The Influence of Social Support on Perception of Nurse Caring and Patient Satisfaction

among CHF Patients in the Emergency Department

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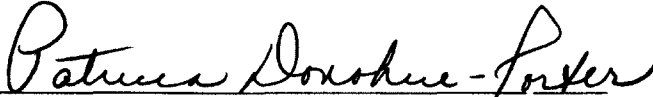
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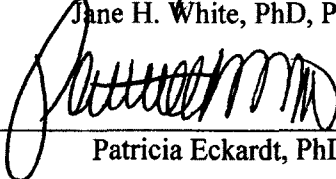
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Abstract

The Influence of Social Support on Nurse Caring and Patient Satisfaction among CHF Patients in the Emergency Department
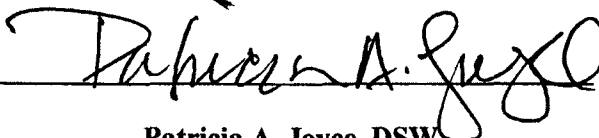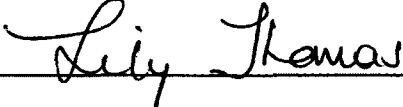
Heart failure patients who visit the Emergency Department often because of chronic nature of their illness require a specific plan of care. Successful engagement requires that nurses identify and act on factors to facilitate transition across the care continuum. This study was undertaken to examine the relationship of three major quality care indicators: social support, perception of nurse caring, and patient satisfaction among patients with heart failure admitted to the emergency department. The study further explored the association of these indicators with demographic and illness variables of the study participants.

The Quality Caring nursing framework was used as the theoretical framework for the study. A total of 115 adult participants, 71 males and 44 females who were admitted in the emergency department of two public hospitals in the mid-Atlantic region of the United States were recruited. Data were collected using a survey package consisting of four instruments: the Medical Outcomes Study (MOS) Social Support Survey measuring perceived social support, the Caring Assessment Tool (CAT) measuring nurse caring, and the Consumer Emergency Care Satisfaction Scale (CESS) measuring satisfaction with care in the emergency department.

Although the major study hypotheses that high levels of social support would be associated with caring and with patient satisfaction were not supported, there were significant associations found between aspects of social support, caring measure and the demographic and illness measures such as marital status and the number the number of household members. Also, those who were employed perceived more social support than those who were unemployed and those who were retired had a significantly higher perception of caring.

These findings challenge nurse clinicians, educators, and administrators to further investigate the roles of social support, caring and patient satisfaction in multiple aspects of chronic illness.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Although there are a number of factors that affect both how patients perceive their

care and how satisfied they are with care, social support as a related factor has not been

studied in depth. Social support is defined as the interpersonal supportive transaction or

behaviors that involve giving and receiving assistance from others throughout the course

of life (Khan, 1979; Cobb, 1976). These early definitions gave rise to such contemporary

models of social support such as Fingfeld-Connett's description of it as an advocative

interpersonal process (2005). Because social support in healthcare has been shown to

significantly improve a patient's wellbeing (Finfgeld-Connett, 2005; Hutchinson, 1999;

Koivula, Paunonen-Ilmonen, Tarkka, & Laippala, 2002; Masters, Stillman, & Spielmans,

2007), the importance of addressing how it might also influence patient perception of

nurse caring and patient satisfaction has been realized and is the focus of this study.

Patient satisfaction has received a significant amount of attention in the lay and

professional literature. In nursing, patient satisfaction has been shown to be related to

multiple factors that will be discussed later (Jurgens, Dumas, & Messina, 2007; Luttik, et

al.,2005; Muntlin, Gunningberg, & Carlson, 2006; Sayers et al., 2008) however patients'

perception of the care they receive from nurses is critical to patient satisfaction (Muntlin

et al., 2006). Caring behaviors are often associated with patient satisfaction and are measured as an indication of quality nursing care (Clancy, 2007; Duffy & Hoskins, 2003).

The Emergency Department is one area in which patients receive care, as well as where hospitals collect information on patient satisfaction; the impact of these factors on the Emergency department however has not been empirically examined as much as in the other patient care units. An emergency department visit can be the most traumatic experience for patients (Kennedy, Rhodes, Walls, & Asplin, 2004; Wilkin & Slevin, 2004). A number of factors including long wait and perceived poor caring behaviors have been studied that positively influence this event (Bradley, 2005; Jensen & Crane, 2008; Wiman & Wikblad, 2004). Although social support has been shown to significantly affect patients' recovery in a number of studies, it has not received much attention as an influential factor in the emergency room, one that might affect the experience for patients and how patients view nursing care and how satisfied they are with their care. Thus, this investigation will address the importance of social support as an influence on patient satisfaction and perceived nurse caring in the Emergency Department.

Patients with heart failure visit the emergency department frequently (Jurgens, Moser, Armola, Carlson, Sethares, & Riegel, 2009; Luttik et al., 2005; Sayers, Riegel, Pawlawski, Coyne, & Samaha, 2008). The literature is replete with recommendations on effective management of patients with chronic heart failure who frequently visit the emergency department. Specifically, this management calls for the understanding of the perspectives of the patients and their care givers by health care personnel and nurses in

particular. Patients with heart failure who visit the emergency department require complex therapeutic regimens as well as the caring support of health care providers and their significant others. Heart failure patients were selected as the target population in this study.

Because a number of patient and demographic variables can affect social support especially those associated with chronic illness and may also influence patients' perception of their emergency department experience, information on selected relevant socio-demographic and illness factors were collected. For the purpose of this study, chronic illness variables are defined to include those attributes associated with heart failure that may impact a patient's quality of life such as living arrangement and length of illness as well as the number of prior emergency department visits (Green et al., 2000).

Purpose

The purpose of the study was to explore the effect of social support on patient satisfaction and nurse caring for a group of patients with heart failure in an emergency department setting.

Background and Scope of the Problem

The concepts of social support, caring and satisfaction are relevant to nurses as both factors have strong impact on health maintenance, adaptation to chronic illness, and recovery from acute illness conditions (Finfgeld-Connett, 2007; Hutchinson, 1999). Perceptions of caring support by individuals with chronic illness conditions including heart failure have been known to improve adherence to treatment regimens and overall

satisfaction with care (Laschinger et al., 2005; Lynn et al., 2007; McCance, Slater &
McCormack, 2008; Sherbourne & Stewart, 1991).

Social support involves interpersonal relationships among a network of
individuals who seek and receive help from one another in order to cope with a given
stressful situation. Although the definition of social support varies among psychology
experts, the types of social support that are widely accepted include: emotional support
which involves caring, love, and empathy and instrumental or tangible support involves
provision of assistance, physical, financial and others. The third component,
informational support, involves guidance or feedback that can provide a solution to a
problem (Cobb, 1976; Sherbourne & Stewart, 1991). Beyond assessing heart failure
patients for the presence and sources of social support, it is necessary that nurses provide
care for these patients in a manner that embraces caring and support that patients and
their families can appreciate.

Caring has been described as the central element of nursing practice. It is an
outcome of a dynamic interpersonal relationship between the person who cares and the
one cared for, as they engage in a mutual dialogue that evokes feelings of empathy and
compassion (Watson, 1988). Perception of caring influences care outcomes, including
compliance with treatment regimens and self-care ability among advanced heart failure
patients who by virtue of their disabling symptoms often depend on others to meet their
care needs (Abdullah, Suliman, Ahmed, Lalji, 2007). While caring is considered to be
the hub of patient-centered care, perspectives on what constitutes caring vary between
providers and care recipients. Healthcare providers tend to view quality care from the
perspective of clinical outcomes, including the diagnosis and treatment of ailments;

consumers' definition of quality tends to focus on the humaneness of the care delivery

process. This dichotomy is evident in the results of quality assessment surveys that often

stress consumer perceptions and satisfaction (HCAHPS, 2009).

Patient satisfaction is a critical performance indicator in the emergency

department where acutely ill patients who seek care are often exposed to a number of

distressing factors including navigating the complex and bureaucratic healthcare system,

while worrying about the appropriateness of care, treatment outcomes, and the prognosis

of illness. Complaints about poor quality care loom as emergency departments have

become inundated with high volume, increased acuity, and at the same time experience

shrinking resources. The pressure on the emergency departments to deliver quality care

even amidst shrinking resources has prompted the implementation of universal measure

of quality standards that require patients' involvement in their care. Accordingly, patient

satisfaction assessment has become a gold standard for quality measurement across

healthcare institutions. A major aspect of patient satisfaction surveys is a patient's

perception of the level of humanistic caring and person-centeredness with which nursing

care is rendered. The principle of person-centeredness recognizes the rights of

individuals as persons, mutual respect and understanding, and the development of

supportive and therapeutic relationships among patients and their significant others

(McCance, Slater, & McCormack, 2008).

