Nurses’ Perception of Caring Using a Relationship-Based Care Model

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Abstract

Throughout its history caring has been a central tenet to the practice of nursing. Despite the significance of caring, multiple factors today threaten the ability of nurses to engage in caring and compassionate roles. The evolution of nursing science and emphasis on evidence-based practice have contributed to a shift from holistic care to a more technically oriented practice contributing to an erosion in the ethos of compassion (Straughair, 2012). Socioeconomic factors may play a role by students who enter the profession for non-altruistic reasons including salary and job security (Straughair, 2012). This trend is coupled with an underlying organizational culture and fast-paced unpredictable work environment which challenge the ability of the nurse to engage in caring relationships (Koloroutis & Trout, 2012; Straughair, 2012).

A model on Relationship-Based Care (RBC) was developed as a method for transforming the health care environment to facilitate patient-centered, relationship-based care (Koloroutis, 2004). At the center of relationship-based care is the concept of caring. Based on the Theory of Human Caring by Watson (1988) and the middle range Theory of Caring by Swanson (1993), the model includes dimensions of leadership, teamwork, professional practice, care delivery, resources, and outcomes (Koloroutis, 2004).

While considerable research has examined patient perceptions and outcomes in response to caring, only two studies examined nurses’ perception of caring when using a relationship-based care (RBC) model. Winsett and Hauck (2011) observed statistically significant increases in both verbal and nonverbal caring behaviors by nurses between the pre-implementation and the 3-month and 12-month post-implementation periods of RBC using the Caring Behaviors Checklist. Porter, Cortese, Vezina, and Fitzpatrick (2014) found that participants had high perceptions of caring behaviors following implementation of a caring, professional practice model using the Caring Behavior Inventory 24 (CBI-24).

This study extends what is known about nurses’ perception of caring using the Caring Assessment for Care Givers (CACG) instrument, a valid and reliable instrument. Unlike the CBI-24 which has been used with both patients and nurses, the CACG instrument was developed specifically for use with nurses in settings that use a RBC model. Using the CACG, nurses’ perception of caring will be examined including the dimensions of caring that nurses report as most and least important. Additionally, the relationship between nurses’ perception of caring will be explored for nurses who care for chronically ill, medical patients versus acutely ill, surgical patients. No previous research was identified which explored the relationship between nurses’ perceptions of caring and the specialty area of practice when using a RBC model. Nurses who work with chronically-ill, medical patients who have a longer length of stay or recurrent hospitalizations may have greater opportunity for the development of nurse-patient connectedness, contributing to an overall higher perception of caring.

A cross-sectional, descriptive, and correlational design will be used. All registered nurses who provide direct patient care on medical-surgical units of a Midwestern medical center will be invited to participate.

Demographic results found that the typical respondent was female (90.4%), Caucasian (73.4%), 36.4 years of age, and held a baccalaureate degree (61.7%). Using the CACG, nurses reported a high perception of caring (4.29 out of a possible 5.0). The subscale, doing for, had the highest score while the subscale, knowing, had the lowest score followed closely by the subscale being with. No significant difference was found between nurses who work with chronically ill versus acutely ill patients (t = .923), df = 83, p = .358). A small to moderate, positive relationship was found between the overall nurses’ perception
of caring score and the years of experience in nursing ($r = .29$, $p < .01$). There was no relationship found between the overall nurses' perceptions of caring score and the highest level of nursing education.

The finding of a high perception of caring using a RBC model is consistent with previous studies. The CACG subscale, doing for, describes the care nurses provide for patients who are unable to provide for themselves more technically oriented behaviors. This finding is consistent with previous research. Porter, Cortese, Vezina, and Fitzpatrick (2014) found the highest perception of caring on the subscale for knowledge and skills. While direct comparison between the subscales on the CBI-24 and the CACG cannot be made, findings from both studies suggest that nurses highly value clinical knowledge and skills.

