities, it was estimated that within a 12 month period the need for more care was the reason given for approximately twenty five percent of residents who left. Chen and Cohen (2002) suggest that nurses are the professionals who can enhance communication among ALF residents, their families and health care providers. This is based on the nurse's knowledge of the geriatric population, social services and community health care systems. Watson's CAN/Team Model (2006) provides a framework by which such communication can take place to maximize effective health outcomes.

Issues of quality of care and quality of life are paramount in meeting the needs of the elderly in community settings such as ALFs. Dupler and Crogan (2004) discussed the process of assessing the knowledge of and providing training to staff providing caring behaviors to older adults in ALFs. Many of these personnel began work with little training and limited knowledge of the normal aging process. After an extensive search of the literature regarding learning needs of ALF staff produced nothing, the nurses took a proactive

role in defining and meeting the training needs of staff while at the same time working to revise and clarify the regulations to guide the operations of such facilities in the state.

In a phenomenological study to explore the adjustment process to life in the assisted living environment, Kennedy, Sylvia, Banii-Issa, Khater and Forbes-Thompson (2005) point out that over the twenty year history of ALFs, there is little data concerning the experiences of cognitively intact residents in relation to every-day decisions making activities. This fact in itself is interesting, since it is the promotion of autonomy and independence which represents an essential facet underpinning the ALF philosophy which has been stressed in the literature for years (Pruchno & Rose, 2000).

The magnitude of the heterogeneity among older adults in relation to differences in health status, life history, adjustment style and day to day experiences highlight the need for knowledge of the uniqueness of the individual for a sense of autonomy in decision making activities and to support a good quality of life (Kennedy et. al, 2005). An intentional and personalized model of care was viewed as essential to support the transition to an ALF. Four themes emerged from the study which supports the overall satisfaction with every-day decision making activities. These themes were: the trigger event, the level of physical functioning, inside and outside support systems of the resident and past patterns of decision making activities. Again, this study highlights the importance of previously identified nurse caring actions which are based on unique knowledge of the individual and the contextual meaning of the environment to support integrity and health. The challenge for ALFs and the staff who provide for residents is to effectively balance the goal of independence for a functionally diverse population that, by definition, is vulnerable and in need of assistance.

This care must be provided by a staff competent in the care of older adults to optimize health outcomes (Stefanacci & Podrazik, 2005).

Significance of Nurse Caring Behaviors

In a recent study on caring behaviors, Henderson, Van Eps, Pearson, James, Henderson and Osborne (2007) proposed that it is through the maintenance of a meaningful relationship that concerns can be recognized and addressed. This type of interaction is perceived to denote caring behaviors and in turn support patient integrity. Interestingly, findings from the study pointed out that opportunities to develop close interactions with the patients were limited. When patients perceived their requests as being ignored they became dissatisfied. Bureaucratic demands and increased workloads had a negative impact on the ability to form close relationships in the setting (2007).

While this study did not take place in an ALF environment, it suggests the importance of caring behaviors to recipients of care. If the integrity of an individual can be strengthened by nurse caring behaviors, supporting the elderly population within an ALF becomes an even more important goal to be achieved. Issel and Kahn (1998) suggest that caring behaviors have economic value to health care organizations evidenced by purported effects on satisfaction, physical well-being and self esteem. Understanding the importance of consumer satisfaction, Perucca (2001) points out that consumers have options and their choices ultimately determine the financial success of an organization.

While bottom-line economics appear to be the norm in the current system of care, Turkel (2001) stresses the need to sustain the caring ideal in a situation which can additionally be cost effective. “Caring reflects quality and occurs in the interrelationship

between nurse and patient. Although caring and economics may seem paradoxical, contemporary health care concerns emphasize the importance of under-standing caring and quality in terms of cost" (2001).

The controversy over the desire to age in place and the actual stress of relocation play an important role in helping to define the proper place of the ALF in the long term care continuum. Chen and Cohen (2002) stress that it is the role of the nurse to insist on high quality care within this environment. By enhancing communication among residents, their families and care providers while offering expertise to facility administrators and government officials, nurses can play an essential role in assuring high quality caring behaviors within the ALF environment. The authors suggest that through evidenced based practice and policy relevant research, nurses are positioned to resolve the challenges that face this burgeoning industry (2002).

Toomey (2000) calls for nurses to represent the needs of patients as the promotion of health and the prevention of illness moves from a framework of biological to social concerns. Nurses must be included as a more integrated health care system is constructed to provide caring behaviors to patients with both acute and long term needs. Toomey stresses the importance of a governing board where interprofessional representation is the new paradigm and patient welfare is a focus based on representation by nursing (2000).

Similarly, Ross, O'Tuatahail and Stufferfield (2005) call for increased nursing leadership within the interprofessional arena. The research, which addressed multidisciplinary assessment of older people, found that working through others, being able to manage uncertainty and meeting unanticipated challenges were key themes which

emerged in the change process. The significance of this study echoes the refrain that clinical change is a process born of nursing research and leadership (2005).

The collaborative role across family and health care teams and the caring relationships promoted by the CAN could help foster growth within the resident, the family and among all members of the multidisciplinary team (Watson, 2003; Duffy & Hoskins, 2003). Nurse caring behaviors are identified as actions which are therapeutic in nature and lead to the improvement of the welfare of the recipient of the caring behavior (Wolf et al., 2004). These nurse caring behaviors, however, are potentially restricted by the composition of the staff of the assisted living environment and overall lack of professional nursing to assist in fostering such actions. The purpose of this study, to explore the perceptions of nursing team caring behaviors among residents of an ALF, could offer some insight concerning the delivery of such behaviors and the importance of the CAN.

"When intentionality and caring consciousness are incorporated into a shared transpersonal framework for nursing practice, one begins to awaken scientifically as well as ethically" (Watson, 2002, p. 12). The work of Watson has always reflected the importance of leadership and work that is both caring and scientifically based (1979). An evolution of sorts has transpired over the past several decades resulting from the utilization of Watson's theory. The transpersonal caring relationship, essential to the process of caring, is grounded in the following behaviors: the nurse's moral commitment to enhancing human dignity, the nurse's caring consciousness to honor the wholeness of the individual, and the nurse's intentional connection with the potential to heal. The model acknowledges that the new caring-healing environment must utilize partnerships, new forms of communication,

intentionality towards caring and healing, and a shift toward spiritualizing of health (2003). All of these actions would support the health and integrity of residents within the assisted living environment. Utilizing the work of Miller and Apker (2002), the model outlines the importance of new relationships including increased interaction with nursing assistants and technicians, improved communication among the various players of the health care team and cooperation with outside agencies. The CAN/Team Model identifies these important communication patterns as interventions of collaboration, conflict resolution, change management and the construction of a new nursing identity (2006).

Conclusion

The CAN/Team Model has emerged at a point in time when nursing, as a profession, has re-identified the importance of caring as a core concept in the practice of the discipline (Brilowski & Wendler, 2005; Swanson, 1999). The utilization of such a model within the ALF environment can enhance the heretofore limited dialogue concerning how best to mange nurse caring interventions based on the perceptions of the recipients whose voices must be heard.

In 2006, Watson called for a more focused approach which acknowledges human presence, intentionality of purpose and a consciousness of the practitioner to return to the caring of the wholeness of the individual.

The current estimation of one million residents represents a cohort of individuals which continues to grow in age and magnitude of need as each day passes. Nursing is poised to address this population understanding the importance of connecting mind, body, and spirit while acknowledging the overarching importance of the environment to support and foster

growth and health (2006). On examination of the data offered in the Assisted Living Sourcebook (2001), they display a marked increase in the percentage of ALFs which offer medication administration and help while, at the same time, they demonstrate a decrease in the percent of ALFs which offer skilled nursing services. As nursing fights for its rightful place at the policy table empirical data regarding nurse caring behaviors can become an effective tool in helping to support the nursing profession's impact within the ALF industry.

CHAPTER III

Methodology

The purpose of this chapter is to describe the research methods selected to assist in the description of individual perceptions of nursing staff caring behaviors among elderly residents of an assisted living facility. This chapter outlines the purpose of the study, the methodology selected as well as the reasoning behind the decision for the methodology, the study participants, selection process, and the setting. In addition, the tools used to perform this study are detailed and issues of reliability and validity discussed. The chapter further outlines the protection of human subjects and a description of the pilot study. Finally, the process of data collection, as well as the procedure for the analysis of the data, are presented.

Statement of Purpose

The purpose of this study was twofold:

1. To identify nursing team caring behaviors as perceived by residents of an Assisted Living Facility for Retired Veterans.

2. To more fully understand nursing team caring behaviors by gathering qualitative data to elaborate upon the quantitative findings.

Design

This descriptive design study utilized triangulation of method (Burns & Grove, 2005) to uncover information in an area where little research has been performed. The issue of caring is identified as such an area (2005). The study employed both quantitative and

qualitative methodology to examine the perceptions of elderly residents of an assisted living facility for retired veterans concerning nursing team caring behaviors.

The methodological approach included utilizing three tools for data collection. A Personal Information Form (PIF) helped provide important demographic details concerning the population examined in the study. These data were used to better describe and therefore better understand the participants of the study. The Quantitative tool, The Caring Behaviors Inventory for Elders Tool (CBI-E) (Wolf et al., 2004) measured perceptions of elders concerning caring behaviors, providing an empirical basis from which the data was examined. Finally, a semi-structured qualitative tool, the Caring Behaviors Focused Interview Guide (CBFIG), based on the five dimensions of nurse caring identified by the CBI-E, was utilized to elaborate upon the data obtained on the quantitative tool.

There is strong support for the utilization of methodological triangulation to study complex concepts such as caring in nursing (Burns & Grove, 2005). The methodology selected allowed for the utilization of a tool specific to the target population (CBI-E) and for the resultant data to be magnified by the focused interview guide (CBGIF) constructed from the tool itself. This process helped to ensure methodological cohesiveness. Triangulation, as designed in this study, allowed perceptions of nursing team caring behaviors among elderly residents of an ALF to be both measured and explored through this process.

Study Participants

The study included a purposive sample of residents of an assisted living facility for retired veterans. At the time of the study, seventy-three residents were eligible to participate as defined by the study criteria.

The selection criteria, which controlled participant inclusion in the study, were the following:

1. Participants were aged 65 years of age or older.
2. Participants were able to speak and understand English.
3. Participants were able to respond to interview questions in a clear manner.
4. Participants were able to demonstrate orientation to person and place displayed by their ability to concentrate on task by answering questions asked from the tools in the study.
5. Participants have resided at the ALF for a minimum of two months at the time of the collection of their data for the study.
6. Participants were willing to participate in the study.

The study was conducted with the intention to offer participation to all of the residents who met the inclusion criteria and consented to participate following informed consent. No exclusions were made based on gender, physical health or ethnic background in this study. Fifty-one residents, aged sixty-seven to ninety-nine years of age, agreed to participate in the study. This represented at seventy percent response rate.

Each participant was asked to respond to the personal information form (PIF) and the Caring Behaviors Inventory for Elders Tool (CBI-E). In addition to the aforementioned quantitative tools, the Caring Behaviors Focused Interview Guide (CBFIG) was offered to every willing participant. Sixteen participants agreed to answer the questions on the qualitative CBFIG Tool.

Table 1 compares national characteristics of ALF residents obtained from the National Center for Assisted Living (NCAL) 2001 Facts & Trends: The Assisted Living

Sourcebook with those of the ALF Veteran cohort for this study. The national data are based on the NCAL's 2000 survey of ALFs and the 2006 Assisted Living Resident Profile. While great variability is observed in examining the data which represent the National ALF Resident's Profile, the participants in this study share interesting similarities among characteristics. The one striking difference between the national sample and the study's veteran cohort was that of gender.

Table 1.

ALF and Resident Characteristics

Characteristics	National ALF Profile	Study ALF Profile
Type of Residence	Varies: stand alone, CCRC,	2 floors in CCRC
Fees	Varies: $2-3,000, ?admission	No initiation fee
Occupancy	Varies: Private/Shared	Mostly private, /some 2 person rooms
Certification	Varies	JCAHO
Philosophy/Mission/Goals	Varies	Stated, web presence noted
Staffing	Varies: RN/LPN/CNA/PCA	NP; RN runs team of LPNs/CNAs,
Resident: Age in years	85	83.82
Gender	Predominately female	Predominately male
Marital Status	Widowed	Widowed/divorced
Ethnicity	White	Predominately white, all US states
Education/Occupation	Varies, high school, some work	Predominately High School Grads, all Retired Military
Assistance with ADLs	Varies 2-3	Varies 2-3
Meds/Day	Varies 6-9	Varies 5-10 some residents self-administrate

As shown in the previous able, the characteristics of the group of participants in this study were quite similar to the characteristics of adults who reside in ALFs in general. The

major exception, evident when viewing these data, was the gender of participants. Normally, widowed women outnumber widowed men at a ratio of four to one in the 65-75 year age group category and 50% of women over age 75 years live alone (FIFARS, 2006). These data are reflected in most studies which include ALF residents. In this study, the majority of ALF residents were male. This reflects the overall gender difference seen among veterans over 65 years of age where men greatly outnumber women. Because of the difference due to the setting, this study offers a perceptual view seldom seen in this older adult ALF cohort.

Setting

The setting for this study was an assisted living facility for retired veterans located in the mid-Atlantic region of the United States. This ALF is part of a continuing care retirement community (CCRC) which offers a continuum of caring options which range from independent living through assisted living to long term care for those residents who need a level of assistance to meet their needs. The community specifically addresses the needs of retired military who have a minimum of 20 years of active duty service and are 60 years of age or older.

The collection of data took take place in a quiet location such as the resident's private room to be supportive of the interview process. All interviews were be conducted by the investigator and scheduled at a time mutually agreed upon by the participant and researcher.

Instrumentation

Three instruments were utilized to collect the data for this study. The instruments were: The Personal Information Form (see Appendix A), The Caring Behaviors Inventory for

Elders (see Appendix B), and The Caring Behaviors Focused Interview Guide (see Appendix C).

The Personal Information Form (PIF)

The Personal Information Form (PIF) was developed by the investigator and was based in part on the demographic information form used with the CBI-E (Wolf et al., 2004). It was used to collect demographic information on all participants in the study, describe the sample, and amplify the data collected from the two remaining tools. The tool is comprised of ten items, including age, gender, ethnicity, marital status, religion, education, length of time in ALF, level of mobility, level of assistance, and health status. Participants were given the option of responding verbally to the questions on the form or self reporting on the form with the investigator in attendance.

Caring Behaviors Inventory for Elders (CBI-E)

Wolf (1989) suggested that caring is the hidden work of nursing oftentimes unrecognized by the patient and family until such behaviors that embody caring are absent. The development of the Caring Behaviors Inventory (Wolf, Giardino, Osborne, & Ambrose, 1994), the precursor to the Caring Behaviors Inventory for Elders (Wolf et al., 2004), allowed for the measurement of perceptions of nurse caring in adult populations and among nurses. The Caring Behaviors Inventory (CBI) was based on Watson's Theory of Human Care (1979, 1988a, 1999), has test-retest reliability r = 0.96, internal consistency reliability (a=0.93-0.98), and construct validity (2004).

The CBI consists of 42 items which are rated with a 6-point Likert type scale. The CBI consists of five dimensions of nurse caring: respectful deference to others; assurance of

human presence; positive connectedness; professional knowledge and skill; and attentiveness to the other's experience. In an examination of quantitative instruments of caring, Beck (1999) noted that the CBI was the only instrument which conceptualized caring as an interpersonal intervention, stating, "This perspective views caring as an intimate exchange between the nurse and patient that can enhance the growth of both parties" (p 30).

The Caring Behaviors Inventory for Elders (CBI-E), (Wolf, Zuzelo, Costello, Cattilico, Cooper, Crothers & Karbach, 2004) was developed from the CBI. This instrument, viewed as more fitting to the elderly population growing in numbers and years of life (Wolf et al., 2004), answers a need for effective data collection in an area where little research has been done to date which is holistic and practical (McClane, 2006). Based on considerations of the unique needs of the elderly, it was developed for senior citizens residing in long-term facilities as well as for their nursing staffs. The CBI-E is a 28 item tool which uses a 3-point Likert type scale in Times New Roman print style with 14 font-size type. For ease of reading, the tool is printed on ivory or light yellow paper. The CBI has content validity of the expert and theoretical type with a Cronbach's alpha coefficient of .94 for the overall tool (Wolf, et al., 2004).

The authors propose that utilization of this tool could help sensitize both caregivers and recipients of caring behaviors to important characteristics inherent in caring relationships. The analysis arising from the perceptions of caring behaviors could measurably improve quality of care and support health through enhanced understanding of care-giver and recipient of caring behaviors (Wolf et al., 2004). The utilization of the CBI-E Tool viewed within the framework of Watson's CAN/Team Model (2006) could help fill the

current gap of knowledge by offering insight into the perceptions of selected elderly residents concerning nursing staff caring behaviors within an Assisted Living Facility.

Caring Behaviors Focused Interview Guide (CBFIG)

The Caring Behaviors Focused Interview Guide (CBFIG) was developed by the investigator and constructed using the five factors of the CBI-E. It consisted of six open-ended questions. The first five questions addressed the five factor areas covered by the CBI-E instrument and included probes to help elicit participant sharing. A final general question was used to gain further insight concerning perceptions of nursing team caring behaviors within the ALF environment. The purpose of the focused interview guide was to help amplify the meaning of data obtained through the use of the quantitative CBI-E instrument, thus elaborating upon the results. The CBFIG was used in a systematic manner offered to every respondent in the study to obtain further amplification of the data offered by those participants who were willing to further share their thoughts and to have their answers be tape recorded. Each discussion was tape recorded and transcribed. The data were explored using content analysis (Elo & Kyngas, 2007; Wilson, 1989). Following completion of this study, the tapes will be erased and transcriptions shredded within a five-year period.

The investigator in the qualitative process is perceived as a tool in the research design. As such, the investigator administered each tool in a consistent and non-threatening manner. The investigator was prepared to terminate an interview if such an action was deemed necessary for the comfort and safety of the respondent.

Protection of Human Subjects

In compliance with the ethical standards followed by The Catholic University of American and its School of Nursing, approval for this study was obtained from the Committee for the Protection of Human Subjects at The Catholic University of America. In addition, permission for the study was obtained through the Institutional Review Board of the Assisted Living Facility in which the research took place.

Initial contact with residents occurred through intermediaries at the ALF. The intermediaries were the Social Workers who worked on the respective ALF floors. All residents who met the inclusion criteria received a letter of explanation. Included with this letter was a postcard containing the researcher's contact information and a place to designate the resident's name and interest in the study. The resident was able to place the card in a box located in a prominent place on the floor or hand the card to their Social Worker to initiate contact by the researcher. In addition, verbal communication of interest to the Social Worker also initiated the process by which a resident was identified. This interest to participate was conveyed to the investigator by the Social Worker. The intermediaries were suggested by the director of the facility, in conjunction with the investigator. Both Social Workers agreed to assist in identification of residents who displayed interest in the study. No direct contact was initiated with a resident by the investigator without his or her prior verbal or written consent.

Every ALF resident within this facility was invited to participate in the study. Each resident was given an explanation of the purpose of the study and the approximate length of time needed to complete the process. The approximate amount of time needed for the PIF

and CBI-E was fifteen minutes. For each participant who agreed to have the CBFIG administered, an additional interview time of approximately twenty minutes was added to the process.