Suffering from debilitating chronic illnesses that require frequent visits to the

emergency department with hospital admissions, and complex treatment regimens can be

an anxiety provoking for patients and their loved ones. Chronically ill patients who visit

the emergency department often report general dissatisfaction with care as well as

uncaring attitudes by the emergency department staff (Boudreaux & O'Hea, 2004;

Muntlin, Gunningberg, & Carlsson, 2006). Heart failure patients are especially

vulnerable because they often present with significant functional impairment, reliance on

others for caring support, and a high degree of medical burden to themselves and their

loved ones. As a chronic condition without cure, the goals of management of heart

failure for patients are the prevention of disease progression and alleviation of suffering

(Green, Porter, Bresnahan, & Spertus, 2000) through caring support. The outcome of this

study's findings may be utilized to improve the standards of nursing care for vulnerable

patient population groups such as heart failure patients, thereby reducing illness burden to

patients and their significant others, and reducing the cost of care.

Theoretical Framework

The Quality-Caring Model

The Quality Caring Model (Duffy & Hoskins, 2003) provides a unique blend of

the phenomena of quality health and human caring, both of which have been known to

share similar characteristics. See Figure 1. The model describes the concepts that impact

the caring perceptions of individuals in a structure-process-outcome framework, by

integrating the biomedical, environmental, and psycho-spiritual factors that are common

in quality healthcare and nursing practice. It is a refinement of the work of key nurse

theorists on caring including Watson, and is based on the belief that individuals are multi-

contextual beings who are situated in a complex pluralistic world. The model's

grounding in the structure-process-outcome quality framework that is widely used by

regulatory agencies makes it applicable to nursing care situations.

The Quality-Caring Model is based on the notion that perception of quality is directly associated with perception of caring and satisfaction with care. While the concept of caring may be difficult to measure, quality outcomes are commonly represented by tangible and measurable patient care indicators. The high degree of association between quality, caring, and satisfaction with care from the consumers' perspective makes the use the Quality-Caring Model most appropriate for use in this study. In addition, use of the Caring Assessment Tool (CAT), a comprehensive tool developed from the model enhances measurement accuracy.

The structural component of the model utilizes the construct of 'causal past' and the concept of 'participants' to highlight the influence of factors that existed in the patient's world prior to his/her caring experience. Causal past is used to represent the influence of the participants in the patient's world with whom the patient had interacted in the past, and may include family members, various healthcare providers, and the health care system in general. Each individual or entity acting as a participant is depicted as possessing unique attributes and characteristics which constitute their causal parts and influence their perspectives or "phenomenal field". The patient as the focus of this structure is influenced by the participants as well as by his/her personal and unique life experiences and issues.

The process component is perhaps the most important component of the model for this study as it is focuses on intervention or practices that the healthcare providers offer. A process is defined as what is done for the patient and is comprised of two categories of activities, technical and interpersonal. Although the process component emphasizes the technical and interpersonal abilities of the health care providers, it recognizes the

multidimensionality and nonlinearity of nursing practice. It acknowledges that the human interpersonal systems are complex and influenced by individuals' values, perceptions, communication, transactions, roles and stress. The process component not only highlights the goal-oriented interpersonal relationships between the nurse and the nursed, it presents the view of nursing as a discipline with three roles that impact the outcome of patient care: independent, dependent, and interdependent roles.

The third component of the Quality-Caring Model is outcome, derived from the early model on Human Caring, and is described as the end results of health care. Outcomes fall into two categories. Intermediate outcomes represent a change in the patient/family's behavior, emotions, or knowledge that can impact the outcome and often include care plan goals, clinical pathways, and thoughts about the health care process. Terminal outcomes are the major end-result concepts such as quality of life, costs of care, and satisfaction with care and personal growth.

Both intermediate and terminal outcomes have reciprocal interactions and are affected by the same sub-concepts of participants (patient/family, provider, and system) which comprise the structure components of the model. Outcomes are dynamic and can be continually improved; the success of outcome realization is dependent on the balance between independent and collaborative relationships that compromise professional encounters (Duffy & Hoskins, 2003).

In summary, this model serves as a useful framework for understanding the relationship healthcare consumers attach to support by others, quality, and caring, all of which combine to drive patient satisfaction. The model's key components of structure, process, and outcome bring familiarity to clinicians and researchers who have become

conversant with using these concepts in their routine performance improvement

measures. In a rapidly changing world of health care information, navigating the health

care system and treatment options has become increasingly complicated for patients with

chronic health problems. Accordingly, the primary focus of treatment has shifted to

health care empowerment, the process and state of being engaged, informed,

collaborative, committed, and tolerant of uncertainty regarding health care (Johnson,

2011). Perhaps, one of the best features of the Quality-Caring Model lies in its

recognition of the dynamic nature of human relationships, as well as the multiple factors

that influence individuals' perceptions of caring, quality, and satisfaction with care.

Applying the Quality Caring model can assist the emergency department nurse in

assessing and providing useful informational support for patients experiencing difficult-

to-predict health outcomes.

Figure 1

The Quality-Caring Model

Structure	**Process**	**Outcome**
(Causal Past)	**Caring Relationships**	**(Future)**
Participants		**Terminal Outcomes**

Provider

Phenomenal Field

Descriptors

Unique Life Experience

Attitudes and Behaviors

Patient/Family

Phenomenal Field

Descriptors

Unique Life Experience

Severity of Illness

Co-morbidities

System

Phenomenal Field

Descriptors

Staff mix/Workload

Interdependent Relationships

Patient/Family-Nurses
(Discipline-specific)

+

Collaborative Relationships
Healthcare Team-Nurse
(Multidisciplinary)

Provider
Satisfaction
Personal growth

Patient
QOL
Safety
Disease-specific
Satisfaction
Knowledge

System
Utilization
Resource
Consumption
Readmission
Costs
LOS

Intermediate Outcomes
Feel "cared-for"

Duffy, Hoskins, & Seifert 2007 (with permission)

Definitions of Variables

Based on the Quality Caring Model and other selected relevant theories, the

following are identified as the major study variables and are defined as follows:

Nurse caring in the emergency department is defined as deliberate, competent,

and humane nursing actions or behaviors in which the identification, validation, and

alleviation of the patient/significant other's concerns is the primary focus. In the Quality

Caring Model, **the nurse** is defined as the provider of care and as a participant in a structure of both independent and collaborative relationship with the patient, his family, and members of the health care discipline.

Social support is defined as the interpersonal supportive transaction or behaviors that involve giving and receiving assistance from others throughout the course of life (Cobb, 1976; Khan, 1979; Norbeck, & Tilden, 1988). In the Quality Caring Model, and within the Process component, the patient, his family, and the nurse are engaged in an interdependent relationship utilizing the informational component of social support as one process or intervention that is critical in this relationship.

Patient satisfaction is identified as an outcome or an end result of care within the Quality Caring Model (Duffy & Hoskins, 2003). Patient satisfaction as a terminal result is impacted by positive changes in patients' behaviors, emotions, perceptions, or knowledge that result from the interaction between the patient/family, the health care, and the system. Also in this model, patient satisfaction subsequently impacts future patient expectations.

Chronic illness variables are attributes of chronic illnesses including physical limitation, symptom severity, social intrusiveness, and self-efficacy factors that impact the quality of life among the chronically ill as well as how they perceive situations. Chronic illness variables for the CHF patients in this study include certain issues of social interaction that significantly alter a patient's life style (Green et al., 2000).

The emergency department is viewed in the Quality Caring Model as the system in the structure component. The emergency department as a phenomenal field or system provides the context in which the interdependent and collaborative relationships occur.

Variables in the emergency department care setting such as staffing mix and workload have impact on the caring relationships and care outcome for patients.

The patient in the Quality Caring Model, for this study, experiencing a specific disease of heart failure, who by the nature and severity of the illness as well as the reliance on a complex emergency department care environment, is vulnerable and requires caring support by family, nurses, and members of the interdisciplinary healthcare team.

Significance of the Study

This study examines the correlation between social support, perception of nurse caring, and patient satisfaction with nursing care. It was premised on a notion that meeting the care expectations of chronically ill patients, including patients with heart failure through identification of issues of care and provision of caring support can improve patients' satisfaction and overall health outcomes. Patient satisfaction is a crucial component of quality care that healthcare facilities strive to maintain in order to deliver excellent patient care and remain competitive in the health care market. The relationship between patients' perception of quality care including clinical care outcomes and patient satisfaction are well documented (Palese, Tomietto, Suhonen, Efstathiou, Tsangari, Merkouris, Jarosova, Leino-Kilpi, Patiraki, Kalou, Balogh, & Papastavrou (2011); Rafil, Hajinezhad, & Haghani, 2008; Wolf, Miller, & Devine, 2003). What does warrant exploration is the impact of unique and subtle aspects of social support during chronic illness and a detailed appraisal by patients of the care they receive. As part of its social mandate by the public, nursing has a key role in patient satisfaction through

ensuring holistic care that meets the physiologic and psycho-social needs of individual patients. The goal of this study is the development of effective nursing management that would lead to improved patient satisfaction, reduced cost of care, improved self care, and enhanced overall quality of life among patients with chronic heart failure.