The CACG subscale, knowing, focuses on the nurse's desire to understand events of those in the nurse's care while the subscale, being with, described the nurse's ability to be emotionally present to others. Using the CBI-24, Porter, Cortese, Vezina, and Fitzpatrick (2014) found the lowest score on the subscale of positive connectedness. While direct comparison between the two instruments cannot be made, results from both studies may reflect the challenge that nurses perceive in fully meeting the therapeutic demands of individuals and families given required job expectations, unpredictable events, or other personal and external factors in a fast-paced, intensive, and complicated clinical environment.

The study found no significant relationship between nurses' perception of caring and the area of nursing practice. Nurses who work on medical units with chronically ill individuals are confronted with similar obstacles to the development of therapeutic relationships as are nurses who work on surgical units. It may be these challenges rather than the opportunities to build longer or ongoing relationships that account for the lack of a relationship in nurses' perceptions of caring. The finding that older, more experienced nurses report higher perceptions of caring suggests that caring might be a skill that can be enhanced through situation-based, experiential learning that occurs with longer clinical practice.

The nurse is the single most important healthcare provider for patients during hospital encounters. It is the nurse who coordinates and communicates with the health care team regarding the patient's plan of care, monitors and assesses for changes in the patient's status, and serves as a patient advocate for changes in the health care plan. Nurses need to recognize the importance of their caring behaviors on patient advocacy. Nurse caring has been found to be a major factor in the patient's intention to recommend or return to a health care facility which poses implications for the financial well-being of the health care facility (Burtson & Stichler, 2010).

While nurses report an overall high perception of caring, lower mean scores on the subscales of knowing and being with suggest that there is still room for improvement. Nursing leadership along with hospital administration should maintain or enhance programs to support use of the relationship-based care practice model. Approaches could include recognition programs for staff who demonstrate exemplary, compassionate patient care. Recognizing nurses for their exemplary care signifies a valuing of the behavior by administration and encourages continued growth of a therapeutic, caring environment.

Title:
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References:

Burtson, P.L. & Stichler, J.F. (2010). Nursing work environment and nurse caring:
Abstract Summary:

Studies are lacking which examine nurses’ perception of caring when using a relationship-based care (RBC) model. This study examines nurses’ perception of caring including the dimensions of caring that nurses report as most and least important using the Caring Assessment for Care Givers instrument (CACG).
Content Outline:
Nurses’ Perception of Caring Using a Relationship-Based Care Model – Outline

I. Obstacles to Caring
   A. Shift to technically oriented clinical environment
   B. Possible selection of nursing as a career for non-altruistic factors
   C. Fast-paced, unpredictable work environment
   D. Time constraints, inadequate staffing, difficult patient circumstances
   E. Personal judgments that cloud objectivity

II. Relationship-based Care Model (RBC) developed to enhance caring and relationships with self, patient, colleagues
   A. Framework – Mid-Range Theory of Caring by Kristen Swanson

III. Previous Studies on Nurses’ Perceptions of Caring Using a RBC Model
   A. Winsett & Hauck (2011)
   B. Porter, Cortese, Vezina, and Fitzpatrick (2014)

III. Research Questions
   A. What are nurses’ overall perceptions of caring when using a RBC Model?
   B. What dimensions of caring do nurses report as most and least important using The Caring Assessment for Care Givers (CACG) instrument?
   C. Is there a relationship between nurses’ perception of caring for nurses who work with acutely ill versus chronically ill patients?

IV. Methodology
   A. Cross-sectional, descriptive and correlational design
   B. Survey of nurses providing direct patient care on medical-surgical units of Midwestern medical center
   C. Instrument – Caring Assessment for Care Givers (CACG) instrument
V. Results

A. Nurses reported overall high perception of caring (CACG 4.29 out of possible 5.0)

B. Of five CACG subscales, the subscale for “doing for” had the highest overall score while the subscales of “knowing” had the lowest overall score.

C. There was no significant different in nurses’ perception of caring on the subscale “being with” for nurses who work with acute versus chronically ill patients; there was a small to moderate relationship ($r = .29$, $p<.01$) between nurses’ perceptions of caring and the years of experience.

VI. Discussion & Implications

A. Role of nurse in patient caring – benefits to patients & nurses

B. Role of nurse in patient advocation

C. Support of caring – ongoing education, administrative support

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