The conversation with the ALF resident began with an introduction of the investigator as a doctoral student from The Catholic University of America School of Nursing. The purpose of the study was presented as well as the fact that data collected as a result of this study might add to the body of knowledge concerning interventions which could better serve the caring needs of residents of ALFs. In addition, information regarding the fact that there was no anticipated risk to the participant by answering the questions from the tools was emphasized. The investigator's phone number and contact information for The Catholic University School of Nursing was included should the participant need to communicate with either concerning the study.

Each participant was informed of his or her rights, including the right to withdraw from the study at any time and for any reason without repercussion. Any questions about the study from a resident were answered prior to obtaining his or her written consent to participate in the study. Participation in the study was voluntary and no compensation for this participation was offered. No expected risks were involved as a result of participation. Should an occurrence take place in which the investigator perceived emotional distress as a result of the interview process, interventions were in place for follow-up referral to a primary care provider as outlined by the director of the facility prior to the beginning of the study. At no time was such distress observed. Maintenance of confidentiality was explained in detail to each participant. Coding through numbers was used to protect participant identity, and any

identifying information was kept in a separate location. All patient data and recorded material were and will be maintained under lock and key by the investigator in a home office. All recorded data will be destroyed, and written information will be shredded five years after the data are analyzed and the study completed.

Pilot Study

Following approval for the study by The Catholic University of America and by the appropriate board of the ALF, a pilot study of five residents was performed. A convenience sample of the first five residents who expressed willingness to participate and who meet the inclusion criteria comprised the sample. The purpose of this study was to supply information on the effectiveness of the research design, as well as to enhance the investigator's ability to obtain data through utilization of the tools.

Each participant was offered the opportunity to answer each of the tools. Experts in both quantitative and qualitative research design and analysis were able to review the results of the pilot interviews and guide the investigator in best practices for continued use. Every participant asked the investigator to fill out the forms. It was noted that in this process, respondents often shared additional comments while answering the CBI-E. Some participants in the pilot study declined the offer to participate in the taped interview following the completion of two quantitative tools when presented with the opportunity. As a result of the information obtained through the pilot study, it was decided to invite every participant to share additional thoughts by

answering the CBFIG. This process allowed each respondent the same opportunity to elaborate on their answers if they so desired.

No major changes were made to the study procedure as a result of the pilot study. Data obtained by the pilot study were included in the main research study since the format and approach were congruent with the methodology of the main research study.

Procedure

Following approval from the Committee for the Protection of Human Subjects at The Catholic University of America and through the Assisted Living Facility Internal Review Board where the research took place, assistance in obtaining dissemination of the information about the study and request for participation was obtained through intermediaries of the ALF. A letter describing the study, its purpose, likely time commitment, and future potential benefits was distributed to every ALF resident who was eligible to participant based on the study criteria (see Appendix D). Contact information was included in the letter along with a postcard (see Appendix E) which, when returned, identified the participant's interest in the study. This postcard was placed in an easily identifiable reply box located in a prominent place on the unit or handed to the Social Worker for subsequent retrieval by the investigator.

Once residents were knowledgeable of the study and verbal consent was obtained, the investigator made contact in person to answer questions and to further encourage participation. If a resident agreed to participate, a mutually agreed-upon time was identified for the investigator to visit the resident, obtain a written informed consent (see Appendix F) and administer the instruments. Most of the participants preferred the investigator to explain

the informed consent and 50 of the 51 participants requested the investigator to fill out the forms while verbally responding to questions. Approximately 20 minutes were required to complete the two instruments. An additional 20 minutes was required to administer the focused interview guide.

Each interview took place in a quiet location such as the resident's room where the participant felt comfortable sharing demographic data and perceptions without interruption. The participant was given an explanation of the purpose of the study and of the potential future benefit to improvement of care through increased understanding of residents' perceptions of nurse caring behaviors in an ALF. The informed consent was discussed and assurance of confidentiality and the ability to withdraw from the study at any time without deleterious effect to oneself was explained. A signature on the informed consent demonstrated an understanding of the process and a willingness to participate. The investigator co-signed and dated the informed consent, and each participant was offered a copy of the form. No participant desired a copy of the informed consent.

The investigator, who has a Master of Science Degree in Psychiatric Mental Health Nursing and who is a doctoral candidate within the school of nursing, assisted the respondent in a neutral manner to fill out the forms when requested to do so. The assistance included reading the questions of the PIF and the CBI-E verbatim and circling responses when the resident requested this help. The investigator filled out the forms, as requested, by 50 of the 51 participants in the study. The investigator sat in attendance while the PIF and CBI-E were completed by the one resident who wished no assistance with the process. Data collected reflected nursing staff caring behaviors over the period of the recent month and included the

caring behaviors as identified by the tools of all personnel who work under the auspices of the RN within the identified ALF and who offer health and personal care services to the residents.

The CBFIG was administered by the investigator to further explore the help elaborate upon the data collected on the CBI-E with each participant who agreed to this portion of the study. The process was tape recorded and transcribed verbatim. Approximately one third of the participants in the study (N=16) agreed to be interviewed with the CBFIG. Five participants were re-visited to validate the data obtained on the CBFIG. This was accomplished with the first five participants who agreed to the re-visit. The re-visit interviews took place in the respective resident's room. The re-visit allowed the resident to further reflect on perceived caring behaviors. These interviews were transcribed verbatim and examined closely in the same manner as the original interviews.

Following completion of the interview process, each resident was thanked for participation and all data were placed in an envelope carried by the investigator. No remuneration was provided for participation. Following each interview, journal notes of the investigator's experience and observations were written in order to foster individual growth in data collection while capturing the overall qualitative impression of the interview. This process supported the organizing phase of the content analysis of the data (Elo & Kyngas, 2007).

At no time did journal notes identify a participant by name. Each participant was informed that a request for a summary of the results of the study could be made and if desired, would be shared once the study was completed. Personal information was separated

from coded survey tools prior to exploration of the data and transcription of recorded material.

Data Analysis

SPSS 15.0 (SPSS Inc., 2006) was used to perform the quantitative analyses of the data collected in this study. Descriptive statistics were utilized to examine the demographic characteristics of the sample (PIF) and the quantitative instrument (CBI-E). These statistics included measures of central tendency; mean, median and mode as well as measures of distribution; standard deviation, range and variance. Response option frequencies and percentages were also generated.

The qualitative data were explored through content analysis (Elo & Kyngas, 2007; Wilson, 1989) using the imposed classifying scheme determined by the CBI-E tool. These data were used to elaborate upon the quantitative results. Magnification of what was perceived by the elderly residents of ALFs to be caring behaviors offered by the nursing team could assist nursing team members in the future to adjust their interventions to match the individual needs of residents under their care.

Summary

This chapter described the research methods selected to assist in the description of individual perceptions of nursing staff caring behaviors among elderly residents of an assisted living facility. It explained that through methodological triangulation, data was collected with two quantitative tools and the results analyzed through utilization of a focused interview guide based on the quantitative instrument. The purpose of the study, the study

participants as well as the overall cohort of residents in ALFs, the selection process, and the setting were described. In addition, the tools used to perform this study and for the protection of human subjects were detailed. Finally, the study procedure and the plans for analysis of the data were presented.

CHAPTER IV

Presentation of the Findings

The purpose of this study was twofold: to identify nursing team caring behaviors as perceived by residents of an Assisted Living Facility for Retired Veterans and to more fully understand the nursing team caring behaviors by gathering qualitative data to elaborate upon the quantitative findings. This descriptive study was completed in an Assisted Living Facility which is a part of a continuing care retirement community for retired veterans located in the mid-Atlantic region of the United States.

This chapter is organized into two primary sections: (a) presentation of the quantitative data and (b) presentation of qualitative data. The quantitative data is first presented for the entire study sample using the following scheme: (a) demographic data obtained on the PIF and (b) analysis of the distribution and descriptive statistics of the scores obtained on the CBI-E. The final quantitative analyses presented are for the sub-set of the total sample that agreed to participate in one-on-one interviews to elaborate further on the data collected. These analyses are presented as follows: (a) demographic data obtained on the PIF and (b) analysis of the distribution and descriptive statistics of the scores obtained on the CBI-E.

The qualitative data are presented according to the domains identified by the CBI-E and the CBFIG tools which became the imposed classifying scheme for the study. The five dimensions are: (a) Respectful Deference to Others, (b) Assurance of Human Presence, (c) Positive Connectedness, (d) Professional Knowledge and Skill and (e) Attentiveness to the Other's Experience. Also presented are additional findings which emerged from the

descriptive data. Following the discussions of the quantitative and qualitative data, a summary of the results is presented.

Pilot Study

Following approval for the study by The Catholic University of America and by the appropriate board of the ALF, a pilot study was conducted at the facility with the first five residents of the ALF who met the study criteria and agreed to participate in the study. This study was performed to supply information on the effectiveness of the research design, as well as to enhance the investigator's ability to obtain data through utilization of the tools.

The collection of the data took place in the resident's private room chosen by each resident in the pilot study. This location allowed for privacy and supported the integrity of the interview process. Each participant was given the option of responding verbally to the questions on the tools or self reporting on the form with the investigator in attendance. All five participants selected the option of verbally responding to the tools. All interviews were conducted by the investigator and performed at a time agreeable to the resident.

Three instruments were utilized to collect the data for this study. The instruments were: The Personal Information Form (see Appendix A), The Caring Behaviors Inventory for Elders (see Appendix B), and optional qualitative tool, The Caring Behaviors Focused Interview Guide (see Appendix C). Following completion of the two quantitative tools, each participant was offered the opportunity to further elaborate perceptions of caring in a taped focused interview. Since some of the participants declined the third tool, a decision was made to invite every participant to share additional thoughts by answering the CBFIG. This

process allowed every respondent in the study the same opportunity to elaborate on their answers if they chose to do so.

Following a review of the pilot interviews for effectiveness of the approach, it was determined that no major changes were to be made. These data were included in the main study since the format and approach were congruent with the study's methodological approach.

Presentation of the Quantitative Data

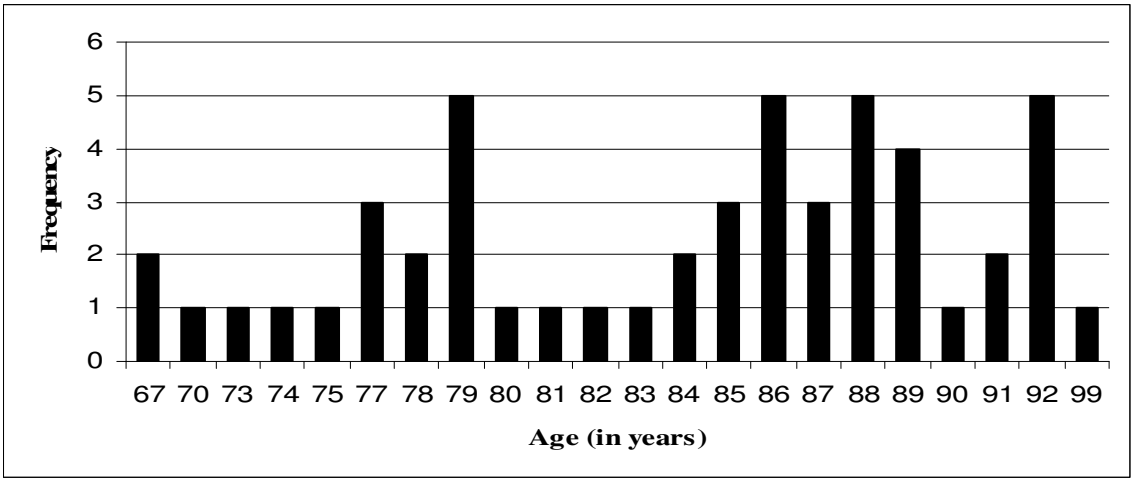
Summary of Total Study Sample

1. Demographic Data

The purposive study sample was comprised of 51 residents of an Assisted Living Facility for Retired Veterans who agreed to participate in the study. All of the participants completed the study and all data obtained from the 51 participants were included in the study. The mean age of the participants was 83.82 ranging from 67 to 99 years (see Figure 3).

Figure 3.

Distribution of Participants' Age



The majority of the participants were male (92.2%) and the dominate race was white (70.6%). The majority of the respondents were either widowed (33.3%) or divorced (25.5%). The dominant religion was Protestant (66.7%). The majority of the respondents in this study had a minimum high school education (83.3%). Many residents had some college classes without a degree (33.3%) and a significant number of respondents had a college degree (23.5%). The average length of stay within the ALF was 39.7 months.

The majority of the respondents either walked with a walker (45.1%) or used a wheelchair (37.3%). Thirty-nine of the 51 respondents stated they needed no assistance with bathing or dressing (76.5%). The majority of the respondents rated their current health status fair (45.1%) and three participants rated their health status poor (5.95%). These data are summarized in Table 2.

Table 2.

Personal Information Form (PIF) Characteristics

	Overall N= 51
Age, mean (SD)	83.82 (6.87)
Gender	
Male	47 (92.2%)
Female	4 (7.8%)
Race	
African American	14 (27.5%)
White	36 (70.6%)
Other[1]	1 (2.0)
Marital Status	
Married	3 (5.9%)
Single	14 (27.5%)
Separated	3 (5.9%)
Divorced	13 (25.5%)
Widowed	17 (33.3%)
Other[2]	1 (2.0%)

	Overall N= 51
Religion	
Catholic	10 (19.6%)
Jewish	1 (2.0%)
Protestant	34 (66.7%)
None	2 (3.9%)
Other[3]	4 (7.8%)
Education	
1st grade to 5th grade	2 (3.9%)
6th grade to 8th grade	3 (5.9%)
9th grade to 12th grade	3 (5.9%)
High School Graduate	13 (25.5%)
Some college classes without a degree	17 (33.3%)
College degree	12 (23.5%)
Other[4]	1 (2.0%)
Length of Time in Assisted Living Facility, mean (SD)	39.7 months (40.2)
Level of Mobility	
Wheelchair	19 (37.3%)
Walker	23 (45.1%)
Ambulatory without assistance	9 (17.6%)
Level of Assistance	
Maximum assistance (100%) needed with bathing, dressing	1 (2.0%)
Moderate assistance (66 %) needed with bathing, dressing	5 (9.8%)
Minimum assistance (33 %) needed with bathing, dressing	6 (11.8%)
No assistance (0 %) needed with bathing, dressing	39 (76.5%)
Self-Rating of Current Health Status	
Poor	3 (5.95)
Fair	23 (45.1%)
Good	13 (25.5%)
Very Good	7 (13.7%)
Excellent	5 (9.8%)

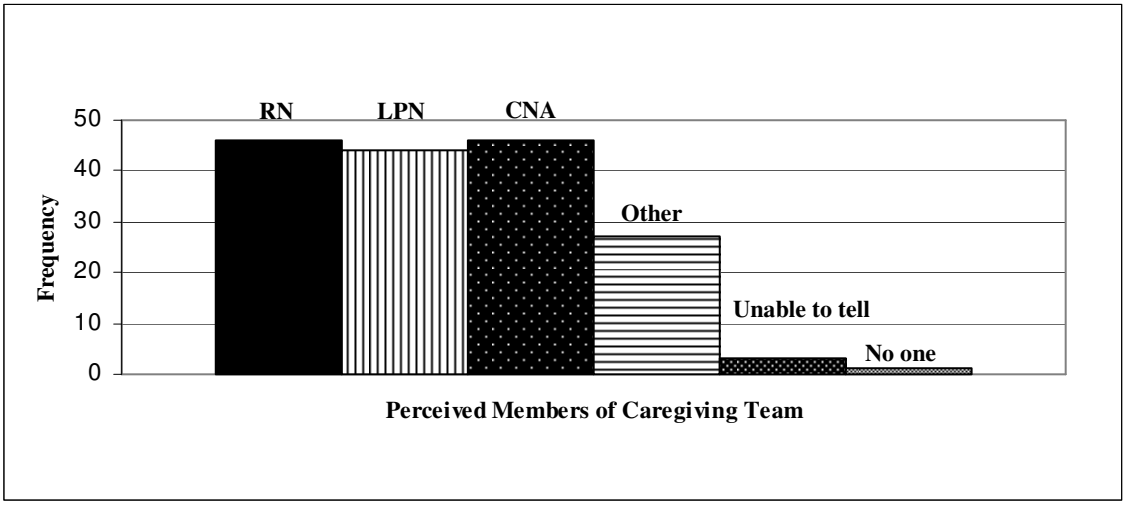
	Overall N= 51
Make up of Caregiving Team in Assisted Living Facility[5]	
The Registered Nurse (RN)	46 (90.2%)
Licensed Practical Nurse (LPN)	44 (86.3%)
Certified Nursing Assistant (CNA)	46 (90.2%)
Other[6]	44 (86.3%)

[1] Other includes: American Indian
[2] Other includes: Selected other, but did not include description.
[3] Other includes: Seventh - day Adventist; Serbian; Morman, and Biblicical Christian
[4] Other includes: PhD
[5] Not mutually exclusive
[6] Other includes: Don't know difference, Medical Doctor, Social Worker, Nurse Practitioner, Podiatrist, Walter Reed/VA, dietary, desk clerk, psych, and everybody – include all

When asked who in their opinion made up the Caregiving Team in the ALF, the majority of the respondents included the Registered Nurse (90.2%) and the Certified Nursing Assistant (90.2%). Forty-four of the 51 residents included the Licensed Practical Nurse (86.3%) as part of the Caregiving Team and other health care providers (86.3%) as members of the Caregiving Team. Interestingly, several respondents shared their perception that they could not tell the difference among Caregiving Team members and one respondent answered no one was on the team (see Figure 4).

Figure 4.

Perceived Members of the Caregiving Team



2. Distribution and Descriptive Statistics of Items

The Caring Behavior Inventory for Elders (CBI-E) was the instrument utilized in this study to measure the perceptions of nursing team caring behaviors among residents of an Assisted Living Facility for retired veterans (see Appendix B). The CBI-E was based on The Caring Behaviors Inventory (Wolf, Giardino, Osborne, & Ambrose, 1994) developed to measure adult patient's perceptions of nurse caring. The CBI-E (Wolf et al., 2004) was developed to meet the unique needs of the elderly population in mind. It consists of a 28 item tool with 3-point Likert type scale. The responses on the tool were 1=rarely, 2=sometimes, 3=often. Scores range from 28 to 84. The higher the score on the CBI-E, the higher the level of perceived nurse caring behavior by the respondent.

Wolf (2004) reported the Cronbach's alpha for the CBI-E as 0.94. The Cronbach's alpha for this study was 0.913. A summary of the frequencies of item responses of the CBI-

E is presented in Table 3. Participants demonstrated full range of the 3-point Likert scale for almost all items, except item 16.

Table 3.