While the concepts of social support, caring, and patient satisfaction have been widely studied as important factors in patient recovery and positive nursing outcomes, the impact of these variables on vulnerable heart failure patients admitted in the emergency department has not been adequately explored. Explicating these variables and incorporating them in the management of heart failure patients may yield improved outcomes, self-care, and quality of life among patients with heart failure. Improving the standard of nursing care for a vulnerable patient population of heart failure patients may reduce illness burden to patients and their significant others, and reduce the cost of care. This study is aimed at uncovering those issues that impact treatment outcomes of heart failure patients and by doing so advance nursing science.

CHAPTER II

LITERATURE REVIEW

This review of literature highlights important theoretical and research literature related to the study variables: social support, nurse caring, and patient satisfaction. Because the population chosen for this investigation was the heart failure patient, the literature on heart failure is synthesized. The setting for this study was the Emergency Department (ED) and therefore key literature about such departments that affect heart failure patients' frequent stays in the ED and especially those that may influence social support are described. Lastly, a critique of the reviewed literature is presented highlighting gaps in knowledge related to the purpose of this investigation.

Social Support

Social support is defined as the interpersonal supportive transaction or behaviors that involve giving and receiving assistance from others throughout the course of life (Cobb, 1976; Khan, 1979). A review of literature indicates that social support, social networks, and social integration are used interchangeably to describe the role of social relationships in health and well-being (House, Umberson, & Landis, 1988). Social support theories postulate that individuals belong to dynamic social networks that exists at all levels and throughout life course (Khan, 1979). The nature of assistance can be emotional, instrumental, informational, or appraisal (Khan, 1979). Social support can be actual/tangible or perceived; perceived social support is the individual's belief that assistance and support is available on an as needed basis (Khan, 1979; Masters, Stillman, & Spielmans, 2007). People who perceive social support cope better with stressful

situations such as illness exacerbation (Koivula, Paunonen-Ilmonen, Tarkka, & Laippala, 2002; Masters, Stillman, & Spielmans, 2007). All persons are said to need some form of social support in the course of life; the level of support needed in time of stress and chronic illness conditions is often intense.

Social support theories describe social networks as including significant others to an individual, including immediate family members, friends, other relatives, health care professionals, and members of other social groups such as churches and community groups (Pagana, 1990; Norbeck & Tilden, 1988). While the structure and processes by which social relationships affect human health and well-being are not fully understood, there is mounting evidence that social support can reduce life stress, including mortality, morbidity, psychosocial stress, and stress from other health hazards (House et al., 1988). Social support is associated with enhanced self-care ability and overall positive outcomes in the chronically ill and especially among heart failure patients (Evangelista & Shinnick, 2008; Dunbar, Clark, Quinn, Gary & Kaslow, 2008). Heart failure patients without a supportive family and those who live alone were reported to be socially isolated and vulnerable to poor self care practices (Dunbar et al., 2008).

The growing number of patients with chronic illnesses requiring complex treatment regimens has prompted a focus on improving the effectiveness of chronic illness management using a patient- centered system (IOM, 2001). Although definitions may vary, patient-centered care stresses patient participation in decision making and individualization of treatment plans based on patient/family situations. By virtue of its therapeutic relationship with patients and by its social mandate, the nursing profession has a major role in ensuring collaborative goal-setting that supports patients' participation

in their care. Nurses are in the best position to assess unique patient care circumstances while providing support that heart failure patients need to manage and cope with their disease.

Social Support and Chronic Illness

A thematic analysis of several publications that examined the challenges and caring processes related to heart failure was conducted by Hopp, Thornton, and Martin (2010). The authors in this study reviewed over 1,500 articles, 848 of which were selected as meeting the inclusion criteria for the study. The authors reported lack of caring support from health care staff and social isolation as having the most negative impact on heart failure patients who often became distant from close friends due to their limitations in social life. These patients reported feeling compelled to depend on others for help to stay connected to their social world. In this study, patients' description of their social system included relationships with significant others, including their care givers.

In another study that explored the impact of social support on outcomes in heart failure patients, Luttik et al., (2005) concluded that social support is essential for adjustment of heart failure. Using a framework that viewed social support as consisting of three categories of social integration, social networks, and relational content, the study examined care outcomes as measured by hospital readmission, mortality rate, quality of life, and depression rate among heart failure patients. Seventeen articles that examined the relationship between social support and outcomes of care over a period of ten years were reviewed. Lack of social support was reported to be a strong predictor of hospital readmission, and mortality in heart failure patients. Emotional support, a component of

relational support, was reported as playing a major role. In the same study, it was found that heart failure patients with spousal support experienced reduction in the number of hospital readmission episodes. The authors further recommended that research on support for heart failure patients include a focus on patients' caregivers who may experience stress in caring for these patients.

In a study of the effects of social support and self-care among patients with heart failure, Sayers et al. (2008) reported that family members were often involved in the medical care of patients with chronic heart failure and provided a range of support to patients. To test the direct impact of social support on self-care, 74 patients with heart failure participated in semi-structured interviews. The investigators concluded that for heart failure patients whose relatives and care providers were involved in various medical tasks, they were more likely to engage in self-care, including medication adherence, symptom monitoring, and dietary adherence.

Social Support in Heart Failure Patients

While family influences have been positively associated with self-care ability and overall treatment outcomes in patients with heart failure, patients with heart failure often require complex treatment regimens that place demand on patients and their care givers in terms of knowledge, cooperation, and active participation (Evangelista & Shinnick, 2008). In their overview of current evidence related to adherence and self-care behaviors among heart failure patients, Evangelista & Shinnick (2008) recommended that effective nursing intervention integrates strategies to motivate, empower, and encourage patients to make informed decisions and to assume responsibility for their care. This review included 22 descriptive studies on adult heart failure patients that reported levels of

performance of self-care behaviors in accordance with current treatment guidelines. In addition, the review included randomized clinical trials in which nurses took a primary role in the disease management program.

A mixed method study investigation on the reasons elderly patients with heart failure often delay response to symptoms of heart failure found multiple factors including lack of social support to be the causes of delay in seeking health care (Jurgens, Hoke, Byrnes, & Reigel, 2009). Although the study reported that social factors were not the predominant reason the 77 heart failure patients, sixty-five years and older, ignored their symptoms, several of the participants reported reluctance to seek care because of social and family-related issues. Specifically, the study cited instances in which family members were instrumental in initiating access to the medical centers for consultation and treatment. While the aim of the study was to raise awareness of the importance of involving patients and their significant others in the education about disease process and management, the importance of positive social support by immediate family members and others was also demonstrated.

A pilot study to test the efficacy of a Shared Medical Appointment (SMA) model confirmed the importance of social support among patients with heart failure. Designed by a cardiology medical practice center healthcare team that included physicians, dieticians, pharmacists, nurses, and social service personnel, researchers enrolled 56 heart failure patients with class III (marked limitation of activity) or class IV (only comfortable at bed rest) designations following a recent hospitalization related to heart failure (Lin, Cavendish, Boren, Ofstad, & Seidensticker, 2008). Thirty -three patients completed the six month pilot program that involved weekly two-hour sessions with six to eight patients

and their significant other per session. Topics on disease process, treatment regimens,

use and side effects of medications, dietary restriction, and self-care were addressed in an

interactive manner participated by patients, their significant others, and the

interdisciplinary team members. Patients had significantly fewer sub-specialty and

emergency department visits, as well evidence of improved self-care, medication

compliance and improved satisfaction. Although the pilot study was aimed at improving

self care, reducing cost of care, and improving overall treatment outcomes among heart

failure, social support was identified as a component of its process.

Sayers et al. (2008) investigated the effects of structural and functional aspects of

social support among patients with heart failure on self-care, including medication

adherence, dietary adherence, and heart failure symptom monitoring functions.

Structural support was defined as the availability of support through one's social

circumstances or social network; functional support was defined as the degree to which

one perceives that others are emotionally and/or practically supportive. The researchers

hypothesized that patients with relatively high levels of social support would report

higher levels of self-care, as functional and structural support were associated with self-

care in simultaneous models predicting self-care. While the study found that being

married increased the likelihood of availability and assistance with healthcare tasks, the

study also found that support from significant others was inversely related to self-care

confidence among heart failure patients. The researchers concluded that living with

others did not necessarily result in social support.

Nursing, Social Support and Heart Failure Patients

A number of studies report a positive relationship between perceptions of caring support and healthcare outcomes among chronically ill patients and heart failure patients in particular; however, the lack of specificity and clarity of definition has made it difficult to measure the construct of social support (Hutchison, 1999). Emotional support, a dimension of social support involves caring, love, and empathy; informational support is another dimension, all of which are relevant to the art of nurse caring. Chronically ill patients who perceive caring support are apt to participate more in their care, exhibit a greater degree of adaptability to chronic illnesses, and fare better in recovery from acute illnesses (Hutchinson, 1999; Jurgens et al., 2007). Nurses' unique position that accords them access to patients' social network further situates social support within nurses' caring role.

Social support by patients' immediate close relatives such as spouses increases the likelihood of the availability of others and the involvement of others in various medical care tasks. Emotional support was found to be consistently related to medication and dietary adherence among heart failure patients. Conversely, support from significant others was found to be inversely related to self-care confidence (Luttik, et al., 2005). The researchers suggest that support from significant others may undermine a patient's perceived abilities. In their discussion, the researchers highlighted the link between the emotional aspects of family relationship and self-care and how this link serves the broader goal of understanding how social relationships may influence clinical outcomes and mortality. The researchers' conclusion that enhancing social relationships in a way

that maximizes self-care would be crucial to efforts for improving outcomes of patients with cardiovascular diseases poses serious nursing implications especially for ED nurses in their encounter with these patients who are in their most vulnerable states.

Nurse Caring

Although multiple definitions of the concept of caring are available in the literature, a common thread among the definitions is the emphasis on promotion of wellness for individuals through caring support. Caring has been described as supporting action for another in need in order to improve the human condition (Leininger, 1988). Caring relationships involve human interactions grounded in clinical caring processes, caring presence, and knowing (Duffy & Hoskins, 2003; Jonsdottir, Litchfield, & Pharris, 2004). Nurse caring goes beyond the expression of empathy and involves nurse-patient engagement that elicits comforting behaviors of compassion, sympathy, commiseration, and reflexive reassurance (Morse et al., 1992).

In the proposed study nurse caring in the emergency department is defined as deliberate, competent, and humane nursing actions or behaviors in which the identification, validation, and alleviation of the patient/significant other's concerns is the primary focus. A critical assumption in this definition is that nurse caring behavior is non-judgmental, information sharing, dynamic, measurable, and goes beyond the mere satisfaction of perceived needs of the patient. An effective nurse caring action is one that generates trust and confidence of patients and their significant others.

Cultural Perspectives on Nurse Caring

Culture as a complex phenomenon has historical, social, geographical, linguistic, and ethnic dimensions which make human caring unique for all cultural groups. Cultural orientation to care may differ based on prevailing societal values, nurse education and training, or the practice environment. The increasing mobility of the nursing workforce around the world demands an understanding of multiple cultures and how culture can effect caring perception.

A quantitative study to determine if significant similarities and differences in the perceptions of caring existed between two cultural nursing groups was conducted by Watson, Rumeu, Hoogbruin, Beunz, McDonald, & McCready, (2003). The survey tool, a 23-item Caring Dimensions Inventory (CDI), was distributed to nurses from the United Kingdom and Spain with comparable profiles. While the findings showed certain similarities, significant differences were reported on the nurses' perception of caring in the two geographically distinct locations. The research findings however were inconclusive in determining whether the cultural behaviors displayed by the nurses were based on the culture of origin or the new culture. It is important to note however that recipients of care are also influenced by social-cultural variables such as social support or lack of it.

Cultural plurality among healthcare providers and consumers has been reported to add to the complexity of care environments (Blackford, 2003; Hultsjo & Hjelm, 2005; Leininger, 2002; Munoz, 2007; Socorro, Tolson, & Fleming, 2001) Health care institutions, and the emergency department in particular, work within an intersection of multiple cultures that may influence how nurses handle as well as how patients respond

to various care situations. Using a phenomenological approach, Socorro et al. (2001) explored the experiences of a multi-cultural group of nurses who provided care to suddenly bereaved family members in a clinical setting after they have been informed of the loss of a loved one. The study findings revealed that while all the nurses were emotionally affected by their experiences of caring for suddenly bereaved relatives, the nurses' accounts of the situations were consistently intertwined with stories from their personal experiences and cultural norms.

The role of culture with respect to caring from the perspective of both the consumer and the provider has become even more important with the recent improvement in international relationships and immigration. In addition, the United States' healthcare policy that assures equal access to emergency care to all individuals irrespective of social, immigration and economic status, continues to attract people of many cultures to the emergency department (Emergency Medical Treatment and Labor Act, 1994).

An exploratory study for nurses who provided care for immigrants seeking care in the emergency department revealed multiple challenges with the provision of care particularly to recent immigrants (Hultsjo & Hjelm, 2005). Using focused group interviews, participants were asked to discuss their experiences with caring for immigrants who sought care from nurses in the study in a psychiatric emergency ward in Sweden. Issues that might have influenced the patients' perception of care in the emergency department were determined to include: differences in cultural behavior expectations, complicated organizational structures, language barriers, reliance on healthcare staff, gender role ambiguity, and loss of contact with relatives (Hultsjo & Hjelm, 2005). The study findings not only emphasized the importance of social support

for these patients, but also the need to support organizational structures for ensuring

sensitivity in the care of a diverse patient population.

Leininger (1988) asserted that culture and personal values are inextricably linked

to health and illness behaviors of individuals, and to perception of caring. The nurse and

the patient bring to the care experience their cultural interpretation and definition of

health and illness, while the culture of the care environment adds yet another dimension

of diversity (Munoz, 2007). Without appropriate grounding in cultural competency, the

process of caring becomes difficult, adding to the complexity of caring for the culturally

diverse patients who are seen in the emergency department. While the framework for

teaching cultural diversity and cultural care is useful (Leininger, 2002), each care

situation is different and may pose challenges because individuals' cultural perspectives

may conflict with that of the care environment.

Technology's Impact on Nurse Caring

The role of advanced technology in contemporary nursing practice has been a

subject of debate among nurse clinicians, educators, and administrators. Some argue that

technological advances have encroached in the development of therapeutic interpersonal

processes thereby interrupting nurses' attentiveness to cues on the affective relationship

with patients, receptivity to patients' opinions and expectations regarding care delivery,

as well as the involvement of patients in decisions about treatment as a critical dimension

of caring (Carter et al., 2008).

A descriptive comparative survey to test Watson's relationship-based model of

caring in a technologically advanced inpatient nursing unit was conducted by Carter et

al., 2008. In this study, the relationship-based model meant that the nurses place at the

center of their work a personal relationship with patients and their families, prompting a

committed involvement with patients at multiple levels. The study findings revealed that

while both nurses and patients acknowledged that caring behaviors occurred between

them, nurses asserted that advanced technology has increased the pace of their work

thereby interfering with their ability to consistently maintain the authentic presence, a

critical component of caring (Carter et al., 2008).

Proponents of advanced medical technology refute the notion that advanced

technology in nursing is necessarily opposed to humanized care, arguing that

technological advances have helped the nursing profession maintain its identity through

improved nursing care (Barnard & Sandelowski, 2001). Locsin (1998) acknowledges

that the practice of 21st century nursing that involves complex biomedical machine

technology that is different from the past, but insists that technology must coexist with

humanistic competence in order for caring to emerge. Roach (2002) identified

technologic competence as one of six 'Cs' of nurse caring attributes, defining

competency as the state of having knowledge, judgment, skills, energy, experience, and

motivation required to respond adequately to the demands of one's professional

responsibilities. Other attributes that may combine with technologic competence for

effective caring are identified as compassion, confidence, conscience, commitment, and

comportment. While it is known that time is needed to achieve technological

proficiency, Roach (2002) urges that nurses use more time in maintaining authentic

presence as a means of demonstrating caring.

A comparative study on the impact of technological and cultural orientation of

nurses from eleven countries outside the United States was carried out by a team of nurse

researchers (Arthur, Pang, Wong, Alexander, Drury, Eastwood, et al., 1999). The aim of

the study was to measure three key components of nursing that included caring attributes,

professional self concept, and technological influences using the tool, *Caring Attribute,*

Professional Self and Technological Influences (CAPSTI). The study's instrument

consisted of a Likert scale questionnaire that included information from each of the three

areas of study focus. The study findings specific to the technological component showed

that the nurses in general agreed that high technology enhances patient care and well

being. The nurses not only valued the mastery of technology as useful in developing

professional status but were clear in their claim that technology benefits practice and the

profession. The findings from this international study were in contrast with the widely

held belief that cultural essences of nursing and caring have been lost because of evolving

technological innovations.

While technological advances in health care have been beneficial for managing

complex illness situations, consumer dissatisfaction with care persists. Healthcare

consumers are more interested in the experience of their care, more than they are

interested in knowing the benefits of advanced biomedical technology (Ward, Rolland &

Patterson, 2005). In a landmark report, *"Crossing the quality chasm: A new health*

system for the 21st century", the Institute of Medicine (IOM, 2001) identified safety,

effectiveness, patient-centeredness, timeliness, efficiency, and equity as the six aims for

transforming health care system. Focusing on patient-centered care, the IOM

recommended that care be based on continuous healing relationships with patients.