Caring Behaviors Inventory for Elders (CBI-E) Frequency of Item Responses

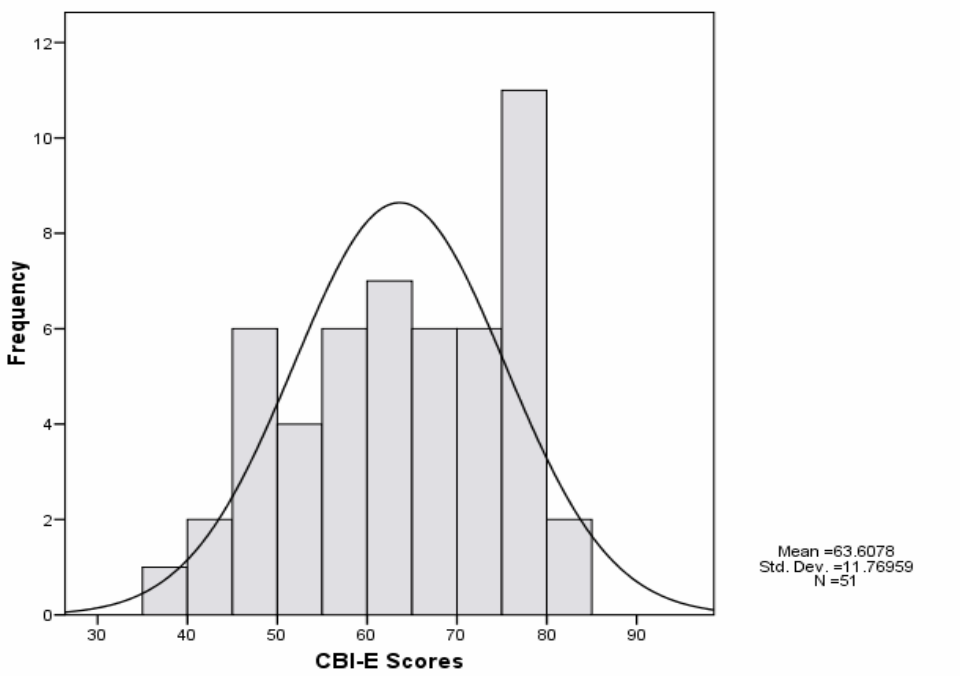
Items	Response Options		
	Rarely	**Sometimes**	**Often**
1. Carefully listening to you.	12 (23.5%)	16 (31.4%)	23 (45.1%)
2. Helping you to feel at home.	11 (21.6%)	13 (25.5%)	27 (52.9%)
3. Helping you and your family make decisions.	27 (52.9%)	11 (21.6%)	13 (25.5%)
4. Calling you by your preferred name.	11 (21.6%)	7 (13.7%)	33 (64.7%)
5. Being honest with you.	6 (11.8%)	16 (31.4%)	29 (56.9%)
6. Assisting you to meet your religious or spiritual needs.	36 (70.6%)	9 (17.6%)	6 (11.8%)
7. Helping you feel comfortable.	12 (23.5%)	12 (23.5%)	27 (52.9%)
8. Recognizing how you feel.	15 (29.4%)	17 (33.3%)	19 (37.3%)
9. Being patient with you.	6 (11.8%)	17 (33.3%)	28 (54.9%)
10. Knowing how to give you needles, enemas, treatments, etc.	4 (7.8%)	17 (33.3%)	30 (58.8%)
11. Adjusting to your limitations	13 (25.5%)	12 (23.5%)	26 (51.0%)
12. Appreciating your life story.	26 (51.0%)	12 (23.5%)	13 (25.5%)
13. Speaking to you with a clear, friendly voice.	9 (17.6%)	12 (23.5%)	30 (58.8%)
14. Knowing your likes, dislikes, and routines.	15 (29.4%)	17 (33.3%)	19 (37.3%)
15. Checking on you.	2 (3.9%)	15 (29.4%)	34 (66.7%)
16. Being pleasant with you.	0 (0%)	12 (23.5%)	39 (76.5%)
17. Including you when planning your care.	22 (43.1%)	9 (17.6%)	20 (39.2%)
18. Protecting your privacy.	11 (21.6%)	14 (27.5%)	26 (51.0%)
19. Watching out for your safety.	5 (9.8%)	10 (19.6%)	36 (70.6%)
20. Meeting your needs whether or not you ask.	5 (9.8%)	19 (37.3%)	27 (52.9%)
21. Responding quickly to your call.	7 (13.7%)	14 (27.5%)	30 (58.8%)
22. Appreciating you as a unique person.	18 (35.3%)	13 (25.5%)	20 (39.2%)
23. Managing your pain.	17 (33.3%)	12 (23.5%)	22 (43.1%)

Items	Response Options		
	Rarely	Sometimes	Often
24. Showing concern for you.	5 (9.8%)	20 (39.2%)	26 (51.0%)
25. Giving your treatments and medicines on time.	3 (5.9%)	9 (17.6%)	39 (76.5%)
26. Trying to relieve your ailments.	14 (27.5%)	10 (19.6%)	27 (52.9%)
27. Standing up for your interests.	16 (31.4%)	11 (21.6%)	24 (47.1%)
28. Giving you a hand when you need it.	10 (19.6%)	8 (15.7%)	33 (64.7%)

The scores on the CBI-E ranged from 38 to 81 with a mean score of 63.61, a standard deviation of 11.77 and a median score of 64 (see Figure 5). In general, it took about fourteen minutes to complete the instrument.

Figure 5.

Distribution of CBI-E Scores Among All Study Participants



The items which earned the highest mean scores were the following five questions from the tool: Being pleasant with you M=2.76, SD =.43, Giving your treatments and medicines on time M=2.71, SD =.58, Checking on you M=2.63, SD =.56, Watching out for your safety M=2.67, SD =.67, and Knowing how to give you needles, enemas, treatments, etc. M=2.51, SD =.64. Four items rated lower than two on the tool. These were the following: Assisting you to meet your religious or spiritual needs M=1.41, SD =.70, Helping you and your family make decisions M=1.73, SD =.85, Appreciating your life story M=1.75, SD =.85, and Including you when planning your care M=1.96, SD =.92. A complete summary of the descriptive statistics for all items of the CBI-E is presented in Table 4.

Table 4.

Caring Behaviors Inventory for Elders (CBI-E) Item Descriptive Statistics

Items (N=51)	Mean ± SD	Variance	Range	Median	Mode
1. Carefully listening to you.	2.22 ± .81	.65	1-3	2	3
2. Helping you to feel at home.	2.31 ± .81	.66	1-3	3	3
3. Helping you and your family make decisions.	1.73 ± .85	.72	1-3	1	1
4. Calling you by your preferred name.	2.43 ± .83	.69	1-3	3	3
5. Being honest with you.	2.45 ± .70	.49	1-3	3	3
6. Assisting you to meet your religious or spiritual needs.	1.41 ± .70	.49	1-3	1	1
7. Helping you feel comfortable.	2.29 ± .83	.69	1-3	3	3
8. Recognizing how you feel.	2.08 ± .82	.67	1-3	2	3
9. Being patient with you.	2.43 ± .70	.49	1-3	3	3
10. Knowing how to give you needles, enemas, treatments, etc.	2.51 ± .64	.42	1-3	3	3
11. Adjusting to your limitations	2.25 ± .85	.71	1-3	3	3
12. Appreciating your life story.	1.75 ± .85	.71	1-3	1	1

Items (N=51)	Mean ± SD	Variance	Range	Median	Mode
13. Speaking to you with a clear, friendly voice.	2.41 ± .78	.61	1-3	3	3
14. Knowing your likes, dislikes, and routines.	2.08 ± .82	.67	1-3	2	3
15. Checking on you.	2.63 ± .56	.32	1-3	3	3
16. Being pleasant with you.	2.76 ± .43	.18	2-3	3	3
17. Including you when planning your care.	1.96 ± .92	.84	1-3	2	1
18. Protecting your privacy.	2.29 ± .81	.65	1-3	3	3
19. Watching out for your safety.	2.61 ± .67	.44	1-3	3	3
20. Meeting your needs whether or not you ask.	2.43 ± .67	.45	1-3	3	3
21. Responding quickly to your call.	2.45 ± .73	.53	1-3	3	3
22. Appreciating you as a unique person.	2.04 ± .87	.76	1-3	2	3
23. Managing your pain.	2.10 ± .88	.77	1-3	2	3
24. Showing concern for you.	2.41 ± .67	.45	1-3	3	3
25. Giving your treatments and medicines on time.	2.71 ± .58	.33	1-3	3	3
26. Trying to relieve your ailments.	2.25 ± .87	.75	1-3	3	3
27. Standing up for your interests.	2.16 ± .88	.78	1-3	2	3
28. Giving you a hand when you need it.	2.45 ± .81	.65	1-3	3	3
Overall CBI-E Score	63.61 ± 11.77	138.52	38-81	64	77
Minutes took to complete instrument	14.25 ± 7.46	55.714	4-35	14	10

The previous discussion offered a complete summary of the descriptive statistics for the demographic data of the PIF and for each of the 28 items of the CBI-E for all 51 participants in the study.

In the following section, there is a further examination of the quantitative data for the cohort of sixteen participants (N = 16) who agreed to the taped qualitative interview (CBFIG). These quantitative data are extracted and presented to more closely examine how

this sub-set from the total number of participants compares to the data of the larger study group since elaboration of the results would be negatively impacted if the subset if 16 were not representative of the main study group.

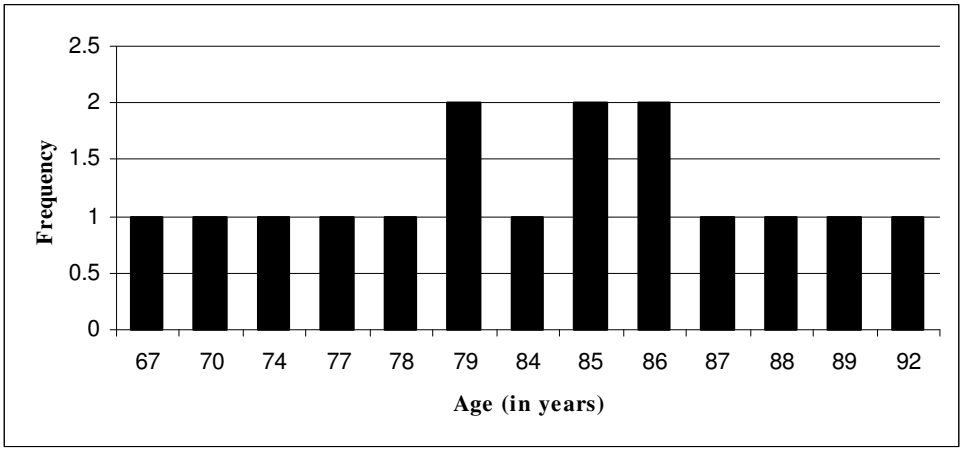
Summary of the Sub-Set of the Study Sample

1. Demographic Data (N=16)

Each of the 51 residents of an Assisted Living Facility for Retired Veterans who agreed to participate in the study was offered the opportunity to share his or her thoughts in a taped interview by answering the CBFIG following the completion of the PIF and the CBI-E. Sixteen residents agreed to elaborate further on the data collected on the quantitative tools. While the data of these 16 participants are subsumed as part of the 51 participants, it is of interest to further examine the quantitative results of this sub-set of the total number of participants. The mean age of the group of 16 CBFIG participants was 81.63 ranging from 67 to 92 years (see Figure 6). This was slightly younger than the mean age of the overall group which was 83.82 years with a range of 67 to 99 years of age.

Figure 6.

Distribution of Interviewed Participants' Age



The majority of the participants were male (87.5%) and the dominate race was white (81%). The majority of the respondents were either single (25%) or divorced (25%). The dominant religion was Protestant (56.3%). The majority of the respondents in this study had a high school education (87.6%). Many residents had some college classes without a degree (33.3%) and a significant number of respondents had a college degree (23.5%). The average length of stay within the ALF was 37 months.

The majority of the respondents either walked with a walker (31.3%) or used a wheelchair (56%). Most of 16 respondents stated they needed no assistance with bathing or dressing (62.5%). The majority of the respondents rated their current health status fair (50%) one participant rated health status as poor (6.3%). When asked who in their opinion made up the Caregiving Team in the ALF, an equal majority of the respondents included the Registered Nurse (93.8%), the Certified Nursing Assistant (93.8%) and other health care providers (93.8%) as members of the Caregiving Team. Fewer residents included the Licensed Practical Nurse (87.5%) as part of the Caregiving Team. These data are summarized in Table 5.

Table 5.

Personal Information Form Characteristics for Interviewed Participants

	Overall N= 16
Age, mean (SD)	81.63 (7.09)
Gender	
Male	14 (87.5%)
Female	2 (12.5%)
Race	
African American	2 (12.5%)
White	13 (81.3%)
Other[1]	1 (6.3%)

	Overall N= 16
Marital Status	
Married	3 (18.8%)
Single	4 (25.0%)
Separated	2 (12.5%)
Divorced	4 (25.0%)
Widowed	3 (18.8%)
Religion	
Catholic	3 (18.8%)
Jewish	1 (6.3%)
Protestant	9 (56.3%)
Other[2]	3 (18.8%)
Education	
6th grade to 8th grade	1 (6.3%)
9th grade to 12th grade	1 (6.3%)
High School Graduate	3 (18.8%)
Some college classes without a degree	6 (37.5%)
College degree	4 (25.0%)
Other[3]	1 (6.3%)
Length of Time in Assisted Living Facility, mean (SD)	37.0 months (47.59)
Level of Mobility	
Wheelchair	9 (56.0%)
Walker	5 (31.3%)
Ambulatory without assistance	2 (12.5%)
Level of Assistance	
Maximum assistance (100%) needed with bathing, dressing	1 (6.3%)
Moderate assistance (66 %) needed with bathing, dressing	3 (18.8%)
Minimum assistance (33 %) needed with bathing, dressing	2 (12.5%)
No assistance (0 %) needed with bathing, dressing	10 (62.5%)
Self-Rating of Current Health Status	
Poor	1 (6.3%)
Fair	8 (50.0%)
Good	5 (31.3%)
Very Good	2 (12.5%)

	Overall N= 16
Make up of Caregiving Team in Assisted Living Facility[4]	
The Registered Nurse (RN)	15 (93.8%)
Licensed Practical Nurse (LPN)	14 (87.5%)
Certified Nursing Assistant (CNA)	15 (93.8%)
Other[5]	15 (93.8%)

[1] Other includes: American Indian
[2] Other includes: Serbian; Morman, and Biblicical Christian
[3] Other includes: PhD
[4] Not mutually exclusive
[5] Other includes: Don't know difference, Medical Doctor, Social Worker, Nurse Practitioner, Podiatrist, Walter Reed/VA, dietary and desk clerk

2. Distribution and Descriptive Statistics of Items

A comparison of the two groups demonstrates strong congruency among the data of the smaller sub-set to the entire group. Similar to the larger group, item 16 did not show a full range of the three point scale. All respondents stated the item, "Being pleasant with you" was an action seen as sometimes and often. No one rated this as a rare occurrence (see Table 3).

The only difference seen between the two groups was an additional item failed to score across the three point range in the smaller group. In this case, "Checking on you" was rated rarely and sometimes. No one of this smaller group rated this item as an often occurrence (see Table 6). In the large group, the majority rated this item often and very few rated it as a rare occurrence. A summary of the frequencies of item responses of the CBI-E for the 16 participants is presented in Table 6.

Table 6. *Caring Behaviors Inventory for Elders (CBI-E) Frequency of Item Responses for Interviewed Participants*

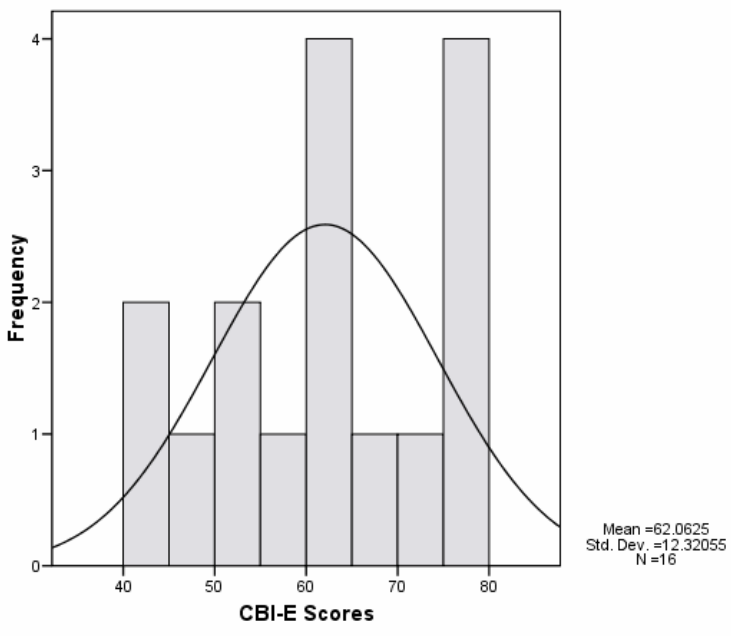
Items	Response Options		
	Rarely	**Sometimes**	**Often**
1. Carefully listening to you.	4 (25.0%)	8 (50.0%)	4 (25.0%)
2. Helping you to feel at home.	4 (25.0%)	5 (31.3%)	7 (43.8%)
3. Helping you and your family make decisions.	8 (50.0%)	4 (25.0%)	4 (25.0%)
4. Calling you by your preferred name.	4 (25.0%)	2 (12.5%)	10 (62.5%)
5. Being honest with you.	2 (12.5%)	8 (50.0%)	6 (37.0%)
6. Assisting you to meet your religious or spiritual needs.	12 (75.0%)	1 (6.3%)	3 (18.8%)
7. Helping you feel comfortable.	4 (25.0%)	4 (25.0%)	8 (50.0%)
8. Recognizing how you feel.	7 (43.8%)	5 (31.3%)	4 (25.0%)
9. Being patient with you.	2 (12.5%)	6 (37.5%)	8 (50.0%)
10. Knowing how to give you needles, enemas, treatments, etc.	1 (6.3%)	6 (37.5%)	9 (56.3%)
11. Adjusting to your limitations	4 (25.0%)	4 (25.0%)	8 (50.0%)
12. Appreciating your life story.	8 (50.0%)	4 (25.0%)	4 (25.0%)
13. Speaking to you with a clear, friendly voice.	3 (18.8%)	4 (25.0%)	9 (56.3%)
14. Knowing your likes, dislikes, and routines.	5 (31.3%)	4 (25.0%)	7 (43.8%)
15. Checking on you.	6 (37.5%)	10 (62.5%)	0 (0%)
16. Being pleasant with you.	0 (0%)	5 (31.3%)	11 (68.8%)
17. Including you when planning your care.	8 (50.0%)	4 (25.0%)	4 (25.0%)
18. Protecting your privacy.	3 (18.8%)	5 (31.3%)	8 (50.0%)
19. Watching out for your safety.	1 (6.3%)	4 (25.0%)	11 (68.8%)
20. Meeting your needs whether or not you ask.	2 (12.5%)	5 (31.3%)	9 (56.3%)
21. Responding quickly to your call.	3 (18.8%)	8 (50.0%)	5 (31.3%)
22. Appreciating you as a unique person.	6 (37.5%)	6 (37.5%)	4 (25.0%)
23. Managing your pain.	5 (31.3%)	3 (18.8%)	8 (50.0%)

Items	Response Options		
	Rarely	Sometimes	Often
24. Showing concern for you.	1 (6.3%)	7 (43.8%)	8 (50.0%)
25. Giving your treatments and medicines on time.	2 (12.5%)	3 (18.8%)	11 (68.8%)
26. Trying to relieve your ailments.	3 (18.8%)	4 (25.0%)	9 (56.3%)
27. Standing up for your interests.	4 (25.0%)	4 (25.0%)	8 (50.0%)
28. Giving you a hand when you need it.	3 (18.8%)	4 (25.0%)	9 (56.3%)

The scores on the CBI-E for the sub-group of 16 respondents ranged from 41 to 78 with a mean score of 62.06, a standard deviation of 12.32 and a median score of 63 (see Figure 7). It took 12.5 minutes to complete the instrument which was lower than the 14.2 minutes which was the average among the larger group.