Rather than focusing on the impact of technology, health care experts suggest a

framework for enhancing the process of care in a manner that emphasizes partnership and

caring relationships between providers and patients (Duffy et al., 2003; Gold, 2007; Gallagher & Rowell, 2003; Ward et al., 2005). The Quality-Caring Model (Duffy et al., 2003), while acknowledging advances in biotechnology as a component of the health care organization structure, stresses the process of care that involves a caring relationship between the patient and the nurse as most critical. As much as the impact of technology on caring has been addressed in the literature, there remains a paucity of studies that show how these clearly beneficial aspects can work synergistically in enhancing patient care outcomes.

Qualitative Research on Nurse Caring

Attree (2001) used a Grounded Theory approach in exploring the perspectives of patients and their relatives on quality of care in a medical nursing unit. Using a semi-structured interview, participants that included 34 patients and seven relatives were asked to describe the quality of their actual care experiences using 'good' and 'not so good, could be improved'. The participants' impressions and experiences were placed into two major categories of caring attributes represented by, 'the nature of care provided' and 'the nature of relationship with patient'. Analysis and interpretation of the data revealed that patients and their relatives considered the nature of care provided to be adequate or 'good' if it was patient-focused, individualized, inclusive, and related to patients' need. The quality of care was deemed as inadequate or 'not so good, could be improved' if it was deemed to be routine, unrelated to need, and delivered in an impersonal manner that depicted distance. This study is useful because it demonstrates the association between quality care and human caring attributes. The findings in this study support the

knowledge that health care providers and nurses in particular are able to interpret

patients' verbal and non-verbal cues when they engage in a therapeutic relationship.

A meta-synthesis of 49 qualitative reports and six concept analyses that

investigating the phenomenon of caring supported the assertion of the interpersonal

nature of caring (Finfgeld-Connett, 2007). The study furthered the understanding of the

concept of caring by formulating an evidence-based interpretation of the concept of

caring that remains illusive. Purposive sampling was used in selecting nursing

publications on caring between the years 1988 and 2006. Using Grounded Theory

methods, the data were coded and analyzed to yield major categories. Final analysis and

synthesis revealed caring to be a context-specific interpersonal process that is

characterized by expert nursing practice, interpersonal sensitivity, and intimate

therapeutic relationships. The synthesis further identified the antecedents to caring as

including the care recipients' need for openness to caring, the nurses' depiction of

professional maturity, moral commitment, and conducive practice environment.

Another perspective on caring is provided by a Grounded Theory methods'

research study of occupational therapy practitioners. The study's aim was to identify and

conceptualize key processes inherent in the practitioners' descriptions of providing

culturally competent care (Munoz, 2007). While the study involved care providers who

were not nurses, findings support the definition of culturally responsive caring as a

process of actively developing synergistic relationships grounded in mutuality and an

intentional respect for a person's culture (Munoz, 2007). This demonstrates that human

caring has practice implications for occupational therapists, similar to the findings

focused on nurses' caring.

Measurement in Nurse Caring

The concept of caring, though difficult to measure, is often included in the list of quality indicators for measuring care outcomes in acute care settings including the emergency department. Although a variety of empirical methods have been used to describe the concept of caring from patient and provider perspectives (Erikson, 2002; Watson, et al., 2003), quality indicators are frequently quantitative in nature and serve as a guide for monitoring and evaluating specific aspects of patient care and support service activities (Muntalin, Gunningberg, & Carlsson, 2006). Consequently, these tools may fail to capture the aspects of caring that can not be quantitatively described, rendering them inadequate as a measurement instrument for the phenomenon of caring.

A study that evaluated the construct validity of a four-dimensional Caring Nurse-Patient Interaction-Short Scale using confirmatory factor analysis and based on the framework of Watson's Theory of Human Caring was carried out by Cossette, Pepin, Cote, and de Courval (2008). The study asked a convenience sample of 531 students in a baccalaureate nursing program to answer a 23 item Likert scale questionnaire that reflected four caring domains: humanistic care, relational care, clinical care, and comforting care. Twenty percent of the students in the baccalaureate program were already registered nurses. Confirmatory factor analysis of the Caring Nurse-Patient Interaction Short Scale was undertaken from which a middle-range theory that reflected Watson's theory emerged. Although the researchers concluded that the instrument fit the study data adequately, they recommended further testing of the instrument using different samples of patients. In addition, the use of student nurses whose experience and/or level

of understanding of caring dimensions was not measured in the study added to the study's

limitation.

Because quantitative scoring tools do not always capture the totality of human

caring experience, qualitative research methods are useful for explicating caring

behaviors from the expression of caring experiences enacted by nurses. Qualitative

measures of caring allow for capturing of the emotional psychological dimensions of

caring. In a Phenomenological study that explored the expressions of caring from

surgical nurses' perspectives, Enns and Gregory (2007) uncovered the theme,

lamentation and loss that supported the emerging essential structures of uncaring

behaviors that included lack of time, lack of caring support, tasking, increased acuity,

lack of continuity of care, emotional divestment and not caring for each other. According

to the researchers, the findings depict the desperate attempts of nurses to foster caring in

the work environment despite the care-eroding influences of the complex contemporary

healthcare environment. One of the study's conclusions was that quantification of these

attributes poses a great challenge to researchers.

In summary, while a number of instruments are available for measuring caring

perceptions of patients and nurses, it has been difficult to agree a universal measure that

reliably captures the essence of caring from all perspectives. Using instruments that

include multiple factors that may result in perception of caring, including social support

and its relationship to patient satisfaction is warranted.

Patient Satisfaction

There is a plethora of theories, research and measurement of patient satisfaction. A patient satisfaction model developed by Comley and Beard (1988), though not empirically tested, appeared to be a useful framework for explaining patient satisfaction. The theory postulated that patient satisfaction was a function of intrinsic factor and extrinsic organizational factors, and therefore not completely under the control of healthcare providers. According to this model, intrinsic factors include a patient's age, gender, socioeconomic status, ethnicity, occupation, diagnosis, and severity of illness. Extrinsic factors include the type of nursing care delivery model, provider competence, promptness of service, comfort and cleanliness of the physical environment, and food quality. The lack of testing of this model limits its application.

Instruments and Patient Satisfaction

Problems in conceptualizing patient satisfaction has made it difficult to have a universal patient framework for explaining patient satisfaction and for developing a universal instrument for measuring patient satisfaction (Laschinger et al., 2005). Like the concepts of caring and social support, patient satisfaction is impacted by multiple factors, including personal attributes of patients, provider attributes, and environmental issues of care. An accurate measure of the impact of nursing care on patients' experiences requires an instrument that has some focus on nurses' technical competence as well as on the art of caring. A few of such instruments are available and include the Caring Assessment Tool (Duffy, 2005) as well as the Consumer Emergency Care Satisfaction Scales (Davis, Bush, & Thomas, 1997). While the meaning of patient satisfaction continues to evolve, satisfaction with nursing care is known to be crucial to satisfaction with the overall

hospital experience (Wagner & Bear, 2009). Satisfaction with hospital experience is known to be associated with expectations and perceptions, whereby satisfaction is the outcome of patient expectations of ideal care measured against his/her perception of the actual care received (Wagner & Bear, 2009). Patient satisfaction in nursing has been defined as the degree to which nursing care meets patients' expectations with regard to many variables, including the art of care, technical competence, physical environment, availability and promptness of care, and the efficacy or overall care outcomes (Davis & Bush, 2003; Mrayyan, 2003).

In response to the paramount importance accorded to patient satisfaction, many healthcare facilities are using various ways for collecting patient satisfaction data to measure quality internally including the use of independent vendors such as Press - Ganey, a known health care industry's leader in patient satisfaction monitoring. Like other independent vendors, Press- Ganey uses patient discharge information to select a sample of recipients who receive mailed satisfaction surveys on critical service points including access to care, service and communication by providers, concern and sensitivity of staff and providers, and overall assessment of the facility. Surveys are returned to the vendors in postage-paid envelops; results are disseminated to facilities sampled.

Driven by consumer demand for improved quality of healthcare and reduced cost of care, multiple initiatives have been implemented both by private and public sectors to include patients' perspectives on healthcare. One of such initiatives is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a survey instrument and data collection methodology for measuring patients' perspective of their

hospital experience. As a standardized instrument for collecting and reporting public

information on patients' experience, HCAHPS was designed to give incentives to

hospitals to improve quality as well as to improve accountability and transparency.

HCAHPS survey comprises 27 items about patients' experiences with critical aspects of

care, including communication with nurses, communication with doctors, responsiveness

of hospital staff, pain management, and cleanliness of hospital environment, overall

rating of the hospital and whether or not patients would recommend the hospital to

others. The survey is administered to patients by mail, telephone or active interactive

voice response, and between 48 hours to 6 weeks following hospital discharge. The

administering agencies for HCAHPS, the Center for Medicare and Medicaid (CMS), and

the Agency for Healthcare Research Quality (AHRQ) require hospitals to designate

trained personnel or data management vendors such as Press-Ganey to collect, analyze

and post performance results on the public website, Hospital Compare.