Figure 7.

Distribution of CBI-E Scores Among Interviewed Participants



The five items which earned the highest mean scores were identical to the five from the group of 51 respondents with a slight variation in the ordering: Being pleasant with you M=2.69, SD =.48, SD =.73, Checking on you M=2.63, SD =.50, Watching out for your safety M=2.63, SD =.62, Giving your treatments and medicines on time M=2.56, and Knowing how to give you needles, enemas, treatments, etc. M=2.50, SD =.63. Five items rated lower than 2 on the tool. These items were identical to the four items noted by the group of 51 with the addition of the final item. The items scoring lower than 2 were: Assisting you to meet your religious or spiritual needs M=1.44, SD =.81, Helping you and your family make decisions M=1.75, SD =.86, Appreciating your life story M=1.75, SD =.86, Including you when planning your care M=1.75, SD =.86 and Appreciating you as a unique person M=1.88, SD =.81. A complete summary of the descriptive statistics for all items of the CBI-E for the 16 interviewed participants is presented in Table 7.

Table 7.

Caring Behaviors Inventory for Elders (CBI-E) Item Descriptive Statistics for Interviewed Participants

Items (N=16)	Mean ± SD	Variance	Range	Median	Mode
1. Carefully listening to you.	2.0 ± .73	.53	1-3	2.0	2
2. Helping you to feel at home.	2.19 ± .83	.70	1-3	3.0	3
3. Helping you and your family make decisions.	1.75 ± .86	.73	1-3	1.5	1
4. Calling you by your preferred name.	2.38 ± .89	.78	1-3	3.0	3
5. Being honest with you.	2.25 ± .68	.47	1-3	2.0	2
6. Assisting you to meet your religious or spiritual needs.	1.44 ± .81	.66	1-3	1.0	1
7. Helping you feel comfortable.	2.25 ± .86	.73	1-3	2.5	3
8. Recognizing how you feel.	1.81 ± .83	.70	1-3	2	1

Items (N=16)	Mean ± SD	Variance	Range	Median	Mode
9. Being patient with you.	2.38 ± .72	.52	1-3	2.5	3
10. Knowing how to give you needles, enemas, treatments, etc.	2.50 ± .63	.40	1-3	3.0	3
11. Adjusting to your limitations	2.25 ± .86	.73	1-3	2.5	3
12. Appreciating your life story.	1.75 ± .86	.73	1-3	1.50	1
13. Speaking to you with a clear, friendly voice.	2.38 ± .81	.65	1-3	3.0	3
14. Knowing your likes, dislikes, and routines.	2.13 ± .89	.78	1-3	2.0	3
15. Checking on you.	2.63 ± .50	.25	2-3	3.0	3
16. Being pleasant with you.	2.69 ± .48	.23	2-3	3.0	3
17. Including you when planning your care.	1.75 ± .86	.73	1-3	1.5	1
18. Protecting your privacy.	2.31 ± .79	.63	1-3	2.5	3
19. Watching out for your safety.	2.63 ± .62	.38	1-3	3.0	3
20. Meeting your needs whether or not you ask.	2.44 ± .73	.53	1-3	3.0	3
21. Responding quickly to your call.	2.13 ± .72	.52	1-3	2.0	2
22. Appreciating you as a unique person.	1.88 ± .81	.65	1-3	2.0	1
23. Managing your pain.	2.19 ± .91	.83	1-3	2.5	3
24. Showing concern for you.	2.44 ± .63	.40	1-3	2.5	3
25. Giving your treatments and medicines on time.	2.56 ± .73	.53	1-3	3.0	3
26. Trying to relieve your ailments.	2.38 ± .81	.65	1-3	3.0	3
27. Standing up for your interests.	2.25 ± .86	.73	1-3	2.5	3
28. Giving you a hand when you need it.	2.38 ± .81	.65	1-3	3.0	3
Overall CBI-E Score	62.06 ± 12.32	151.80	41-78	63.0	62
Minutes took to complete instrument	12.50 ± 6.20	38.53	4-25	12.0	15

Summary of Quantitative Results

Upon review of the PIF data, both groups were strikingly similar. The majority of the participants were male, the dominant race was white, the mean age was 83 years and the dominant religion was Protestant. The majority of respondents were widowed or divorced, had a high school education and had resided in the ALF for more than three years. The

majority of the respondents used a walker or wheelchair and stated they needed no assistance with bathing or dressing. Most of the residents rated their health status fair. An item of interest was seen in the answer to the question regarding the make up of the caregiving team. Both groups rated the LPN lower than either the RN or CNA. In the sub-set group, the category "other" also rated higher than the LPN as members of the caregiving team.

The CBI-E was utilized in this study to measure the perceptions of nurse caring behaviors among residents of an ALF and had a Cronbach's alpha of 0.913. A review of the data from both the large group and smaller sub-set of 16 presented almost identical results. A full range of the 3-point Likert Scale was demonstrated across almost all of the items on the tool. The mean score of the CBI-E was 63. It took approximately 14 minutes to complete the instrument. The investigator assisted 50 of the 51 participants in this study with filling out the PIF and CBI-E instruments. A serendipitous result of this assistance was the capturing of qualitative responses which accompanied the quantitative answer.

Presentation of the Qualitative Data

The purpose of the qualitative portion of the study was to more fully understand the nursing team caring behaviors perceived by residents of an Assisted Living Facility for Retired Veterans by gathering qualitative data to elaborate upon the quantitative findings. Throughout the interview process while filling out the CBI-E, the investigator consistently wrote qualifying comments verbalized by the participants in addition to circling the one word answer "rarely, sometimes or often" to each of the 28 questions. There was a conscious decision by the investigator not to limit the respondents' answers to just one word. Although the CBI-E is a purely quantitative tool, an unexpected source of data related to the tool items

emerged from the informal comments made by study participants during the process of answering the questions on the tool. This procedure was applied in a uniform manner across all 50 participants who asked for assistance in filing out the PIF and CBI-E forms. This serendipitous information, along with the data obtained through use of the CBFIG, offer elaboration on the quantitative results.

Analysis of the CBI-E Generated Qualitative Data

The quantitative data presented the importance of each of the CBI-E items through descriptive statistics already presented. The following tables help explain the quantitative scores by amplifying the responses of the participants beyond the raw number. For instance, in some cases, respondents gave an item a low score because it was not seen as an item the respondent would consider necessary for the caring team member to perform. Alternatively, some items received a low score because the respondent viewed a lack of this behavior in the ALF experience. Across the five domains, the comments appeared to fall into two basic categories. "The Good Nurse" encompassed behaviors identified by participants which were seen as supportive and respectful to the individual. "The Non-Attending Nurse" on the other hand, described actions not seen as needed or behaviors of caregiving team members which did not support the type of individualized attention which is the essence of caring behaviors.

The Dimension Respective Deference to Others included items which demonstrated a courteous regard for the feelings and experiences of the other individual. The items on the CBI-E and their scores were: Calling you by your name (2.43), Helping you feel at home (2.31), Protecting your privacy (2.29), Listening to you (2.22), Appreciating you as a unique individual (2.04), Helping you make informed decisions (1.73), and Including you in

planning your care (1.96). The qualifying comments further elaborated upon these results (see Table 8).

Table 8.

CBI-E Related Qualitative Data

Respectful Deference to Others

Respectful Deference to Others	
"The Good Nurse"	**"The Non-Attending Nurse"**
• Really friendly • Some are friendly, some not • The nursing team and housekeeping, they take care of me on a daily basis, they are there • They leave decision making to me • If there were the opportunity they would be there for me • They are good with what they do but they shift them around so much, they don't get to know anybody • They protect my privacy the best they can • The regulars do a good job • It depends on the person • Always nice to me • They treat me with respect, I have earned that	• It is distancing to call me Mister • They don't come around • Often listen but very little interaction • A lot of them come & go, very little interaction • All three would be right, rarely, sometimes, never • They just do it (the care) • Never include me except for yearly meeting • I am not included • What's privacy? • There are so many people here, sometimes they don't know how to • They don't care • Difficult because of their perspective • I don't think about it much

The Dimension Assurance of Human Presence included items which reflected an investment in the other's needs and security. The items on the CBI-E and their scores were: Responding quickly to your call (2.45), Meeting your needs whether or not you ask (2.43), Showing concern for you (2.41), Adjusting to limitations (2.25), Knowing your likes, dislikes & routines (2.08), and Appreciating your life story (1.75).

In addition, the following qualifying statements further elaborated on the quantitative results of the CBI-E, (see Table 9).

Table 9.

CBI-E Related Qualitative Data

Assurance of Human Presence

Assurance of Human Presence	
"The Good Nurse"	**"The Non-Attending Nurse"**
• Can't be 'Johnny on the spot" have a lot of people to take care of • Depends on the person some really care about me, including the person at the desk • For sure! 2 or 3 are exceptional! • I'm sure, it is their profession • They adjust all the time. They don't push you beyond your limits. • Know me as well as I know myself. • No complaints I guess • Sometimes staff can be so caring…other times… • Sometimes the NAs know my limitations, RNs rarely • I hesitate to share my story, I talk with the NP sometimes • They listen, they take it in.	• Depends, spotty • Nobody here • I never ask for anything • Three meals a day a place to sleep • I don't think they are concerned • Depends, not from agency workers • I don't think they are concerned, I am just a damned nuisance. • They don' know me. • Don't come in contact with them, only when giving meds. Half don't know I have bad eyesight. • All in a hurry, no one has time. • I am more patient with them than they are with me. • They change so much, don't know me. • Twenty years here, never asked. • I hesitate to share it. My fault.

The Dimension Positive Connectedness included items from the CBI-E which indicated an optimistic & constant readiness to help the other. The items on the CBI-E and their scores were the following: Being pleasant with you (2.76), Watching out for your safety (2.61), Being honest with you (2.45), being patient with you (2.43), and Recognizing how

you feel (2.08). Additionally, the following qualifying statements helped to further elaborate on the quantitative results of the CBI-E (see Table 10).

Table 10.

CBI-E Related Qualitative Data

Positive Connectedness

Positive Connectedness	
"The Good Nurse"	**"The Non-Attending Nurse"**
• A good bunch of people. • Like family • I work with them, they hug you. • I get along, we kid a lot. • I suppose you don't notice but they watch out for your safety. • Patience, depends on the person. • Always. • They treat me good. • I know they recognize my feelings, they are trained pros. • Especially my health. • It depends, those who know you recognize. If they are from other countries, that makes a difference too. • They ask all the time.	• I watch out for my own safety. • They don't discuss anything with me. • Sometimes they hold things back. • Have to have MD orders. • Difficult, don't communicate much. • 50-50, not that they don't want to be. • They don't know, they don't care. • How are you?... is purely social. • They don't communicate it to me. • I have learned to do that for myself. • They brush me off. • If you can take care of yourself, they let you, I didn't see anyone yesterday.

The Dimension Professional Knowledge and Skill included caring behaviors which are perceived as proficient, informed and skillful. The items on the CBI-E and their scores were: Giving your treatments & medications on time (2.71), Knowing how to give you needles, enemas, treatments, etc. (2.51), Speaking to you with a clear friendly voice (2.41), Trying to relieve your ailments (2.25), and Managing your pain (2.10). The qualifying comments further elaborated upon these results, (see Table 11).

Table 11.

CBI-E Related Qualitative Data

Professional Knowledge and Skill

Professional Knowledge and Skill	
"The Good Nurse"	**"The Non-Attending Nurse"**
• Always on time with medications. • I take my own meds but my nurse takes my blood pressure. • Within 30 minutes. • I feel fortunate, they are very good. • They know heir business. • Depends on who you get, lab girl very good. • Foreigners not too clear but they try very hard. • We ignore each other but they are nice people. • Oh yes, you must slow them down. A subject they are touchy on. I like the dialogue but often the sound is muffled. • You must tell them and they will try and help you. • Some help with ailments, it depends. • I have had diarrhea problem for two years, they help often. • Use to have a problem, not that they are not trying, just can't relieve the pain.	• I don't like the way they do it, on their time. • Really don't know what I am getting, when it should be… • Yea, 5am, if you can find them. • Depends on who it is, some I wouldn't let near me. • Nine of ten are difficult to understand. • Some don't speak English, very difficult. • Never look at you. • I don't know how to answer that, I don't understand them half the time. • Difficult diction, ask them to repeat it and they get ticked off and leave… • If it's not in your chart, no help. • Throw the med at you and that's it. • CAN yes, RNs no, they don't know, just do the pills. • Don't manage pain in a unique way. • I manage my own pain.

The Dimension Attentiveness to the Other's Experience demonstrated an appreciation of and engrossment in the other's perspective and experience. The items on the CBI-E and their scores were: Checking on you (2.63), Giving you a hand when you need it (2.45), Helping you feel comfortable (2.29), Standing up for your interests (2.16), Assisting you to

meet your religious or spiritual needs (1.41). Further qualifying statements are included (see Table 12).

Table 12.

CBI-E Related Qualitative Data

Attentiveness to the other's Experience

Attentiveness to the Other's Experience	
"The Good Nurse"	**"The Non-Attending Nurse"**
• They always check on you. • Constantly, they are good at that. • Tricky, they change and then you see a difference • They check more than I would. • It's rare I need a hand but when I ask, it is always right there. • They are great, this is the best place I could be. • They don't interfere with that, make sure you get to Church. • Go every Sunday. They are aware (Hard to answer). • They explain things better when the residents get frustrated. • They are good at making you feel comfortable. • NAs joke with you. • If they ever stop in… • If they know you some will stand up.	• I am not here during the day, I don't know. • They know when you can get along by yourself and don't come by. • Generally they don't pay much attention to you, do the same thing each day. • I get peeved and go ahead and do it myself, they sit in the hall. • No, not a religious person. • Don't know me. • Had difficulty, but MD made it work. • Don't require it. Never. • Back to the CNAs, RNs, no time. • I do that, I don't like to bother… • Don't know, never see them. • I watch out for my own interests, don't go running to the RN. • Hard one. Don't know who's standing up for you…

Summary of CBI-E Generated Data

The previous discussion presented an amplification of the quantitative data obtained on the CBI-E from the 50 participants who requested the investigator to fill out the tool. These data presented the perceptions of the study participants beyond the raw number obtained through use of the CBI-E. While the respondents in the study identified many

different members of the caregiving team, the responses in this section were focused on the various members of the nursing staff unless otherwise noted. These serendipitous findings combine with the following qualitative responses of the subset of 16 to elaborate on the quantitative results of the study.

Analysis of the Caring Behaviors Focused Interview Guide

The Caring Behaviors Focused Interview Guide (see Appendix C) was developed by the investigator and constructed using the five dimensions of the CBI-E (Wolf et al., 2004). It consisted of six open-ended questions. The first five questions addressed the five areas covered by the CBI-E instrument. The five dimensions are: (a) Respectful Deference to Others, (b) Assurance of Human Presence, (c) Positive Connectedness, (d) Professional Knowledge and Skill and (e) Attentiveness to the Other's Experience. The Caring Behaviors Focused Interview Guide (CBFIG) included probes to help elicit participant sharing. A final general question was used to gain further insight concerning perceptions of nursing team caring behaviors within the ALF environment. The final question was, "Would you care to share any additional thoughts or concerns you may have regarding your perceptions of nursing team caring behaviors?"

The purpose of the focused interview guide was to help amplify the meaning of data obtained through the use of the quantitative CBI-E instrument, thereby obtaining elaboration of the quantitative results. Participation in the CBFIG was offered to every respondent in the study after the completion of the PIF and the CBI-E. The purpose of the tool, to obtain a further amplification of the data, was explained to every participant. The freedom to decline participation in this part of the study was stressed with each individual. It was noted that all

participants showed no hesitation and either accepted or declined the invitation without reservation. All of the participants were thanked for their involvement in the study regardless of their decision.

Sixteen participants agreed to answer the CBFIG and further share their thoughts by having their answers tape recorded. Each discussion was tape recorded and transcribed verbatim. The CBFIG data were explored using content analysis in a deductive manner since the structure of the analysis was imposed on the basis of the five dimensions of the CBI-E (Elo & Kyngas, 2007). The qualitative data are presented according to the domains identified by the CBI-E and the CBFIG tools which represented the classifying scheme for the study. Utilization of content analysis allowed a deeper exploration of theoretical content and enhanced understanding of the data (Elo & Kyngas, 2007).

The 16 CBFIG transcripts (Participant ID 1-16) were transcribed verbatim. The investigator read the transcripts repeatedly to become immersed in the data. Five participants were re-visited (RV 1-5) to validate the previously collected data obtained on the CBFIG. This was accomplished with the first five CBFIG participants who agreed to the re-visit. Each re-visit interview took place in the respective resident's room. The re-visit allowed the resident to further reflect on perceived caring behaviors. These interviews were transcribed verbatim and examined closely in the same manner as the original interviews. All of the data obtained through the revisit period supported previously obtained information.

The organizational structure of the CBFIG followed the dimensional themes outlined by the CBI-E (Wolf et al., 2004). Similar to what emerged when exploring the data from the entire group, under each of the dimensions two major categories emerged with the sub-set

group of 16. Consistently, participants verbalized qualities of the Caring Attending Nurse (Watson, 2006) when describing actions which demonstrated an individualized approach. These behaviors supported the dignity of the resident and were beneficial to both parties. These data support the tenet that caring consists of consciousness (2006). Behaviors which failed to support the dignity and integrity of the individual where also clearly expressed across the five dimensions as being devoid of conscious regard. The following is a presentation of the data obtained on the CBFIG which further magnifies the serendipitous qualitative findings reported in Tables 9-13.

CBFIG Generated Qualitative Data

Dimension: Respectful Deference to Others

The Dimension Respective Deference to Others included items which demonstrated a courteous regard for the feelings and experiences of the other individual (Wolf et al., 2004). The corresponding items on the CBI-E and their scores were: Calling you by your name (2.38), Helping you feel at home (2.19), Protecting your privacy (2.31), Listening to you (2.0), Appreciating you as a unique individual (1.88), Including you in planning your care (1.75), and Helping you make informed decisions (1.75). Residents in this study perceived caring behaviors within this dimension across a spectrum of actions which were supportive of their dignity to areas where their input seemed to be ignored. Under this dimension they stated:

ID6 “I find the nursing team outstanding. They make every attempt; I can’t imagine what else they can do. They make every attempt to meet my needs and to even anticipate my needs. And, they certainly try very hard to take care of me to the highest possible degree. I cannot extol them enough.

ID10 “Well they do that. I-I definitely was able to adjust to this place quickly. I didn’t want to come here but all those people that was in the – Independent Living at the Scott Building was in wheel – in wheelchairs, they started to evaluating us and uh they evaluated me that I couldn’t fully take care of myself. But, I was able-because of the nurses made you feel at home here, I was able to adjust very quickly to this here.”

ID12 “Uh, most of the time pretty good. Uh, sometimes it depends on their attitude so on and so forth. They’re –sometimes they’re lazy, sometimes they don’t give a darn.”

ID5 “Well that basically make me feel at home by listening to my stories, listening to my tales or maybe they’ve got to.”

ID3 “If they are not too busy. Sometimes they’ll start listening and they’ll be interrupted and walk off and leave you talking.”

ID6 “They recognize it and they try to console me and they kid me, and I have a wonderful-the thing with these girls is that I have – they’re not just CNAs to me. I have sort of a personal relationship with each and every one of them including the ones who frequently come out here from the temp agencies. And, I know I make it a point to know them al by their first names and I make efforts-some little thing, I may offer them a piece of candy or some little treat. I try to keep little treats in my room that I offer because I appreciate them so much. They make little extra gestures to please me and I try to do the same thing in return. As a result, I really consider them very much my family.

ID8 “Well, they uh-they don’t do no planning now for me, which us pretty well goes with my style because it’s the way intended. And, if I do have a question, they a lot of times don’t know how to answer me. I get no response. No back call.”

ID14 “I will tell you this, I mean no circumstances should they have a meting about the patient and just have the doctor and the social worker, and the head nurse there and not the patient. Or, someone form the patient’s family, that’s fine too. But, if the patient’s not there, they can say anything or anything and whether it’s true or not. And, like the last meeting they had here, I was nowhere to be seen because they never told me they were having anything.”

Dimension: Assurance of Human Presence

The Dimension Assurance of Human Presence included items which reflected an investment in the other’s needs and security (Wolf et al., 2004). The items on the CBI-E and their scores were: Responding quickly to your call (2.13), Meeting your needs whether or not

you ask (2.44), Showing concern for you (2.44), Adjusting to limitations (2.25), Knowing your likes, dislikes & routines (2.13), and Appreciating your life story (1.75). Residents in this study perceived caring behaviors within this dimension under the auspices of knowledge of the other and a ready response to individual needs. Under this dimension they stated:

ID2 "And also there is a lack of many or most of getting to know the individual person and they try to treat you as a group. Instead of treating you as individuals and that's something they have to be trained in and they have to learn. Everybody is different. Everybody's requirements are different. Everybody's desires are different. That's what makes us different people in most of the world You have to be able not to treat people as a group…You have to treat people more-what I'm trying to say is this, treat people more as individuals. And, try to be flexible enough if you're in that position to adjust to each individual."

ID10 "I mean they definitely understand that. They know the residents pretty well. They know the problems most of them have. There's some of them-some of the residents here that's really bad off. I mean I don't consider I'm bad off; I'm handicapped but not bad off. I do a lot of things for my own self."

ID8 "I feel let down. Cause uh-cause they push back in a corner. They ain't no concern how you feel or nothing else. They don't know if you had a bad day or not. They come in and they ay something to you, I feel all right. They ignore that in the conversation, it doesn't matter."

ID9 "Let me think about that as far as from a life story, why the-I think the nurses here actually do understand and appreciate what the men went through, particularly that those-even knowing my background itself. I fought in three different wars, uh and uh I have-have a long military history and career behind me. And, I think the nurses understand that too in their treatment with me, which I appreciate very much."

ID15 "Well, they know me, yeah. At least you know some of them, some don't. We have a different one every-almost everyday, you know they rotate them around someplace.

ID16 "I don't know if they know-I don't really have much of a routine to tell you the truth because I don't even have a television set you know. So, I go down to eat, I come back to my room. Well, that's because I have some kind of a bowel problem too you know. So I'd rather spend my time here in my room than other places.

Dimension: Positive Connectedness

The Dimension Positive Connectedness indicated an optimistic & constant readiness to help the other (Wolf et al., 2004). The items on the CBI-E and their scores were the following: Being pleasant with you (2.69), Watching out for your safety (2.63), Being honest with you (2.25), Being patient with you (2.38), and Recognizing how you feel (1.81). Residents in this study perceived caring behaviors within this dimension under the auspices of knowledge of the other and a ready response to individual needs. Under this dimension they stated:

ID3 "I believe they try. I believe they try. Everybody has their bad days. Sometimes a nurse will come in and she'll be in a funk but they can't help that. You know I worked with depression all my life and I understand it so mostly they try real hard."

ID5: "They watch out for my safety pretty much and they do at all times take care of me and my family."

ID7: "Yeah, I'm sure. I don't mind that. It's just-it's these uh so-called nurss. The just come ein here and work. They got a place over there-they got all that food and everything and they say that we're not supposed to do this; we're not supposed to do this. What do you mean, we aren't supposed to do it?..."

ID8 "Oh yeah, I had another on of the nurses last night. I didn't go to supper, she came walking right here. I didn't go to eat supper at all because I was still in bed. She comes in and asks Mr. --- is something wrong. I said no. I said they ain't had anything I wanted to eat so I didn't go. She said will I didn't know, I thought you were sick. But, she's about the only one pays any attention."

ID9 "…Uh, even-even the nurse-nurse that had uh lost her cool with me. The reason behind that I considered-I consider is that because she didn't keep-she didn't know or didn't understand my position and my-my feelings towards why I was doing it. For instance, I went to her uh early in the morning and I got my medication the first thing in the morning about 530 you know or about that time. And then I had to catch an 8 o'clock bus, I knew that. So, I went to her and uh I told her, I says I have to catch an 8 o'clock bus, can I have my medication-this is my second medication that we get in the morning. And, they usually give it to us about 8 o'clock so I wanted my medication early. Well, she didn't understand my feelings of it and she uh-she lost her cool. So, she did in a very, very loud voice, she did speak up really harshly to me. And, this didn't-this didn't just uh-didn't last for just a minute

or so, this continued on and on and on for I don't know how-a definite time anyway. Fortunately, there was another nurse, a male nurse walked down the hallway. And, he overheard this conversation uh and the screaming and he went up and got the medication that I needed. He came and-went and gave to me and then I left and caught the bus…It was just a bad incident that happened. So, that-I can understand that maybe she had a bad night or maybe she was on duty all night and she was tired, and this-this will happen. This will happen."

ID11 "See, I cannot understand the-their language. I cannot understand it very well because I mean they talk you know-I don't understand it. There's once-once- every now and then, I can understand a couple of words and they blah, blah, blah. I can't understand it. But, I just know I try you know to understand it. Sometimes I get one or two words of what they are saying or trying to say. Or, I might have to ask them a second time."

ID12 "At times, I think they hire somebody off the street that don't know one-nothing. And other times I think they do very well…Some are good and some are not…And, some people give a darn and some people don't give a darn."

ID13 "It's um-I find no problems with it. Uh they are courteous and interested. There's just no-nothing I could uh complain about. I say I feel quite-quite lucky."

ID15 "I-I'm not very well associated with that. I don't think there's that many nurses here. See, these are all LPNs or something. I guess they can do as good a job as anybody. I don't know."

ID16 "They're too pleasant. (laughter), They come in here with a big smile on their face but I don't know how they leave when they turnaround. They're always nice to you, you know. But, you never know if they really mean it. I mean that's just my feeling."

Dimension: Professional Knowledge and Skill

The Dimension Professional Knowledge and Skill included nursing team caring behaviors which are perceived as proficient, informed and skillful (Wolf et al., 2004). The items on the CBI-E and their scores were: Giving your treatments & medications on time (2.56), Knowing how to give you needles, enemas, treatments, etc. (2.50), Speaking to you with a clear friendly voice (2.38), Trying to relieve your ailments (2.38), and Managing your pain (2.19). Residents in this study perceived caring behaviors within this dimension discussing

proficiency of skill, an individualized knowledge of the other, attention to issues surrounding pain and a cheerful ready response to individual needs. Under this dimension they stated:

ID1: "Well, I'm concerned about the issue of professionalism. In this respect, they handle the medications with their hands, their bare hands, next to the patient's mouth, I've seen them before, take the medicines, put them in the patient's mouth, mine included….They hire people from all over the world, pay them the lowest price they could get, and they're the lowest professionalism they could get, too. And then we're suffering for it...

ID3: "That I don't know-quite a few nurses are from different countries and they interpret things differently on the way you feel and the way you do. It's not their-I've had discussions with a couple of them and it's perceptive that they have certain beliefs and they were raised a certain way and they don't always respond like you would think that thy ought to or something or other. But, it's workable"…

ID4: "Well, it's kind of hard with an accent and I know they try but there is an accent that shutters out the real sound. And, I think that is a mistake especially in medicine. I don't think they should be handling medicine whatsoever."

ID6: "They cannot-they cannot they're-so many of them are from other countries and I don't mind their not being able to speak clear English because we all know that if we had to go to another country, it would take us a little time. What gets me is their total indifference to speaking it to the level an American can easily understand. They just make a shotgun shot at English instead of a rifle shot…I would do well if it understood one word out of ten or fifteen. Somehow a con got into the conversation. She kept talking about this con and I said-and she kept repeating hen I asked her. She'd say con, con, con. And, I said how do you spell it? And, it came out c-o-r. And, I said oh, hon, in America you are going to have to say the R. Con is not what we call corn. And she pronounced corn perfectly. Instead of persisting in that pronunciation she immediately fell back to using con. So, she was totally indifferent. That's what gets me, is the word indifferent…And it is so frustrating, you just give up and it's demoralizing because you can't communicate."

ID10: "Yeah, they-they have a friendly clear voice. It's some of them because of their origin, where they come from-there's just a couple of them I don't understand you know maybe they're not American born."

ID11: Um, see I mean that's like um some of the nurses there I don't know, seem like they speak a different language you know. I mean the way they talk about you know, and they be talking real fast remember and now I miss-like say now since I'm getting old it seems like I'm losing most of all that."

ID12: "Not really, no. I have no-qualms or-they're doing their job, they're doing what they're told to do and they-some try as I say try to do it very well. Other times they

don't give a darn…Their personality, their individualism. There's some people try to understand and try very hard to do what they can-can do but I don't know how."

ID14: "And, they-if they have the knowledgeable nurse on, that nurse can tell them when you treat Mr. X he'll show you what medicine. Or, either they can take them over right then and show them, or either they can tell them when you treat him, he'll show you what medicine. And, he'll show you how to put it on and if you don't want to listen to him-but they have their instructions written out in a book as to what to do. But, a lot of times, the medication will change and the book doesn't change."

ID16: "They might ask. In fact, they always ask how do you feel or gat any pain, or something like that. They always ask them that."

RV2: "The nurses here aren't really nurses. They just hand out pills that's all they do. They have no decision-making to do. They don't decide anything."

RV4: "Sometimes you wait an hour, hour and a half finding somebody. Like I say, I use to –before I got here I was taking all the medicines. I didn't have any trouble. I knew what I-got my tablets in order. Took two of them, one at night, put my eye drops in. Sometimes they forget my eye drops. Oh yeah, right, you got eye drops, we'll find them."

RV5: "Especially if a person has arthritis. He ought to be checked on more often, I think. He shouldn't have any problem getting medication. If you have it coming, you know. I prefer they don't have to be there the time you actually get it but they should check on you to ask you if you need it. If you need it, they should give it to you. That's the way I feel."

Dimension: Attentiveness to the Other's Experience

The Dimension Attentiveness to the Other's Experience demonstrated an appreciation of and engrossment in the other's perspective and experience (Wolf et al., 2004). The items on the CBI-E and their scores were: Checking on you (2.63), Giving you a hand when you need it (2.38), Helping you feel comfortable (2.25), Standing up for your interests (2.25), Assisting you to meet your religious or spiritual needs (1.44). Residents in this study perceived caring behaviors under this dimension as an appreciation for the other's point of view and an understanding of the personal feelings of the resident. No residents elaborated upon the data

obtained from the CBI-E regarding the need for assistance with meeting religious or spiritual needs. Under this dimension they stated:

ID3: "Oh, yeah, when one of the nurses first started out here, she just looked on this as a job. She really had no interest in the patients and I'd tell her that, and oh, she'd get mad. And, I'd say you're in the wrong profession, you ought to be working at McDonald's or somewhere. And, she'd get mad and holler at me. We'd have it out. But, the past six months, since-especially since her load has gone down, she changed. She does pay attention and she does act like a nurse. So, I think when you have the pressures of too many patients for the job, I think that can get to you. And, then some people you know they just start out looking for a job and they don't realize what it is all about: it takes a while for them to learn. So, she's improved a bunch now."

ID5: "Well, they know that-when I need help the staff and things, they know when I need help with everything that-and how often I don't need help."

ID9: "They do. They just-all the nurses on this floor know me by my-by my first name. Of course, they always address me by mister, but they all know me. Yes indeed. So, I know that
they have a personal interest in the individual. Yes, they know me and what's wrong with me."

ID14: "And, not only her, it's-well, it's-it's at least seven or eight nurses here during the daytime and some of them have part of the afternoon shift, that will help me because they been around and they know me. They been with me long enough, that makes a difference…Yeah, it makes a difference when you're together and you been together for a long time. And, it's important in a lot of ways-you know that person and they know you. They know when I go down to eat or we want to order something, we-they can tell you what I want before I even make-make a suggestion."

RV2: "Listen to your patient…Even when they're old, listen to your patient. Now, some of them are wacky granted. I'm half wacky myself aren't I. But, these nurses don't take the time to listen to you because everybody is moaning and groaning anyway about their own self…I'd like to see nursing get a little more like nursing instead of just pill pushing…Yeah, spend more that 10 seconds with them in the room. Come into the room, you know say how you doing, fine, and out the door they go you know. Don't even have a-don't even ask you hardly if you need anything. You know some do, some don't. So, it's as if they're just like robots. At least, that's the way I look at it. And, then sometimes they are so very nice and like this one lady the other day. She wasn't a nurse thought, she was a CNA."

RV3: "I think some of the attitude of the nurses comes from the environment from which they come from…they think differently than we do about responsibility and perhaps

the level of responsibility that they[re showing in this matter with those rats in that room is acceptable to to them…they don't-they don't think the ay we do when what is occurring is acceptable to them…Yeah, see a lot of these people are from down in the Caribbean and hey live with that sort of thing day in and day out. So, it is a way of life for them. You know it doesn't bother them as much as it would you and I..."

Sixth Question: *Other*

The final question from the CBFIG allowed the participant to share any additional information about nursing team caring behaviors. In this study, when asked if there was anything else they would like to share, residents stated:

ID3: "Taking an interest in the patients. Before she would just-she was just going through the motions and she would get angry real easy. You know like not considering somebody's limits and disabilities. And, now she does seem to do that. And, she doesn't jump on people like she did before."

ID5: "Well, I'd say that the nursing team I have is an excellent one. They are excellent in their work and that they have the –have the number one concern is they know their jobs."

ID6: "Yes, I would and I feel very strongly on this and I resent it deeply the way these vile patients and unfortunately, it's a very high percentage, the vile degradation they subject the staff to and nobody seems to care. Nobody takes up for those-I call it the direct care staff…And, I resent that very deeply because these girls deserve a lot better. They are wonderful people. As a whole they're just a wonder. And, they're human beings and nobody needs to be called the names-and nobody ever seems to be around or cares…"

ID8: "Well, I thank you too. The nursing should uh know how to talk about uh how-you should go out and walk. Know your diets. Stuff like this, you know where you help. You get none of that…Cause you say I can't do anything about that. I don't want to hear that crap."

ID10: "No, I-I don't have anything to criticize any of them about and uh they do an outstanding job I believe. Yeah, they do. I mean it's true. I mean they got people that bother them unnecessarily but they seem to be able to handle that. And, they got people always calling them for assistance and I don't know, it's-no, they-they really take care of me."

ID11: "Um, well, I'll say that living here um in the um-in the retirement home is real nice and a good experience. Anyone who out there on the street and not have a good job and been in the service and did a good term in the service, and unable to support themselves out

in the street-now it's best that is to come into the um-into the retirement home. That'll be as his best there to keep'em from getting into trouble out there in the street and starving to death."

ID13: "No, I-I feel lucky that's for the room, food and of course the medical care and treatment, why uh I think is just fine…Yeah, I-I just can't differentiate of uh different members of the team."

RV1: "yeah, well, it's assumed that not much seriousness going on there. That's mainly just pill popping. Well, you know I might like to add one thing. The food here is terrible, which is irrelevant to what you're here for. But, I do find that the mess hall has very high sanitation standards as opposed to bed care-I mean assisted living room care, which fails…if just somebody who knows better would just hire these people and watch them on their routine care. I don't even trust the-you know it's one of those deals where they think the gloves are to protect them…the crux of it is right there, they know what they're being taught but they can't grasp how it relates-how the schoolroom translates to my wastebasket."

RV5: "I don't know. Maybe check on the patients more often to see how they feel and see what they can do for them…"

Summary of CBFIG Generated Qualitative Data

The Caring Behaviors Focused Interview Guide, a tool developed by the investigator and based on the CBI-E (Wolf et al., 2004) was administered to 16 participants in the study. These participants agreed to share their perceptions of nursing team caring behaviors in a taped interview following the completion of the PIF and the CBI-E. The purpose of the CBFIG was to further amplify the data collected with the CBI-E. It utilized the five dimensions of the CBI-E and included a final question to obtain any additional information participants might wish to share with the investigator. These data, the result of the 16 interviews and five repeat visits to validate the information, were taped and transcribed verbatim. Through the utilization of content analysis (Elo & Kyngas, 2007), the result was a deeper understanding of the theoretical content imposed on the data from the dimensions of the CBI-E beyond the quantitative numbers.

Across the six areas of questioning, residents made statements which encompassed the spectrum of caring behaviors. At one end, data showed perceptions which reflected "The Good Nurse." These were behaviors which supported the dignity and individuality of the resident. At the opposite end of the spectrum were those statements which reflected perceived behaviors which undermined the autonomy and individuality of the resident. These data were congruent with the qualitative findings presented in Tables 9-13.

Conclusion

The chapter presented a discussion of the identified nursing team caring behaviors perceived by residents of an assisted living facility for retired veterans. This was accomplished by exploring the quantitative data obtained on the Personal Information Form and on the Caring Behavior Inventory for Elders Tool. In addition, the quantitative data were further elaborated upon through examination of the statements obtained from the Caring Behaviors Focused Interview Guide as well as qualifying statements which emerged in the process of filling out the Caring Behavior Inventory for Elders Tool.

The study sample was comprised of 51 residents of an Assisted Living Facility for Retired Veterans. The majority of the participants were white males with a mean age of 83.82 and were widowed or divorced. The dominant religion was Protestant and the majority of the respondents in this study had a minimum high school education. The average length of stay within the ALF was 39.7 months. The majority of the respondents walked with a walker or used a wheelchair, stated they needed no assistance with bathing or dressing and rated their current health status fair. When asked who in their opinion made up the Caregiving Team in the ALF, the majority of the respondents included the Registered Nurse,

the Certified Nursing Assistant, the Licensed Practical Nurse, and other health care providers. Under this area, respondents included the Medical Doctor, Nurse Practitioner, Social Worker, the Desk Clerk and various staff at other Veteran Facilities as examples of members of the Nursing Caregiving Team. . Interestingly, several respondents shared their perception that they could not tell the difference among Caregiving Team members and one respondent answered no one was on the team. All of the participants completed the study and all data obtained from the 51 participants were included in the study.

From the group of 51 participants, 16 participants agreed to partake in an additional audio-taped focused interview which allowed for elaboration of the thoughts expressed on the CBI-E. The demographic data of this sub-set were found to be a congruent match to the larger group.

The quantitative tool for this study was the CBI-E (Wolf et al., 2004). The CBI-E was based on the Caring Behaviors Inventory (Wolf, Giardino, Osborne, & Ambrose, 1994) and developed to meet the unique needs of the elderly population. Framed by Watson's Transpersonal Caring Theory (1988a), the CBI-E consists of 28 items with a 3-point Likert type scale. The responses on the tool are 1=rarely, 2=sometimes, 3=often. Scores range from 28 to 84. The higher the score on the CBI-E, the greater the perception of caring by the respondent. The tool is based on the five dimensions of nurse caring (Wolf et al., 1994). The five dimensions are: Respectful Deference to Others, Assurance of Human Presence, Positive Connectedness, Professional Knowledge and Skill, and Attentiveness to the Other's Experience.