Patient Satisfaction and Nurse Caring

Perception of caring is often a major component of patient satisfaction surveys

that are used in the measurement of quality care in all settings including the emergency

department. A review of nursing research studies investigating patients' perceptions of

caring demonstrates a strong correlation between perceptions of caring and patient

satisfaction (Henderson, et al., 2007; Clark, et al., 2007; Elder et al., 2004; Hayes &

Tyler-Ball, 2007; Davis & Duffy, 1999). While perceptions of caring may vary between

nurses as givers and the patients as recipients of care, caring behaviors are commonly

agreed upon as those that preserve individuals' self-worth, and include such actions as

informing, treating with respect, and showing concern for an individual's stressful

condition (Henderson, et al., 2007).

In an effort to make the healthcare practice environment more client-centered,

health care administrators are recognizing that they must improve the care experiences of

their clients. Patient satisfaction can be influenced by patients' perspectives on any of the

multiple dimensions of care including the environment of care and social support status.

It is also known that patients' perception of quality caring rarely align with that of

providers (Muntlin, Gunningberg, & Carlson, 2006). While certain behaviors are

perceived by nurses as caring, patients' perceptions often differ. The notion that patients'

perceptions of their care may differ from that of providers challenges nurse leaders and

healthcare administrators to consistently monitor patients' view of their care.

The complexity of the linkage between patient satisfaction with hospital

experience and the quality of nursing care calls for a nursing framework for

understanding patient satisfaction. The Quality Health Outcomes Model (QHOM),

(Mitchell, Ferketich, & Jennings, 1998) is frequently cited in the literature as a

comprehensive framework for evaluating nursing characteristics, including practice

environment, adequacy of nurse staffing, and patient outcomes that impact patients'

perception of quality care and satisfaction. The QHOM model also includes a focus on

hospital characteristics such as number of inpatient beds, teaching status, and use of

advanced technology. The QHOM model on the other hand, has minimal focus on

patient-nurse interaction as an important factor.

Cox (1982) offered a more patient-nurse interaction explanatory model for patient

satisfaction. The Cox's Interaction Model of Client Behavior identified patient and nurse

factors described as personal client resources and the nature of the client-provider interaction. Key components of this model have been found to be consistent with measures of patient satisfaction cited in the literature, and include affective support, access to health information, decisional control, and professional competence. The Cox's model for client behavior has been empirically tested and is supported by known patient satisfaction concepts.

A concept analysis of patient satisfaction with nursing care was undertaken by Wagner and Bear (2009), utilizing Cox's Interaction Model of Client Behavior as a framework. The analysis included 44 papers on patient satisfaction published over the period of 1998 to 2007, and identified categories of nursing attributes that lead to patient satisfaction including: affective support, health information, decisional control and technical competence. Antecedents to patient satisfaction included patients' personal demographic data, social influence, previous healthcare experiences, environmental resources, intrinsic motivation, cognitive appraisal, and affective response. Consequences of achieving patient satisfaction with nursing care were identified as including greater market share of healthcare finances, compliance with healthcare regimen, and better health outcomes (Wagner & Bear, 2009).

In a further effort to develop a comprehensive model for understanding patient satisfaction and its impact on a number of health care outcomes, Doran et al. (2002) developed the *Nursing Effectiveness model*. The Nursing Effectiveness model was based on the structure-process-outcome model of quality care in which the structure component consisted of the nurse, the patient, and the nursing unit. The Nursing Effectiveness Model has well-defined concepts with clear delineation of relationships among variables.

The process component consisted of the independent, dependent, and interdependent role functions of nurses. The independent role functions were identified as those functions for which nurses had sole accountability. Nurse's dependent role comprised of the clinical judgments and activities related to implementation of medical orders and medical treatment. The model is applicable in all nursing care units and has been tested in medical-surgical nursing units. Although similar to other models of patient satisfaction that are based on structure-process-outcome quality of care, this model falls short on emphasis on nurse-patient interaction processes that impact patient satisfaction with health outcomes. While many models on patient satisfaction are available, not every model has an associated patient satisfaction tool, and not every patient satisfaction measure is associated with a conceptual model. It is important that frameworks are scrutinized for congruence to the study in question. In some instances, information from multiple frameworks may be combined in order to achieve the best result (Laschinger et al., 2005).

In a correlation study of cardiac patients undergoing interventional cardiology procedures, Wolf, Miller and Devine (2003) examined the relationship between nurse caring and patient satisfaction at a tertiary hospital in Philadelphia. The study utilized a convenience sample of male and female adult patients. While the results showed a moderately strong correlation between nurse caring and patient satisfaction, there was no significant difference in perception between the males and the females. In concluding that nurse caring behaviors were important for positive care outcome of cardiac patients, the researchers emphasized the need for practicing nurses to appreciate the connection of caring behaviors to patient satisfaction.

In another study that correlated patient satisfaction with perception of caring in

six European countries was conducted by Palese et al. (2011). Other purposes of the

study were to determine if differences existed across various countries on the correlation

of caring and patient satisfaction, as well as to determine whether caring behaviors

affected patient satisfaction. A convenient study sample of 2,565 patients was drawn

from 34 general hospitals of the countries of Italy, Finland, Cyprus, Czech Republic,

Greece, and Hungary. Data collection was undertaken using the Caring Behaviors

Inventory (CBI) 24-item version, the Patient Satisfaction Scale and a demographic

instrument. The result not only showed that caring behaviors enacted by nurses

determined a consistent proportion of patient satisfaction, but also determined a

statistically significant positive correlation between patient satisfaction and their

perception of caring in all the six countries. Interestingly, the study showed that the

'knowledge and skill' component of the CBI instrument did not contribute significantly

to explaining patient satisfaction.

A non-experimental study investigated the influence of multiple factors including

patients' perception of nurse caring and registered nurse job satisfaction on the patient

satisfaction with inpatient care (Hobbs, & Burant, 2004). The study utilized a

convenience sample of 362 male and female patients from two medical units of an

academic medical center in West Virginia. Data were collected using five instruments

that included Patient Judgment of Nursing Care, CBI, Quality of Life Index, Work

Quality Index, and patient demographic questionnaire. In addition to showing a strong

influence of patient-perceived nurse caring on the patient's satisfaction, the study

indicated that nurse-physician collaboration and RN job satisfaction had a positive

influence on patient satisfaction. In presenting the study results, the researchers cited previous studies in which patient satisfaction and perception of nurse caring were correlated. The researchers further supported the consensus that patients' perception of nurse caring strongly contributed to patient satisfaction, stressing that nurse administrators should implement and monitor processes to enhance nurse caring practices among their nurses.

There is interest in the quality of health care across the world. Rafil, Hajinezhad, and Haghani (2008), examined the relationship between patients' reports of nurse caring and their satisfaction with hospital services in a university hospital systems in Tehran. Nurse caring was defined as an interactive and intersubjective process that occurs during moments of shared vulnerability between the nurse and the patient. Utilizing Watson's Theory of Human Science and Human Care as a framework and the Caring Behaviors Inventory (CBI) as a data collection tool, a cross-sectional survey of 250 male and female adult patients hospitalized in medical-surgical wards was conducted. While the study findings support literature evidence that nurse caring is associated with patient satisfaction with nursing care, the impact of attributes such as culture, religion, and practice environment was also highlighted.

Another study that analyzed the relationship between nursing workforce issues including nurse staffing and the context of work place environment on quality of care and patient satisfaction was conducted by Carthon, Lee, Sloane, Cimiotti, and Aiken (2011). Patient discharge data from 2006 and 2007 were obtained from state offices of nonfederal acute care hospitals in California, Pennsylvania, New Jersey, and Florida that participated in voluntary reporting of patient data, using nurse-specific indicators from the Hospital

Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Nursing data

were obtained for the same period of patient admission using sample questionnaires on

the nurses' work environment and staffing levels in their employing hospitals, as well as

occurrences of adverse events, including hospital acquired infections. The response rate

to the mailed survey of nurses was 9,800 nurses or 36%. The study findings showed that

there was a strong relationship between structural hospital characteristics, quality of care,

and patient satisfaction. Although the study limitations included the notation that the

study was conducted in an institution that had patients who were predominantly of ethnic

minority groups, corresponding HCAHPS survey data supported the findings that patients

were dissatisfied with their care because of the same care issues.

Nurse Caring and Patient Satisfaction in the Emergency Department

A limited number of studies report nurse caring specifically in the ED. In a

prospective, descriptive survey study to determine how patients defined quality care and

how this influenced satisfaction with emergency department care, two hundred ED

patients with non-urgent illnesses and injuries were asked to complete the Quality from

Patient's Perspective (QPP) questionnaire (Muntalin, Gunningberg, & Carlsson, 2006).