In this study, the scores on the CBI-E ranged from 38 to 81 with a mean score of 63.61, a standard deviation of 11.77 and a median score of 64. Full range of the scale was demonstrated for all items on the tool except for the item, "Being pleasant with you" which scored the highest among the items (M = 2.76).

The items which earned the highest mean scores were the following five questions from the tool: Being pleasant with you, Giving your treatments and medicines on time, Checking on you, Watching out for your safety, and Knowing how to give you needles, enemas, treatments. Four items rated lower than the average of the number two on the tool, demonstrating these behaviors were perceived as rarely performed. These included: Assisting you to meet your religious or spiritual needs, Helping you and your family make decisions, Appreciating your life story, and Including you when planning your care. The subset of 16 qualitative respondents also included, Appreciating you as a unique person, within this lower range.

Although the CBI-E is a purely quantitative tool, an unexpected source of data emerged from the informal comments made by the participants who requested assistance with filling out the tool. Qualitative comments were captured in addition to the process of quantitatively answering the questions on the tool. This procedure was applied in a uniform manner across all 50 participants who asked for assistance in filing out the PIF and CBI-E forms. This serendipitous information, along with the data obtained through use of the CBFIG, offered elaboration on the quantitative results.

The purpose of the qualitative portion of the study was to more fully understand the nursing team caring behaviors perceived by residents of an Assisted Living Facility for

Retired Veterans through elaboration upon the quantitative findings. The qualitative data are presented according to the five dimensions which became the imposed classifying scheme for the study. Across all five dimensions two major categories emerged. Qualitative responses consistently demonstrated a tendency to describe actions seen as those of "The Good Nurse" versus the actions of "The Non-Attending Nurse." While the caregiving team was perceived by the participants in the study to be comprised of more than nurses, the responses to the three tools were specific to nurse caring behaviors unless otherwise specified.

Consistently, participants verbalized qualities of the Caring Attending Nurse (Watson, 2006) when describing actions which demonstrated an individualized approach. These were the actions of "The Good Nurse" which supported the dignity of the resident and was beneficial to both parties supporting the tenet that caring consists of consciousness. Furthermore, behaviors which failed to support the dignity and integrity of the individual where also clearly disclosed across the five dimensions as being devoid of conscious regard and became representative of behaviors of the "Non-Attending Nurse."

The Caring Behaviors Focused Interview Guide (CBFIG) was developed by the investigator and constructed using the five dimensions of the CBI-E. It consisted of six open-ended questions. The first five questions addressed the five areas covered by the CBI-E instrument. The tool included probes to help elicit participant sharing. A final general question was used to gain further insight concerning perceptions of nursing team caring behaviors within the ALF environment.

The purpose of the focused interview guide was to help amplify the meaning of data obtained through the use of the quantitative CBI-E instrument, thereby obtaining elaboration

of the quantitative results. The CBFIG was offered to every respondent in the study after the completion of the PIF and the CBI-E. Sixteen participants agreed to answer the CBFIG to further share their thoughts regarding nursing team caring behaviors. The resultant taped interviews were transcribed verbatim and examined closely through utilization of content analysis. An imposed theoretical structure of the five dimensions of the CBI-E was utilized for this process.

Similar to the qualitative data serendipitously generated by the quantitative CBI-E, an examination of the data of the CBFIG exhibited the emergence of two major categories. The respondents to the CBFIG verbalized the actions of "The Good Nurse" which supported the dignity of the resident and was individualized in approach (Watson, 2006). Additionally, behaviors which failed to support the dignity and integrity of the individual where representative of behaviors of the "Non-Attending Nurse" which consistently lacked a conscious regard for individualized caring.

In the final chapter, the findings of this study will be interpreted and compared to findings in the literature. Special emphasis will be placed on a comparison of the results of this study to The Science of Caring and Watson's Caring Attending Nurse/Team Model® (2006), which comprise the theoretical basis for this study. The chapter will follow the following format: (1) study overview, (2) quantitative results, (3) qualitative results, (c) discussion, (d) implications for nursing, and (e) recommendations.

CHAPTER V

Study, Overview, Discussion, and Implications for Nursing

Introduction

This chapter will address the major findings of the study and how they compare with Watson's Science of Caring Theory and Caring Attending Nurse/Team Model ® (2006) which comprise the theoretical foundation for this research study. The data will be compared to caring research findings as reported in the literature. The limitations of the study will be addressed. In addition, implications for nursing suggested by these findings with recommendations for potential impact in areas of nursing practice, nursing education, nursing research, and health policy formation will be presented. The chapter will follow the following format: (1) study overview, (2) quantitative results, (3) qualitative results, (c) discussion, (d) implications for nursing, and (e) recommendations.

Study Overview

People are living longer in unprecedented numbers. While the overall population in the United States tripled between 1900 and 2000, the increase in the number of older adults was 11 fold. The present changes of family structure, the decrease in the number of trained health care personnel, and a lack of formal knowledge regarding how to provide the best type of caring behaviors for older adults come together to undermine the individuality of this older population. The Centers for Disease Control and Prevention (CDC) and the Merck Institute of Aging and Health (MIAH), (2004) identify long term care needs as perhaps one of the greatest challenges to the burgeoning population of those over 65 years of age. It has

been noted that the 1.5 million frail elderly Americans who rely on long term care services today will total 12 million by the year 2020 (AHCA & NCAL, 2008). The Assisted Living Facility (ALF) has emerged in response to consumer demand for residential long-term care however, little is known concerning how elders in ALFs truly fare in relation to caring behaviors. This is due to a dearth of research concerning the 1 million individuals who choose this option of long term care delivery (Burdick, Rosenblatt, Samus, Steele et al., 2005).

The preservation of human dignity, support of a sense of integrity and transpersonal connectedness through meaningful relationships are outcomes identified in connection with caring behaviors (Watson, 2006). With a burgeoning population of frail elderly residing in ALFs, it is incumbent upon nurse researchers to examine the issue of caring behaviors within the ALF milieu from the perspective of the residents. This study has a two fold purpose: To identify nursing team caring behaviors as perceived by residents of an Assisted Living Facility for Retired Veterans and to more fully understand the nursing team caring behaviors by gathering qualitative data to elaborate upon the quantitative findings.

The Theory of Human Care (Watson, 1979) forms the theoretical structure for this study. The focus revolves around what is identified as the "core" of nursing. This core, reflecting nurse caring behaviors, refers to the caring processes which effect positive health changes from practices intrinsic to the nurse-patient relationship. In addition, the theory is built on specific caring assumptions which assert that caring can be demonstrated and can help to fulfill needs and support a sense of autonomy to make informed choices regarding one's personal health (1979).

As a response to looming critical shortages and concerns about safety, Watson offers *The Caring Attending Nurse/Team Model* ®, (2006). The responsibilities of the Caring Attending Nurse (CAN) within this team approach are essential to the overall achievement of an individualistic caring response. The CAN guides and sustains caring relationships with patients and families across the entire interprofessional team including para-professionals of the nursing staff. This coordination of care is achieved by assessing caring needs from the patient's frame of reference. In this manner, the CAN co-creates a plan for caring and healing that intersects with the medical plan. This intentional and individualized process helps to assure comprehensive team planning even when direct care is not administered by the CAN (2006).

Exploration of the perceptions of nursing team caring behaviors among residents of an ALF was accomplished through use of Watson's Theory and the CAN/Team Model. Intentional caring behaviors within the ALF were described and measured through the quantitative and qualitative exploration of resident's perceptions of such caring behaviors.

This descriptive study utilized triangulation of method (Burns & Grove, 2005) to uncover information in an area where little research has been performed. The concept of caring in an ALF is such an area (2005). The quantitative portion of this study was based on the Caring Behaviors Inventory for Elders Tool (CBI-E) (Wolf et al., 2004) which offered a convenient and easy method to elicit perceptions of nurse caring behaviors. The Demographic Information Form (PIF) was used to describe the study population. Since the "average" resident of an ALF is a white female in her early 80's, the studies which take place

in this setting often present information from a mainly female point of view. In this study, the predominate gender is male thereby offering a new perspective.

The qualitative portion of this study utilized a focused interview guide (CBFIG) designed by the investigator and based on the five dimensions of the CBI-E. This tool allowed for elaboration of the quantitative results to further explain the data. Sixteen participants agreed to this aspect of the study and interviews were audio-recorded and transcribed verbatim. To ensure integrity of the results, five re-visits were performed, audio-taped and transcribed in the same fashion. For the purpose of reporting the results of the study, numbers were used to identify study participants. Data were analyzed using SPSS 15.0 (SPSS Inc., 2006) for the quantitative data and Content Analysis for the qualitative results. The five dimensions of the CBI-E Tool were imposed on the qualitative data to help categorize the results in relation to the existing theory.

Quantitative Results

Personal Information Form (PIF)

This descriptive study sample was comprised of 51 residents of an Assisted Living Facility for Retired Veterans. The mean age of the participants was 83.82 ranging from 67 to 99 years. The participants were predominately male (92.2%) and the dominate race was white (70.6%). The majority of the respondents were either widowed (33.3%) or divorced (25.5%) and the dominant religion was Protestant (66.7%). The majority of the respondents in this study had a minimum high school education (83.3%). Many residents had some college classes without a degree (33.3%) and a significant number of respondents had a college degree (23.5%). The average length of stay within the ALF was 39.7 months. The

majority of the respondents either walked with a walker (45.1%) or used a wheelchair (37.3%). Thirty-nine of the 51 respondents stated they needed no assistance with bathing or dressing (76.5%). The majority of the respondents rated their current health status fair (45.1%) and three participants rated their health status poor (5.95%).

While great variability is observed in examining the data which represent the National ALF Resident's Profile, the participants in this study share many traits while being very different at the same time. The average resident of an ALF, if there is such an entity, is a white female in her 80's who is a high school graduate, cognitively intact and widowed. While the study population was, in many ways similar to the national profile as evidenced in Table 1 presented in Chapter III, the striking difference between the two cohorts is that this study population was overwhelmingly male. Through this descriptive study, the opportunity to examine perceptions of a population seldom seen in significant numbers in the ALF milieu, offers a different set of data to be explored regarding the area of caring behaviors.

The final question on the PIF asked the participant, "Who in their opinion made up the Caregiving Team in the ALF." The vast majority of the respondents included the Registered Nurse (90.2%) and the Certified Nursing Assistant (90.2%) at the same extremely high rate. The Licensed Practical Nurse (86.3%) along with other health care providers (86.3%) were viewed as members of the Caregiving Team on an equally sizable rate. Interestingly, several respondents shared their perception that they could not tell the difference among Caregiving Team Members and one respondent reflected no one was on the team. The facts that almost all of the participants viewed the Caregiving Team as interprofessional and that some respondents voiced an inability to differentiate team

members speak to the importance of the CAN supporting a individualistic caring response while sustaining caring relationships across the interprofessional team (Watson, 2006).

The sub-set of 16 was examined for congruence with the larger group of 51 and was found to be quite similar. A summary of the frequencies of item responses of the CBI-E for the 16 participants is presented in Table 6. Parallel to the results of the data for the group of 51 participants, item 16 did not show a full range of the three point scale. In this study, all respondents rated the caring behavior, "Being pleasant with you" as either sometimes or often. No one in this study perceived this item as rarely performed. Examining the data from the subset of 16 participants, an additional item failed to score across the three point range. "Checking on you" was rated between rarely and sometimes. No one of this smaller group rated this item as often. In the larger group (N=51), this item was perceived closer to the often rating and had a larger mean score in comparison.

Caring Behaviors Inventory for Elders Tool (CBI-E)

The Caring Behavior Inventory for Elders was the instrument utilized in this study to measure the perceptions of nursing team caring behaviors among residents of an Assisted Living Facility for retired veterans. The CBI-E (Wolf et al., 2004) was based on the Caring Behaviors Inventory (CBI) (Wolf et al., 1994), and developed to meet the unique needs of the elderly population and consists of a 28 item tool with 3-point Likert type scale. The responses on the tool are 1=rarely, 2=sometimes, 3=often. Scores range from 28 to 84. The higher the score on the CBI-E, the higher the level of perceived nurse caring behavior by the respondent.

The CBI-E is based on the five dimensions of nurse caring which are the foundation of the CBI. The five dimensions are: (a) Respectful Deference to Others, (b) Assurance of Human Presence, (c) Positive Connectedness, (d) Professional Knowledge and Skill and (e) Attentiveness to the Other's Experience. Wolf (2004) reported the Cronbach's alpha for the CBI-E as 0.94. The Cronbach's alpha for this study was 0.913. Participants demonstrated full range of the 3-point Likert scale for almost all items.

In this study, the scores on the CBI-E ranged from 38 to 81 with a mean score of 63.61, a standard deviation of 11.77 and a median score of 64. In general, it took about fourteen minutes to complete the instrument. The items which earned the highest mean scores were the following five questions from the tool: Being pleasant with you M=2.76, SD =.43, Giving your treatments and medicines on time M=2.71, SD =.58, Checking on you M=2.63, SD =.56, Watching out for your safety M=2.67, SD =.67, and Knowing how to give you needles, enemas, treatments, etc. M=2.51, SD =.64. Four items rated lower than 2 on the tool which means the behaviors were perceived to occur between rarely and sometimes. These were the following: Assisting you to meet your religious or spiritual needs M=1.41, SD =.70, Helping you and your family make decisions M=1.73, SD =.85, Appreciating your life story M=1.75, SD =.85, and Including you when planning your care M=1.96, SD =.92. The frequency data for all 28 items are presented in Table 3 presented in Chapter IV.

In this study it appears that items which obtained higher scores on the CBI-E, while caring in nature, were less likely to be involved with individually based knowledge of the resident. Conversely, those items which obtained lower scores on the CBI-E in this study were reflective of less individualized understanding of the residents. These results have

serious implications if interventions are to be supportive of one's overall health. These data were presented in both Table 3 and Table 4 found in Chapter IV.

Following the completion of the PIF and the CBI-E, 16 of the 51 residents who took part in the study agreed to share his or her thoughts in a taped interview by answering the Caring Behaviors Focused Interview Guide (CBFIG). The purpose of the CBFIG was to allow the participants to elaborate further on the data collected with the quantitative tools. While the data of these 16 participants are subsumed as part of the 51 participants, it was important to examine the specific quantitative results of this sub-set to explore the congruence of this sample in relation to the larger group of participants.

Generally, the subset of 16 was representative of the overall group. The mean age of the group of CBFIG participants was 81.63 ranging from 67 to 92 years. The majority of the participants were male (87.5%) and the dominate race was white (81%). The majority of the respondents were either single (25%) or divorced (25%) and the dominant religion was Protestant (56.3%). The majority of the respondents in this study had a high school education (87.6%). Many residents had some college classes without a degree (33.3%) and a significant number of respondents had a college degree (23.5%). The average length of stay within the ALF was 37 months. Most of the respondents either walked with a walker (31.3%) or used a wheelchair (56%). The majority stated they needed no assistance with bathing or dressing (62.5%) and rated their current health status fair (50%). One participant rated health status as poor (6.3%).

When asked who in their opinion made up the Caregiving Team in the ALF, an equal majority of the respondents included the Registered Nurse (93.8%), the Certified Nursing

Assistant (93.8%) and other health care providers (93.8%) as members of the Caregiving Team. This group also included the Licensed Practical Nurse (87.5%) at a lower percentage as part of the Caregiving Team, although like the larger group the majority did perceive them as part of the team at a high number. These data are summarized in Table 5 which is presented in Chapter IV. While some nuanced differences existed, overall the demographic data of this subset of individuals was congruent with the larger sample. It was important for this smaller sample to be representative of the whole since the qualitative data which would elaborate on the quantitative results were based on their feedback.

The scores on the CBI-E for the sub-group of 16 respondents ranged from 41 to 78 with a mean score of 62.06, a standard deviation of 12.32 and a median score of 63. These data are presented in Figure 7 in Chapter IV. It took 12.5 minutes to complete the instrument which was lower than the 14.2 minutes which was the average among the larger group. The five items which earned the highest mean scores were identical to the five from the group of 51 respondents with a slight variation in the ordering of the items. Five items rated lower than 2 on the tool. These items were identical to the four items noted by the group of 51 with the addition of the fifth item, Appreciating you as a unique person M=1.88, SD =.81. A complete summary of the descriptive statistics for all items of the CBI-E for the 16 interviewed participants is presented in Table 7 found in Chapter IV.

Once again when examining the quantitative data some interesting points emerge. Those caring behaviors which score highest on the CBI-E are less individualized in scope. The lower scored items represent those important caring behaviors which are more likely to support the holism of the individual and to effectively meet the needs of a growing frail

population as discussed in the work of Meyer, Cecka and Turkovich (2006). Also of note is the fact that while the Licensed Practical Nurse (LPN) is certainly identified as part of the Caregiving Team, the LPN is consistently perceived at a lower percentage than the other members of the nursing staff.

In this study, there is support from both Registered Nurses and Nurse Practitioners across both ALF units. This is not always the case within the ALF environment. However it is important to note that the quantitative data show that the Certified Nursing Assistants (CNAs) scored higher in caregiving behaviors than the Licensed Practical Nurses. This suggests that it is not simply the status of educational preparation which explains these results. The forthcoming qualitative data help to more fully explain the quantitative results and add to the understanding of the previous discussion.

Qualitative Results

The purpose of the qualitative portion of the study was to elaborate upon the quantitative findings in order to more fully understand the nursing team caring behaviors perceived by residents of an Assisted Living Facility for Retired Veterans. While the quantitative data present a numeric importance for each of the 28 items from the CBI-E, the qualitative data offer a further exploration of the scope and breadth of the qualifying responses.

This elaboration is a result of two separate developments. Qualitative responses were serendipitously captured as a result of the process of administering the CBI-E to 50 of the 51 participants who accepted assistance in filling out the tool. There was a conscious decision by the investigator not to limit the respondents' answers to just the numerical answer of one

word. This process was applied in a uniform manner across all 50 participants who accepted the investigator's offer for assistance.

Although the CBI-E is a purely quantitative tool, this unexpected source of data related to the tool items emerged from the informal comments made by study participants during the interview process. This serendipitous information, along with the planned qualitative data obtained through utilization of the CBFIG, combine to offer a rich an even more substantial elaboration of the quantitative results.

CBI-E Generated Qualitative Data Results

Examination of the qualitative data, which emerged during the quantitative interviews, presented an amplification of the raw numbers generated by the CBI-E tool. In some cases, respondents gave an item a low score because it wasn't seen as an item the respondent would consider necessary for the caring team member to perform. A response of, "I do that for myself" demonstrated that while the response might be scored: 1 = rarely, the grade may not represent an omission on the part of the caregiving team member since it was not an expectation of the resident. On the other hand, some items received a low score because the respondent viewed a lack of this behavior in the caregiving experience. For instance, a comment such as, "I am never included" or "They don't know me," offers insight into caring behaviors which are not seen as regular occurrences in the perception of the resident.

An additional significant consideration resulting from the use of this tool is the fact that the tool allows for better knowledge of the needs of the respondent while at the same time allowing the resident to see that there are options for care that the resident may not have

know existed. Thus, use of the tool could offer new insight to the recipient of care outlining caring behavior standards one should expect in the particular health care environment.

In this study, across the five dimensions of the CBI-E, the comments appeared to fall into two basic categories. "The Good Nurse" encompassed behaviors identified by participants which were seen as supportive and respectful to the individual. Interestingly, these behaviors did not necessarily depend on the educational status and role of the caring team member. Comments referring to CNAs who, "Really help me most" or "Even the person at the desk is part of this team," represent the fact that caring interactions take place across all team members in support of Watson's CAN/Team Model (2006).

Non-Caring Behaviors on the other hand, described actions not perceived as needed or behaviors which lacked the individualized attention which is the essence of caring behaviors. In both instances, Watson's Theory of Human Care (1979) is supported by the results. Through utilization of the CBI-E, a broad spectrum of answers specifies which behaviors are perceived by the participants as supportive to one's needs or lacking in caring response. A review of Tables 9 through 13 presented in Chapter IV, demonstrates clearly how knowledge of the social role and task delivery comprised more of the higher scoring items from the tool.

Conversely, those items which necessitated a deeper knowledge of the individual and a commitment to holistic care, tended to score lower in this study suggesting that these caring behaviors were less often perceived by the participants in the study. Thus, Zimmerman's "awkward union" (Zimmerman et al., 2005) brought about by a desire for resident autonomy, versus the quality based care which must be individualized and needs based, further

highlights the importance of a team member who can offer consistent caring behaviors which cover the entire 28 item spectrum. In fact, it is exactly this issue, providing individualized caring behaviors which are knowledge-based to support the dignity of the elderly, which the CDC and MIAH (2004) point out is both an imperative while at the same time cost effective. Within the CAN/Team Model, Watson (2003) calls for more interaction with nursing assistants and greater collaboration with the entire health care delivery team. The CAN, by offering caring and competent guidance through interpersonal skill and critical thinking behaviors builds effective partnerships to provide and sustain delivery of holistic and cost effective health caring practices.

CBFIG Generated Qualitative Data Results

The Caring Behaviors Focused Interview Guide (CBFIG) was developed by the investigator and constructed using the five dimensions of the CBI-E. It consisted of six open-ended questions. The first five questions addressed the five areas covered by the CBI-E instrument. The tool included probes to help elicit participant sharing. A final general question was used to gain further insight concerning perceptions of nursing team caring behaviors within the ALF environment. The question was, “Would you care to share any additional thoughts or concerns you may have regarding your perceptions of nursing team caring behaviors?”

The purpose of the focused interview guide was to help amplify the meaning of data obtained through the use of the quantitative CBI-E instrument and was offered to every respondent in the study after the completion of the PIF and the CBI-E. Sixteen participants agreed to answer the CBFIG to further share their thoughts and have their answers tape

recorded. Following the process, five additional re-visit interviews were performed to validate the data. Each discussion was tape recorded and transcribed verbatim.

The CBFIG data were explored using content analysis in a deductive manner since the structure of the analysis was imposed on the basis of the five dimensions of the CBI-E (Elo & Kyngas, 2007). The qualitative data were explored and presented according to the dimensions identified by the CBI-E and the CBFIG tools which formed the classifying scheme for the study. The utilization of content analysis allowed deeper exploration of theoretical content and enhanced understanding of the data (2007).

Strikingly similar to what was evidenced when exploring the unexpected data from the 50 participants who qualified their answers on the CBI-E, two major categories emerged with this sub-set group of 16 under each dimension of the CBFIG. Consistently, participants verbalized qualities of the Caring Attending Nurse (Watson, 2006) when describing actions which demonstrated an individualized approach which in turn supported the dignity of the resident and was beneficial to both parties. These perceptions support the tenet that caring consists of consciousness and must be predicated on more than good intentions.

Caring must be knowledge based and intentional. Furthermore, behaviors which failed to support the dignity and integrity of the individual where also clearly stated across the five dimensions as being devoid of conscious regard. These data are summarized in the previous chapter and support the notion that human to human caring is central to nursing and can support well-being, comfort, trust, and in the process, even be cost effective. Conversely, lack of caring can be humiliating to the recipient and can result in feelings of alienation, helplessness and despair. Such feelings can negatively impact health and healing

(Swanson, 1999). Examples of both the "Good Nurse" and the "Non-Attending Nurse" are evident across the dimensions of the qualitative data and will be explored on light of the caring behaviors outlined by Watson's caring theory.

Dimension: Respective Deference to Others

The Dimension Respective Deference to Others included items which demonstrated a courteous regard for the feelings and experiences of the other individual. In this study, Calling you by your name, Helping you feel at home, and Protecting your privacy scored higher than 2, while items such as, Listening to you, Appreciating you as a unique individual, Including you in planning your care, and Helping you make informed decisions scored lower.

Recalling that the American Geriatric Society (AGS), (2005) identifies the move to an ALF as a critical life transition and states positions regarding staffing practices which support adequate numbers as well as knowledge of individual needs, the CAN-Team model is supported by both the results of this study and the AGS position. Furthermore, listening to the needs of residents and their families has been shown to improve their lives through the validation of their unique experience (Iwasiw et al., 2003).

In this study, residents shared perceptions that sometimes members of the nursing team were outstanding, really friendly and willing to listen. Other comments referenced the high turnover rate and that interaction was lacking. Inclusion in the plan of care was rated as a rare experience. Specific caring behaviors outlined by Watson's Caring Theory outline interventions based on the practice of loving kindness and authenticity of self. These practices are seen in such statements as, "I was able to adjust quickly to this place…the nurses made you feel at home" and "They are like family." On the other hand, such

comments as, “It depends on the individual” or “I am not included” demonstrates that there is a need to give more emphasis to guide behaviors which would effectively maintain the dimension of Respectful Deference within the AFL environment to support the dignity and self esteem of these residents.

Dimension: Assurance of Human Presence

The Dimension Assurance of Human Presence included items which reflected an investment in the other’s needs and security. In this study, Responding quickly to your call, Meeting your needs whether or not you ask, Showing concern for you, Adjusting to limitations, and Knowing your likes, dislikes & routines all scored above 2. Appreciating your life story was the single item in this group which scored lower at 1.75. Data collected under this dimension is congruent with the study by Kennedy (2005) which highlights the need for knowledge of the uniqueness of the individual for a sense of autonomy in decision making activities and to support a good quality of life. An intentional and personalized model of care was viewed as essential to achieve this dimension. The CAN/Team Model (Watson, 2006) could easily fulfill this requirement by becoming the model of practice to guide interventions.

Caring behaviors outlined by Watson include knowledge of oneself to better meet the needs of others, and the careful development of relationships which are based on building trust and offering helpfulness. There is nothing new or magical about these caritas processes. Indeed, the therapeutic use of self is foundational to the role of the nurse. It differentiates between nursing actions which are needs based and actions which are purely social in nature. In addition, utilization of the CBI-E, closely based on Watson’s work (1999, 2002, 2005),

can easily sensitize both caring team members and recipients of care to behaviors which should be expected as part of the relationship.

From the comment, “They know me as well as I know myself” to “All in a hurry, no on has time” the spectrum across this dimension is displayed. But the item which received the lowest quantitative score overall reflected a general lack of knowledge of the individual. With the leadership of the CAN, this knowledge base would be foundational to the caring process.

Dimension: Positive Connectedness

The Dimension Positive Connectedness indicated an optimistic and constant readiness to help the other. In this study, Being pleasant with you, Watching out for your safety, Being honest with you, and Being patient with you scored above 2. Recognizing how you feel was the single item under this dimension to score under 2. As seen in the study by Meyer, Cecka and Turkovich (2006), caring behaviors must be perceived as primary activities rather than something nice to do when one has extra time in order to foster a holistic approach to meeting individual needs. Watson cautions that there has been an emphasis on superficial, and at times, trivial socialized-caring which can detour the actual work of nursing (2006). Nurses are seen as the professionals who can best enhance communication among ALF residents and their numerous caring partners (Chen & Cohen, 2002). As such, nurses must embrace ownership of actions which tell each ALF resident their feelings are both known and important.

Watson identifies such processes as, being present to and supportive of the individual, and the creative use of self, as able to support caring and healing. Comments

ranging from “Always” to “It depends” again run the spectrum of answers under this dimension. However, responses such as, “They brush me off” and the sharing of an unfortunate incident by respondent ID9, regarding the request to obtain medications early (p 90) demonstrate that at times the connection is neither positive nor healthful in nature. Being able to address unanticipated challenges and meet them in a collaborative manner is an expectation that must be an essential component within the ALF setting (Ross, O’Tuatahail, & Stubberfield 2005). While many positive responses were made under this dimension, the repetition of the statement, “It depends on the team member,” seen too frequently throughout this discussion, is disturbing. Perhaps this issue could be more effectively addressed in an environment guided by Watson’s model.

Dimension: Professional Knowledge and Skill

The Dimension Professional Knowledge and Skill included nursing team caring behaviors which are perceived as proficient, informed and skillful. In this study, Giving your treatments & medications on time, Knowing how to give you needles, enemas, treatments, etc., Speaking to you with a clear friendly voice, Trying to relieve your ailments, and Managing your pain all were rated above 2 demonstrating the occurrence of the caring behaviors at a level between sometimes and often.

As seen throughout the study, “The Good Nurse” was demonstrated by a team member who was perceived as caring and responsive. What is important to remember when examining these data is that some comments clearly specified that a caring approach depended on the particular individual giving the care and not necessarily the title of the team

member. Issues of quality of care and quality of life are paramount in meeting the needs of the elderly in community settings such as ALFs according to Dupler and Crogan (2004).

However, many personnel begin work with little training and limited knowledge of the normal aging process. Assessing the knowledge of and providing training to staff providing caring behaviors to older adults in ALFs would help to alleviate the discrepancies among care givers no matter their cultural background or level of education.

The comment of ID16 who mentions, "…if they have the knowledgeable nurse on, that nurse can tell them…"(p. 92) also supports Watson's Model. Interestingly, the comments made on a revisit referring to the fact that the nurses aren't really nurses, that they just hand out pills but make no decisions demonstrates that recipients of care expect nurses to do more than hand out pills. The issue of teaching and learning behaviors, always an important process in nursing, refers not only to the needs of the recipient but to those of the caring team members as well. Studies have underscored the importance of including even nursing assistants in planning care to help insure these team members can better understand the connection between interventions and outcomes (Stone & Weiner, 2001). The supportive nature of the CAN/Team Model supports this inclusive process.

Dimension: Attentiveness to the Other's Experience

The Dimension Attentiveness to the Other's Experience demonstrated an appreciation of and engrossment in the other's perspective and experience. In this study, Checking on you, Giving you a hand when you need it, Helping you feel comfortable, and Standing up for your interests, scored above two. Assisting you to meet your religious or spiritual needs scored very low (1.44). This outcome has been evidenced in other studies in which the CBI-

E tool has been used, (Wolf et al., 2004). Interestingly, the authors realize the importance of having caring behaviors support the holistic patient whether or not the patient sees a need for caring regarding the spiritual dimension at a particular point in time. Indeed, one resident commented, "I never even thought of that," regarding the item. Through utilization of the CBI-E, the knowledge that such behaviors would be available if needed is in itself, caring in nature.

Creating a healing environment across all levels of need and attending to the spiritual nature or wholeness of the individual, support this dimension as defined by the caring processes. The remark, "They are great, this is the best place I could be" is a wonderful statement and one worthy of praise. Watson (2005) stresses that the nurse-patient interaction is both life-giving and life-receiving in nature. Through the inclusion of intentionality on the part of the nurse, basic needs are met and the humanity of all involved is supported. On a re-visit, one respondent RV2 shared the following, "Listen to your patient…even when they're old, listen to your patient…you know, some do, some don't…"(p 93). Active listening is elemental to the Can/Team approach.

Any Additional Thoughts or Concerns

The final question from the CBFIG allowed the participant to share additional information about nursing team caring behaviors. In this study, when asked if there was anything else they would like to share, residents stressed: The importance of adequate professional knowledge of the work which caregivers were performing, taking a personal interest in their patients, and mutual respect across the transpersonal relationships. Interestingly, all of these suggestions comprise essential aspects of a caring environment.

Some residents shared how lucky they felt to live in the ALF. Some shared their number one concern was that the staff knew their job. Some residents shared that they felt really "cared for." An important point regarding the inability to differentiate different members of the team was one which was mentioned here and had been repeated throughout the study. Although this is a pervasive problem in all of health care, it is particularly non-caring in nature considering this particular setting and this particular population.

It is important to recognize the significance of the perceptions shared by residents in this study. It is the responsibility of every member of the staff to interact with residents in a manner which supports the needs and desires of each resident. While it is noted that most ALF workers aspire to offer supportive relationships which are respectful and caring in nature, (Kemp, Ball, Perkins, Hollingsworth & Lepore, 2009) differences in race and culture can create barriers to an effective caring approach. The role of the CAN would be to guide behaviors and build partnerships among residents, staff, and family based on individualized knowledge and needs of both residents and staff (Watson, 2006).

Discussion

There are several limitations that should be taken into account when considering the study and its potential contribution to the area of caring behaviors. This descriptive study must be viewed in terms of the specific setting and purposive sample which define the parameters of the work. No causal inferences can be derived from the data and generalizability can be extended only with caution to similar settings. Additionally, lacking in this study were the perceptions of nurses and other team members. Additional research is needed from the perspective of members of the caregiving team, including the para-

professional members of the caregiving team to better understand how caring behaviors are delivered by also exploring their perspective.

Results of this study support the theory of the Watson CAN/Team Model (2003). The inclusion of a Caring Attending Nurse (CAN), the leader of the nursing team, can cultivate an intentionality of caring across all team members. In addition, the CAN fosters effective and individualized patient care among the interprofessional team. Watson proposes that human caring is an essential human resource and proposes that utilization of the CAN/Team Model refocuses the attention of nursing to the holistic person in the workplace.

Throughout this study, the perceptions shared by the residents consistently supported Watson's Caring Theory and offered substantial feedback to justify incorporation of this transpersonal approach into the ALF environment. Caring is presented as a conscious process which creates understanding among the individuals involved in the transaction. When directed toward the good of the patient, the caring process demonstrates a moral commitment to the person while reflecting the vulnerability of both parties sharing in the human caring experience (Wolf et al., 2006).

It must be noted however, that nurse caring behaviors can be potentially restricted by the composition of the staff within the Assisted Living Environment which oftentimes may lack the influence of professional nursing in fostering caring behaviors. For instance, following a request from a resident, a response such as, "I can't do anything about that" should never be made. Under the philosophy of the CAN/Team Model, it would be unacceptable.

In this study, veterans who experienced such responses were reluctant to make additional requests of the individual. Participants gave excuses for staff behavior, but this lack of attention to the other's experience was demeaning and did not support the dignity of the individual. The potential for the positive impact of the CAN/Team Model on such an environment as the ALF can not be overestimated. Application of this model and the growth which could result offers potential implications for extending the length of stay of residents in the ALF which fosters autonomy and independence while being less costly than the nursing home alternative.

The major serendipitous finding which resulted from this study was the ability to view the quantitative tool, The Caring Behaviors Inventory for Elders, (Wolf et al., 2004) as both a quantitative and a qualitative tool in one. The CBI-E tool as developed, is made to provide a number which reflects the respondent's perception and guide further interactions. However, it was found that the corresponding qualitative comments offered additional data regarding "why" the respondent feels a particular way. It enables the reviewer to discern if a low score is a result of the item not being an expected caring action or if the item is seldom performed. This is an important element of the CBI-E tool which should be considered and can easily be resolved with a column on the tool for qualitative responses. Finally, in this study, it was soon apparent that although this tool could be read and filled out by the respondent, various issues with sight and fine motor control made the process much more enjoyable for the participants by verbally responding to the tool. Fifty of the 51 participants accepted the offer for assistance from the investigator in filling out the tools. This resulted in a capture of qualitative responses while allowing the opportunity to effectively share

perceptions and feelings. On one occasion a respondent stated, “No one has ever asked me how I feel before.”

Implications for Nursing

This descriptive study serves as a guide for continued development of caring research studies to impact nursing practice, nursing education, nursing research, and the development of health care policy formation regarding the assisted living environment.

Nursing Practice

As the burgeoning number of frail elderly select ALFs to help them meet their needs, the utilization of Watson’s Theory of Human Caring offers an effective strategy to utilize patient and family perceptions to guide the team of staff members who offer nurse caring behaviors and implement strategies to support integrity and health. Nursing must champion an individualized approach to effectively support the health of this fragile population.

The magnitude of the heterogeneity among older adults regarding differences in health status, life history, adjustment style and day to day experiences highlights the need for knowledge of the uniqueness of the individual for a sense of autonomy in decision making activities and to support a good quality of life (Kennedy et al., 2005). Engagement through the CAN/Team Model presents a strategy in which the Caring Attending Nurse (CAN) employs a collaborative approach grounded by knowledge of the individual and effective communication strategies to support the patient.

Utilization of holistic knowledge of the patient and the environment offers the nurse the opportunity to affect caring behaviors even when not in a position to deliver such actions

directly. Evidence suggests that the consequences resulting from such caring are believed to comprise an essential component of how one manages living. Believed to be necessary for survival, these actions offer meaningful support throughout each stage of life and may even impact how one approaches death (Leininger, 1984). Such caring actions are the essence of nursing and, as such, must be evidenced in thoughtful, theory based practice (Watson, 1979; Leininger,1981; O'Brien, 2003; Brilowski & Wendler, 2005).

The fact that not all ALFs have a full time Registered Nurse as part of the staff is not a problem when viewed through the lens of the CAN/Team Model. When a member of the caregiving team (no matter the title or educational level) offers individualized, supportive caring behaviors to residents, these actions support the integrity and dignity of the patient. Under the guidance of the CAN, the caregiving team can be supported by in-service education specific to the needs of the elderly population being served in the ALF to support caring behaviors which are culturally competent in nature.

When a team member learns that to answer a request with "That's not my job" is unacceptable, alternative responses can be discussed and evaluated. This can serve to fulfill the needs of both residents and team members alike by supporting the humanness of all involved.

Incorporating a CAN/Team Model approach together with the utilization of an inventory tool such as the CBI-E can guide behaviors which support all individuals involved in the ALF environment. The result could be an holistic approach defined by individualized caring behaviors even when the Registered Nurse is not actually administering the interventions.

Implementing such a model to guide caring interventions offers hope that the philosophy of the ALF, to foster independence and a sense of autonomy to its residents, would remain a realistic goal. While the number and heterogeneity of residents continue to pose concerns, the ability to age in place within the assisted living environment can be better achieved through this focused approach.

Nursing Education

As the population ages and older adults account for a greater percentage of health care services, the majority of nurses of nurses practicing in the United States are caring for geriatric patients. It is essential for entry-level nurses to acquire the specialized knowledge, skills and abilities to effectively meet the needs of this fragile population (Gebhardt, Sims & Bates, 2009).

The transpersonal approach to caring behaviors must be nurtured throughout nursing school. The theoretical base to the concept of caring has been explored in an evidenced based manner over the last several decades. Caring, in a very real sense, has become a post-modern exemplar. It is no longer enough to define caring as the "Art" of Nursing. Rather, it is imperative that caring now be seen as both the "Art" and the "Science" of Nursing.