Another purpose of the study was to identify issues of the emergency department care

that could be improved. The survey questionnaire consisted of a number of questions

that measured four dimensions of care: medical-technical competence, physical-technical

conditions, identity-oriented approach and socio-cultural atmosphere. The dimensions

were mutually dependent and combined in constituting quality of care. While many

dimensions of nursing care scored high marks on quality, one area identified as needing

improvement included the caring behavior of nurses. The findings revealed that patients'

perceptions of quality care depended on their subjective estimations of the importance of the various dimensions of care (Muntalin et al., 2006). The researchers recommended further study of patient satisfaction in the emergency department as this study did not explore all aspects of the practice environment that may influence quality perception and patient satisfaction.

The Emergency Department

The emergency department as a frontline of America's healthcare is faced with multifaceted issues. The emergency department is inherently fast-paced as it was originally designed to provide expedient assessment, diagnosis and stabilization of individuals presenting with acute illness and injuries requiring urgent attention. Recently, however, emergency departments have become overburdened with multiple issues, including the provision of non-emergent care, resulting in increased complexity and a shift of emphasis on expedience for service delivery (Frank, 2002). In addition, the combination of federal and regulatory agency mandates and fiscal pressures has left emergency departments overstretched beyond their ability to provide care that is sensitive to human caring (Kennedy, Rhodes, Walls, & Asplin, 2004).

Contemporary Issues in Emergency Departments

Overcrowding, technological advances, high patient acuity, episodic violence and workforce issues such as staff burnout, and moral dilemmas affect nurse caring and patient satisfaction. Each of these issues can impact the factors under investigation in this study.

Overcrowding. Overcrowding has received extensive coverage in the literature

since it is an issue of utmost concern in the emergency department. Overcrowding results

from a number of factors including consolidation of hospitals and emergency services,

staffing shortage and legislative mandates for open emergency care access (McCraig &

Burt, 2005). While the number of visits has increased, the number of hospital emergency

departments has decreased. Within the period of ten years, from 1996 to 2006, the

number of hospital EDs decreased in the nation from 4,019 to 3,833 (Pitts, Niska, Xu, &

Burt, 2008). Though not intended to be the primary source of care, the ED serves as the

primary entry point into the health care system, admitting over 60 percent of the

hospitals' inpatients (Schriver, Talmagde, Chuong, & Hedges, 2003). Emergency

department overcrowding has been associated with poor quality of care issues including

long waiting times, increased medical errors, dissatisfaction with care, emotional

exhaustion among staff, and a negative work attitude of the nursing staff (Kilcoyne &

Dowling, 2007; McCraig & Burt, 2005).

Technological Advancement. Innovations in the clinical and technological

management of patients seeking care in the emergency department have added to the

complexity of the emergency department (Wilkin & Slevin, 2004). While improvements

in biomedical technology yield advanced treatment outcomes, improved mortality and

morbidity rates, and prolonged life, these improvements have challenged the ED nurse to

simultaneously maintain a focus on the character of human caring while attending to the

technical environment. In addition to the time required for achieving competency in the

use of technology, the use of advanced medical technology amounts to an increased work

load which takes away from the time spent in developing therapeutic nurse-patient

relationships(Lesniak, 2005; Wilkin & Slevin, 2004). Acquiring proficiency in the use of medical technology is an integral part of caring as it helps the nurse to deliver care that is safe and fulfilling for both the nurse and patients (Roach, 2002; Locsin, 1998). Competent nursing care in the 21st century has been described by many as encompassing the ability to apply complex biomedical machine technology while maintaining caring as the core of nursing (Barnard & Sandelowski, 2001; Locsin, 1998; Roach, 2002). In the view of many caring theories, nursing *is* caring and nursing competency in biomedical technology is an integral part of caring. Caring that does not align with technologic competency is an intrusion into the life of persons and can be detrimental to human caring (Roach, 2002).

Acuity: The complexity of emergency nursing is further compounded by issues of increasingly high acuity of patients who visit the emergency department. A breakdown of the acuity level of the patients visiting the emergency department in 2004 showed a 2.4% increase in patients categorized as emergent, a 33.3% increase in patients categorized as urgent, a 20.7% increase of those categorized as semi-urgent, and a 13.9% increase of patients categorized as non-urgent (Pitts et al., 2008). Within the same time period, an estimated 25% of emergency department patients are elderly and chronically ill patients with co-morbid medical conditions that require long treatment time as well as complex and specialized care (Pitts et al., 2008). The same authors reported ambulance diversion as occurring in an average of 11% for all emergency departments.

Staffing, Burnout, and Moral Dilemma. The growing volume of emergency department visits along with high patient acuity, nursing shortage, and heightening consumerism have added to the pressure of emergency department nursing workforce.

Staff stress resulting from the struggle to balance shrinking resources amid growing emergency department volume and activity often reduces positive attitudes of human caring. Factors related to overcrowding, impediment of patient flow, inadequate staffing conditions, inadequate material resources, and patients' violence towards the emergency department staff have been associated with stress and burnout among nurses (Buerhaus et al., 2005;Clark et al., 2006; Letvak & Buck, 2008; Luck, Jackson & Ursher, 2007; Robinson, Jagim & Ray, 2005). Gillespie and Melby (2003) reported that nurses working in emergency departments which encounter frequent overcrowding are likely to experience burnout.

Elusive care emerged as one of three inter-related central themes in a study highlighting nursing issues associated with overcrowding, also termed *access block* in the emergency department (Kilcoyne & Dowling, 2007). Drawing from the philosophic views of Heidegger, the researchers analyzed the narratives of eleven experienced ED nurses. The study examined patient care issues in admitted patients who could not be readily transferred to inpatient units within a reasonable time frame. Elusive care was described as the illusion that nursing care was being rendered to patients when in fact the contrary was true. Other central themes included lack of space and powerlessness while the sub-themes included issues of health and safety, infection control, poor service delivery, and lack of respect/dignity. The study findings revealed that nurses had the knowledge that patients' basic human caring needs were not met, but claimed their awareness was shadowed by issues that included inadequate resources, lack of space, not feeling valued, moral distress, and stress/burnout. The researchers concluded that nurses

experienced moral conflicts when they are unable to carry out their responsibilities because of factors beyond their control.

Violence. Humane emergency nursing is further challenged by the increasing trend of behavior outburst of patients that may include some form of abuse, assault, or aggression towards emergency department staff (Badger & Mullan, 2003; Luck et al., 2007). Although many assumptions on the causes of violence in the workplace are found in the literature, the lack of a standard definition of violence makes it difficult to implement specific strategies for addressing the issue. Luck et al. (2007) postulated that consumers who seek care in the emergency department come already stressed with fear and hopelessness as well as frustration from unpredictable diagnoses, prognosis and treatment outcomes, all of which are easily exacerbated by an unfamiliar emergency department environment. The study further suggested that nurses may be afraid of confronting violent acts by frustrated consumers with a resulting strain on nurse-patient relationships.

The incidence of violence committed by patients and/or their significant others towards emergency department nurses has been known to be underreported or underestimated (Luck et al., 2007; Pawlin, 2008). The reasons given for such underreporting range from staff acceptance of certain abusive behaviors are normal occurrences of the setting to the excessive and lengthy reporting process requirement (Erickson & Williams-Evans, 2000; Pawlin, 2008). Erickson et al., (2000) conducted a correlation study of workplace violence in two emergency departments, a level 1 trauma and a tertiary emergency department, both in an urban setting. The aim of the study was to investigate the frequency of nurse abuse and the nurses' attitudes towards abuse. The

study findings revealed that although 86% percent of the nurses surveyed reported having been a victim of some form of abuse during their careers, only 56% reported the abuse. The same study reported that a significant number of the nurses in the emergency department had contemplated transferring out of the emergency department or leaving nursing altogether because of fear of workplace violence. A mixed method study of emergency department nurses' perceptions of acts of violence from patients, their families and friends was conducted by Luck et al. (2007). The study findings showed that nurses reacted to patients based on their anticipation of the threat or actual acts of violence by patients, and exhibited caring or uncaring behaviors towards patients based on their previous experiences of violent encounters by patients and their families.

In summary, several contemporary issues in emergency departments have impacted the type of care patients receive and the ability of nurses to adequately care for patients. A number of studies have directly addressed nurse caring and the emergency department.

Nurse Caring and the Emergency Department

Multiple programs on caring in the emergency department have been proposed or implemented over the years; a few were designed with a focus on improving nurse caring practices based on assessment of patients' characteristics. The complex nature of the emergency department that requires that an interdisciplinary ED staff work collaboratively in treating urgent conditions presented by patients is partially responsible for this. Yet, patients and their families do communicate when the quality of nursing care falls short of their expectations.