While better able to be understood in this frame of reference by the professional nurse, the socialization of the Caring Attending Nurse (CAN) cannot wait until the nurse is working in a specific environment as a professional. It is incumbent on all levels of nursing education to incorporate caring as an essential building block in the approach to patient care no matter the level of educational preparation. The National League for Nursing (NLN) a voice for all levels of nursing education, identifies Caring as the first of its four core values

and refers to it as the foundation for practice for promoting health, healing, and hope in the effort to support the human condition. (NLN, n.d.).

The Caring Attending Nurse (CAN) has the responsibility of coordinating the many members of the interprofessional caregiving team. Interfacing in a knowledgeable manner with all the persons, places and things which comprise the life work of the patient, the CAN guides intentionality in caring through effective communication. It is through knowing the ALF residents' demographics, ethnicity, family structure, levels of disability and resultant needs that a health promoting environment can be supported (Kane, Wilson, & Spector, 2007). As such, the CAN supports a collective vision for the patient which is life affirming, keeping everyone on track and running effectively. It is the intersection of the medical plan of care with the plan for caring and healing which must permeate the educational process at every level of nursing education. .

Nursing Research

This study used the CBI-E and methodological triangulation to explore the perceptions of nurse caring behaviors within an environment too little explored among a population too seldom studied. The significance of a study of this type has implications on several levels. While such a study cannot generalize outside of the specific ALF in which the data were collected, it offers a unique insight into the perceptions of the elderly population so ignored in the literature to date. The utilization of both quantitative and qualitative techniques combine to enhance understanding of concepts such as caring – long considered too difficult to study. The ease of use of the CBI-E, along with the potential of transpersonal

growth resulting from caring theory, could offer important benefits such as improved communication, increased need satisfaction and improved quality of life as a result.

Research demonstrates that the protective role afforded by psychosocial resources can strengthen the link between physical and mental health and can support the integrity of the older individual as it helps to foster a more positive attitude toward the aging process (Jang, Bergman, Schonfeld & Molinari, 2006.) In addition, individualized caring behaviors have implications for designing effective strategies to support the mental health of residents of ALFs (2006). Yet the scarcity of research regarding this aging population undercuts such support (CDC & MIAH, 2004). The dramatic growth of individuals over the age of 65 years combined with the lack of understanding of health care providers to meet the specific needs of this growing population combine to create a problem which, while staggering in scope, must be embraced and addressed through nursing research.

Interestingly, it is increases in cognitive impairment, worsening depression and worsening medical health, rather than demographic issues such as increasing age or education which predict the likelihood of functional impairment in residents in ALfs (Burdick et al., 2005). The authors stress the need for additional studies to help design strategies to support quality of life and improve overall functioning. The application of the CAN/Team Model combined with the utilization of the CBI-E across residents and staff would offer an excellent next step in this important work through an individualized and knowledge based approach to support health.

Health Policy

The issue of long term care delivery to the growing population of individuals over the age of 65 years has been identified as one of the greatest challenges facing policymakers, families, health care providers and businesses today (FIFARS, 2006). While bottom-line economics appear to be the norm in the current system of care, Turkel (2001) stresses the need to sustain the caring ideal can additionally be cost effective. Caring is reflective of quality and is present in the interrelationship between the nurse and the patient. While perhaps seemingly paradoxical in the realm of contemporary health care, both caring and economics emphasize the importance of caring and quality in terms of cost (2001).

While it is understood that the health of individuals who are aging commonly declines, this process is not linear, guaranteed or even predictable. This is foundational to the policies which must guide the sustainability of a resident within the ALF environment (Kissam, Gifford, Mor & Patry, 2003). It has been noted however that to implement an individualized system of care within the ALF environment is a large undertaking. It requires a shift in philosophy among facility leadership and staff members alike. This process would require specialized education, and acceptance among the providers of care as well as the residents and family members (Ball et al., 2000).

Nursing, with sound clinical insight and knowledge of family systems, is positioned to address the challenges facing residents of AFLs. Nurses must add their voices to guide the important work of policy formation which must be protective while at the same time flexible regarding the ability of residents to age in place.

Interestingly, research has shown that having a full-time registered nurse on staff has a measurable positive effect on the likelihood that a resident of an ALF can avoid nursing home placement and age in place (Phillips, et al., 2003). However, it is noted that simply having a registered nurse as director of an ALF is in itself not sufficient to effectively meet the caring needs of the residents. Specialize understanding in the care of older adults and an ability to both articulate and support a philosophy which is oriented to wellness is also needed (Mason, 2003).

Data describing the perceptions of caring behaviors from elderly residents of ALFs may begin to supply important information supporting policy and practice in meeting the needs of this expanding and vulnerable population (Lowe et al., 2003). Additionally, Ross, O'Tuatahail and Stubberfield (2005) call for increased nursing leadership within the interprofessional arena. The research, which addressed multidisciplinary assessment of older people, found that working through others, being able to manage uncertainty and meeting unanticipated challenges were key themes which emerged in the change process. The significance of this study echoes the refrain that clinical change is a process born of nursing research and leadership (2005). Here is where the five dimensions of the CBI-E and the utilization of Watson's clinical processes could help to bridge the gap among the areas of theory, research and practice.

There is an apparent growth in the willingness of various stakeholders in society to begin to address the impending demographic shift with specific action. While nursing is represented in the collection of professionals who are working to address the needs of this growing vulnerable population, the issue of nurse caring behaviors is noticeably absent.

"Nurses have a significant opportunity - as well as a professional obligation - to help develop appropriate policies for assisted living and to shape the role of nursing, the delegation of responsibilities, and accountability in the care of residents" (Mitty, 2003, p.35).

Recommendations

Based on the findings of this study further utilization of the CBI-E within the Assisted Living Environment is suggested. This tool could be used for the collection of data for individual use or among all residents of a particular facility as a system review. Used in a serialized fashion, it could supply important longitudinal information to guide effective practice compared over time. Additionally, the CBI-E was developed to be administered to both recipients of care and providers of care. Although in this study, the focus was limited to the perceptions of the residents themselves, obtaining data from both residents and staff could provide important information to support a caring environment.

When utilized to measure individualized outcomes of caring behavior, an important reason for the development of the CBI-E, pairing both quantitative and qualitative observations could present a more thorough understanding of the data for each individual respondent. This triangulated use of the tool would address the problem which arises when a low score is obtained because the respondent doesn't see an item as needed rather than not perceiving the caring behavior itself. Additionally, exploration of both quantitative and qualitative data could enhance understanding across resident, family, and team members and perhaps reduce the barriers of cultural differences often seen as an issue in this study, and in the area of Geriatric Care in general.

Sustaining further research within the ALF environment supports amplified understanding of an individual's deficits and targets interventions based on knowledge to support independence and dignity. Caring begins with consciousness. Knowledge takes commitment. Both caring and knowledge combine to meet the moral imperative to support the ability to age in place, the essence of the ALF philosophy. Through the utilization of Watson's Caring Attending Nurse/Team Model combined with the individualized knowledge offered through the CBI-E, we can assist residents to *belong* and *become* the environment which Watson so eloquently champions (2005, p.96).

Conclusion

This study explored the perceptions of nursing team caring behaviors among residents in an assisted living facility for retired veterans to help build greater understanding concerning the importance of caring in an environment seldom studied. Guided by the theoretical model of the Attending Caring Nurse Team along with utilization of the Caring Behaviors Inventory for Elders, perceptions of residents were revealed and explored. Honoring the unity of the whole human being while attending to an environment which is healing and supportive may perhaps support the ability of residents to age in place. As dignity is supported by knowledge and the conscious utilization of the transpersonal relationship, nursing can truly potentiate healing and lead the team in authentic caring behaviors (Watson, 2006).

Appendix A

Personal Information Form: ALF Resident

Participant number: _____

Please circle the number under each category or fill in information that best describes your current life experience. (Your experiences within the last month.)

Age: _____ years

Gender:
1. Female
2. Male

Ethnicity:
1. African American
2. Asian American
3. White
4. Latino
5. Other _____

Marital Status:
1. Married
2. Single
3. Separated
4. Divorced
5. Widowed
6. Partner
7. Other _____

Religion:
1. Catholic
2. Jewish
3. Muslim
4. Protestant
5. Other _____

Personal Information Form: Page 2

Education:

1. 1st grade to 5th grade
2. 6th grade to 8th grade
3. 9th grade to 12th grade
4. High School Graduate
5. Some college classes without a degree
6. College degree
7. Other Schooling: _____

Length of time in Assisted Living Facility: _____years _____months

Level of Mobility:

1. Wheelchair
2. Walker
3. Cane
4. Ambulatory without assistance
5. Other _____

Level of Assistance:

1. Maximum assistance (100%) needed with bathing, dressing
2. Moderate assistance (66 %) needed with bathing, dressing
3. Minimum assistance (33 %) needed with bathing, dressing
4. No assistance (0 %) needed with bathing, dressing
5. Other: _____

Personal Information Form: Page 3

Health Status: How would you rate your current health status?

1. Poor
2. Fair
3. Good
4. Very Good
5. Excellent
6. Other _____

Nurse Caring Behaviors: Please tell me who, in your opinion, make up your caregiving team here at the assisted living facility?
(circle all that apply, do not use names)

1. The Registered Nurse (RN)
2. The Licensed Practical Nurse (LPN)
3. The Certified Nursing Assistant (CNA)
4. Other: _____

Appendix B

Caring Behaviors Inventory for Elders

Please read the list of items that describe ***nurse caring behaviors***. For each item, please ***circle*** the answer that shows how **often you felt that** any member of the nursing staff cared for you during your experience over the last month.

1. Carefully listening to you.	Rarely	Sometimes	Often
2. Helping you to feel at home.	Rarely	Sometimes	Often
3. Helping you and your family make decisions.	Rarely	Sometimes	Often
4. Calling you by your preferred name.	Rarely	Sometimes	Often
5. Being honest with you.	Rarely	Sometimes	Often
6. Assisting you to meet your religious or spiritual needs.	Rarely	Sometimes	Often
7. Helping you feel comfortable.	Rarely	Sometimes	Often
8. Recognizing how you feel.	Rarely	Sometimes	Often
9. Being patient with you.	Rarely	Sometimes	Often

10. Knowing how to give you needles, enemas, treatments, etc.	Rarely	Sometimes	Often
11. Adjusting to your limitations.	Rarely	Sometimes	Often
12. Appreciating your life story.	Rarely	Sometimes	Often
13. Speaking to you with a clear, friendly voice.	Rarely	Sometimes	Often
14. Knowing your likes, dislikes, and routines.	Rarely	Sometimes	Often
15. Checking on you.	Rarely	Sometimes	Often
16. Being pleasant with you.	Rarely	Sometimes	Often
17. Including you when planning your care.	Rarely	Sometimes	Often
18. Protecting your privacy.	Rarely	Sometimes	Often
19. Watching out for your safety.	Rarely	Sometimes	Often
20. Meeting your needs whether or not you ask.	Rarely	Sometimes	Often
21. Responding quickly to your call.	Rarely	Sometimes	Often

22. Appreciating you as a unique person.	Rarely	Sometimes	Often
23. Managing your pain.	Rarely	Sometimes	Often
24. Showing concern for you.	Rarely	Sometimes	Often
25. Giving your treatments and medicines on time.	Rarely	Sometimes	Often
26. Trying to relieve your ailments.	Rarely	Sometimes	Often
27. Standing up for your interests.	Rarely	Sometimes	Often
28. Giving you a hand when you need it.	Rarely	Sometimes	Often

Please identify how many minutes it took to complete this instrument in minutes. _____ minutes.

Appendix C

Caring Behaviors Focused Interview Guide*

*Based on the Caring Behaviors Inventory for Elders Tool (CBI-E) Wolf et al.(2004)

Five Dimensions of Nurse Caring	Open-ended Questions based on the Caring Behaviors Inventory for Elders
1. RESPECTFUL DEFERENCE to OTHERS (The incorporation of a courteous regard for others)	***Would you share with me your perceptions of how well you believe the nursing team helps you feel at home?*** **Nursing Team Members:** **a. Call you by name?** **b. Make you feel comfortable?** **c. Listen to you?** **d. Appreciate you as a unique person?** **e. Help you to make informed decisions?** **f. Include you in the planning of your care?**
2. ASSURANCE of HUMAN PRESENCE (The reflection of an investment in the other's needs and security.)	***Would you share with me your perceptions of how well you believe the nursing team shows concern for you?*** **Nursing Team Members:** **a. Respond quickly to your call?** b. **Know your likes and dislikes?** c. **Know your life story?** d. **Meet your needs whether or not you ask?** e. **Respond quickly to your call?**

3. POSITIVE CONNECTEDNESS (The indication of an optimistic and constant readiness on the part of the nurse to help the other.)	***Would you share with me your perceptions of how well you believe the nursing team is ready to help you?*** **Nursing Team Members:** **a. Recognize how you feel?** **b. Are patient with you?** **c. Help you with a pleasant manner?** **d. Watch out for your safety?**
4. PROFESSIONAL KNOWLEDGE and SKILL (Denotes nursing care which is proficient, informed and skillful.)	***Would you share with me your perceptions of how well you believe the nursing team knows your abilities and understands your needs?*** **Nursing Team Members:** **a. Are timely and skillful with treatments such as medications and needles?** **b. Try to relieve your aliments and manage your pain?** **c. Speaks to you with a clear and friendly voice?**
5. ATTENTIVENESS to the OTHER'S EXPERIENCE (Appreciation of and engrossment in the other's perspective and experience.)	***Would you share with me your perceptions of how well you believe the nursing team knows you as a unique individual?*** **Nursing Team Members:** **a. Stand up for your interests?** **b. Give you a hand when you need it?** **c. Try to relieve your ailments?** **d. Help to make you feel comfortable?**

	Would you care to share any additional thoughts or concerns you may have regarding your perceptions of nursing team caring behaviors?

Appendix D

THE CATHOLIC UNIVERSITY OF AMERICA
School of Nursing
Washington, D.C. 20064
202-319-5400
FAX 202-319-6485

Invitation to Participate in a Research Study

Dear Resident,

You are invited to participate in a study to describe the perceptions of nursing team caring behaviors among residents of an assisted living facility for retired veterans. You have been invited because as a resident who is 65 years of age or older and have resided within this assisted living facility for at least 2 months, you meet the criteria of the study. This study is being conducted as a part of an educational program at The Catholic University of America School of Nursing. Through this study, we hope to better understand the nurse caring needs of residents who reside in assisted living facilities. Your participation in this study may assist other residents in similar situations by increasing our understanding of your experience through your descriptions of the nurse caring behaviors you receive.

If you choose to participate in this study, you will be asked to respond to 28 questions on a form which describes caring behaviors. In addition, there may be an opportunity to share your thoughts concerning caring behaviors which you have experienced within the assisted living environment in a taped interview. You will also be asked to provide some information about yourself such as your age, gender, marital status, ethnicity, religion and education.

You may withdraw from the study at anytime. Participation or withdrawal will not interfere with the care you receive as a resident in the assisted living facility. The information you share during the study will be handled in a responsible manner and will be kept as confidential as possible. Your identification will be kept separate from your responses. The information will be protected against release to unauthorized people.

To participate, please sign the informed consent form included with this letter.

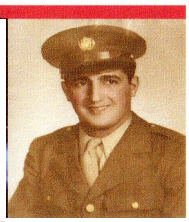
Thank you,

Lisa C. Jordan PhD(c), RN
Cell phone: 301-332-0090
The Catholic University of America
School of Nursing

Appendix E

Invitation to Volunteer Postcard

VOLUNTEER!!!



You may contact me. I am willing to take part in this study.

_____

Signature

_____

Date

Please place this card in the box located near the elevator.
Or call: Lisa Jordan RN (240-479-0441)

Appendix F

THE CATHOLIC UNIVERSITY OF AMERICA
School of Nursing
Washington, D.C. 20064
202-319-5400
FAX 202-319-6485

INFORMED CONSENT FORM: Resident

NAME OF STUDY: The Perceptions of Nurse Caring Behaviors Among Residents of an Assisted Living Facility for Retired Veterans.

INVESTIGATOR: Lisa C. Jordan, PhD(c), RN
Doctoral Candidate

SUPERVISOR: Sister Mary Elizabeth O'Brien, PhD, RN, FAAN
Telephone: (202)-319-6459

QUESTIONS: Lisa C. Jordan
Telephone: 301-493-6156
e-mail: 29jordan@cua.edu

DESCRIPTION AND PURPOSE OF THE STUDY: I understand that I am being asked to participate in a research study. I understand that the purpose of this study is to describe the perceptions of nurse caring behaviors among residents of an assisted living facility for retired veterans. The results of this study may provide information which could assist in the improvement in caring behaviors currently provided to residents in such an assisted living facility. This study is being conducted in an assisted living facility for retired veterans located in the mid-Atlantic region of the United States. I understand that this study is being carried out to fulfill partial requirements for a Doctor of Philosophy Degree in Nursing at The Catholic University of America School of Nursing.

DESCRIPTION OF PROCEDURES: As a retired veteran who is at least 65 years of age, I am being approached for participation in this study. As a resident of an assisted living facility for retired veterans for at least two months, I qualify to participate. The researcher has discussed the study and reviewed the informed consent with me. The investigator has my permission to verify my date of arrival as a resident of this facility. I will be asked to respond to 28 questions on a form which describes caring behaviors. In addition, I may be asked to share my thoughts in a taped interview concerning caring behaviors I have experienced as a resident within the assisted living environment. I am aware that I will be

requested to give some personal information such as my age, gender, marital status, ethnicity, religion and education. I understand that my personal information will be kept separate from my answers to protect my privacy.

FORESEEABLE RISK, INCONVENIENCES, OR DISCOMFORTS: I understand that participation in this study is voluntary. I understand that no risks are anticipated as a result of my participation in this study. I understand that I can request to discontinue my participation from this study at any time and for any reason and it will not affect my care in any manner.

BENEFITS THAT MAY OCCUR: I understand that there are no immediate benefits from my participation in this study. By sharing my perceptions of nurse caring behaviors, I understand there is the potential to influence the process by which nurse caring behaviors are provided to residents of assisted living facilities. I understand there is no monetary compensation for my participation in this study.

CONFIDENTIALITY OF SUBJECT IDENTITY/RESEARCH RECORDS: I understand that the questions asked do not identify me by name. I understand that my privacy will be secured by keeping my personal data separate from my responses. I understand that all information obtained as a result of participation in this study will be kept as confidential as legally possible. I understand that all information obtained as a result of this study will be presented in a group format which identifies no individual specifically.

USE OF AUDIO EQUIPMENT AND SUPPLIES/STORAGE OF STUDY TOOLS: I understand that all study materials will be stored under lock and key for five years at a secured location controlled by the investigator after which time they will be destroyed. I understand that identifying data such as those obtained on the informed consent will be kept separate from the questionnaires and interview transcriptions. Only the investigator will have access to the documentation related to this study.

TERMINATION OF PARTICIPATION: I understand that participation in this study is entirely voluntary. I understand that I may refuse to participate and can withdraw my consent at any time during the study without penalty in any manner. I understand that I may refuse to answer a particular question if I so choose.

I understand that any information obtained as a result of my participation in this research study will be kept as confidential as legally possible.
I have had the opportunity to ask any questions about the research and about my participation in the research, and these have been answered to my satisfaction.
I understand that I may receive a signed copy of this consent form if I so choose.
I volunteer to participate in this study.

_____	_____
Participant's Signature	Investigator's Signature
_____	_____
Date	Date

Any complaints or comments about your participation in this research project should be directed to the Secretary, Committee for the Protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, DC 20064; Telephone: (202) 319-5218.

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