A process of implementing a caring-based model grounded in nursing as caring in a community hospital was described by Boykin, Bulfin, Balwin, and Southern (2004). The purpose of the model was to develop a culture of care in the emergency department in which nursing as caring is the theoretical base. Within this framework, nursing is presented as a profession with the focus of nurturing persons, living and growing in caring. The project implementation lasted over a six-month period and involved nursing staff and others meeting biweekly to share caring experiences in a dialogue. The outcome of this intervention was, however, not significant.

A descriptive study of perceptions of caring among moderately injured trauma patients cared by nurses in a level one trauma unit was conducted by Hayes and Tyler-Ball (2007). Using the *Caring Behaviors Inventory* designed with a 6-point Likert type questions on caring dimensions, the researchers collected data from a mixed gender group of 18 adult post-trauma patients. The patients had generally positive perspectives of the care they received with recommendations for improvement. They rated keeping their information confidential as the highest caring behavior as well as receiving support to help them cope. Interestingly, the use of touch to demonstrate caring was rated low and patients in this group said they did not wish to be touched and that this specific part of nursing care did not demonstrate caring to them. The reliability of information obtained from patients who suffered traumatic injuries of various types may be reduced because of their severe stress. In addition, trauma rooms are often chaotic and staffed with a mixed of interdisciplinary staff; discerning care by nurses from that of other personnel is often difficult for patients.

While it is known that nurse caring behaviors in the emergency department are impacted by multiple factors, including provider, patient, environment, and system related issues, nurses' perspectives on caring behaviors towards patients may differ from that of patients. To maintain its commitment to human service, nurse leaders must continue their quest in developing appropriate measurement of caring behaviors and in instilling caring competence among nurses in all practice environments.

Nurse Caring, Patient Satisfaction and ED Patients

A survey study on the effect of emergency department overcrowding on patients' satisfaction among patients admitted in the emergency was conducted by Pines, Iyer, Disbot, et al., (2008). In this study, adult patients received the Press-Ganey Likert scale survey, questions that queried their levels of satisfaction with aspects of ED care including nursing care, physician care, explanation of delays, and overall satisfaction about the ED. Overcrowding was measured by use of hallway, boarding time in the ED, and treatment times. While the study had limitations that included a low response rate of 15% and use of only one study site, overcrowding and hallway placement in particular was predictive of lower likelihood of recommending the ED to others, lower overall ED satisfaction, and lower overall satisfaction with the hospitalization.

Perception of nurse caring is often a major component of patient satisfaction surveys that are used in the measurement of quality care in all settings including the emergency department. A review of nursing research studies investigating patients' perceptions of caring demonstrates a strong correlation between perceptions of caring and patient satisfaction (Clark et al., 2006; Ekwall et al., 2007; Elder, Neal, Davis, et al., 2004; Hayes & Tyler-Ball, 2007; Henderson et al., 2007). While perceptions of caring

may vary between nurses as caregivers and patients as recipients of care, caring behaviors are commonly agreed upon as those behaviors that preserve individuals' self-worth, and include such actions as informing, treating with respect, and showing concern for an individual's stressful condition (Henderson et al., 2007).

In a study that examined the relationship between patient satisfaction and triage nurse caring behaviors in a rural emergency department, Elder et al., (2004) used the Consumer Emergency Care Satisfaction Scale (CESS) to collect survey data from 65 patients and 11 nurses. The study findings showed that perceptions of patient satisfaction, caring satisfaction, and medical condition were used as predictors of intent to return to that ED.

Studies on patients' perceptions of caring and satisfaction in inpatient care settings show similar results when compared with those of outpatient and emergency care centers. Davis and Duffy (1999) surveyed two groups of emergency department patients from rural and urban emergency centers using quantitative and qualitative approaches. The quantitative instrument, the Consumer Emergency Care Satisfaction Scale (CESS), was designed to compare satisfaction with care in rural and urban settings, and to determine factors that lead to patient satisfaction with care in the emergency department. Quantitative analysis findings showed that behaviors patients identified as caring, particularly the nurses' ability to provide accurate information, rated high on patient satisfaction. Qualitative theme analysis in the study, in contrast, showed that patients viewed nurses' technical competence as more important than other aspects of care.

Chronic Heart Failure (CHF)

The literature review in this section relates to the definition of and an explanation of the chronic aspects of heart failure, the burden of chronic heart failure on patients and their families, and how patients with heart failure deal with emergency department management of their disease. Chronic heart failure (CHF) is a prevalent clinical condition that affects over five million Americans with a growing number of older adults (American Heart Association (AHA), 2006). According to American Heart Association statistics, CHF is the most common Medicare diagnosis related group (DRG) at discharge and is associated with poor survival rates, and poor quality of life (AHA, 2006). Despite medical advances in the management of heart failure, mortality is high, with a two year mortality rate reaching 90 percent for those with class III and class IV of the New York Heart Association classification of heart failure (Stewart, 2003).

Heart failure is reported to be at epidemic proportion because of an increasing incidence, frequent hospitalization, healthcare cost, and mortality; the prediction is that the current trend will continue with the expected increase in the older population in the coming years (AHA, 2006). CHF describes a chronic progressive syndrome in which the heart can not adequately pump blood through the body, requiring complex therapeutic regimen involving multiple medications, strict dietary restrictions, and vigilant symptom management (Jurgens, Dumas, & Messina, 2007). The pathophysiology of CHF involves systolic dysfunction with corresponding decreased ventricular contractility and ventricular ejection fraction. In addition to problems from CHF, co-morbid conditions are common among CHF patients (Albert, Eastwood, & Edwards, 2005). Consequently,

CHF patients tend to be debilitated and often unable to perform activities of daily living due to activity intolerance.

The Burden of CHF on Patients and Families

Patients with heart failure and their care givers suffer undue stress resulting from a symptom cluster including dyspnea, peripheral edema, fatigue, limited vital capacity, and adverse effects of treatment regimen (Jurgens, Moser, Armola, Carlson, Sethares, & Riegel, 2009; Luttik et al., 2005; Saunders, 2010). It is estimated that about 25% of CHF patients are readmitted within six months of previous hospital admission (Albert et al., 2005). The extensive needs of heart failure patients due to their functional limitations from a failing heart means that CHF patients must often depend on caregivers for their daily struggle for survival. Caregiver burden has been reported as a salient outcome of heart failure, as caregivers as required to carry out many activities for heart failure patients (Dunbar, Clark, Quinn, Gary, & Kaslow, 2008; Saunders, 2010). Dealing with illness burden, patients with heart failure are also concerned about the burdens placed on their family members and often fail to complain about symptom distress to avoid stress on their caregivers (Jurgens et al., 2009; Saunders, 2010). Saunders (2010) identified multiple factors that are associated with caregiver burden in heart failure family caregivers including lack of social support for caregivers themselves as they endure significant levels of burden in caring for CHF patients. For heart failure patients who live alone and for those with no significant source of social support, self-care and adherence to treatment regimen can be tremendously tasking.

Ultimately, heart failure patients and their families face multiple distressing and complex care issues requiring frequent emergency department visits and disruption of

self care routines. The high vulnerability of heart failure patients and the high cost of heart failure management challenge health care providers to find ways of ensuring continuity of care for these patients through bridging the service gap between inpatient and outpatient care, including emergency medical service.

CHF Patients and ED Care

The severely ill, particularly heart failure patients, face enormous challenges from illness symptoms and/or treatment regimen. Of the 110 million reported ED visits in the US in 2002, 1.8 million were related to heart disease (McCraig & Burt, 2005). Like other acutely ill patients admitted through the ED, most CHF patients spend a great deal of time in the ED waiting for the availability of inpatient beds, adding to the illness burden. Patients are often assessed in the ED through a classification of their heart failure status. The New York Heart Association (NYHA) has developed a system for categorizing and describing the impact of heart failure on patients' activities of daily living (Bennett, Riegel, Bitter, & Nichols, 2002). Clinician-assigned and originally developed in 1928, the four category system (class I, II, III, & IV) has received a series of revisions and is currently the most commonly used tool for prediction of outcomes in heart failure. Although rarely used, an objective assessment section ranging from class A through D and aimed at enhancing the objectivity of the tool was added during a recent revision.

The NYHA Class I category includes patients with cardiac disease but with no limitation of physical activity. The corresponding class 'A' objective section includes no objective evidence of cardiovascular disease. Class II category captures patients with cardiac disease resulting in slight limitation of physical activity. Class II category corresponds with the objective evidence of minimal cardiovascular disease. Class III

category covers patients with cardiac disease resulting in marked limitation of physical

activity; the corresponding class C objective assessment includes moderately severe

cardiovascular disease. Class IV category of the NYHA classification includes patients

with cardiac disease resulting in inability to carry out any physical activity without

discomfort and includes the objective evidence of severe cardiovascular disease.

Although rarely used, an objective assessment section ranging from class A through D

and aimed at enhancing the objectivity of the tool was added during a recent revision.

Moreover, although the two sets of classification categories describe severity levels and

expected impact on heart failure patients, the sets are recommended for use in any

combination that fits a patient's condition (Bennett et al., 2002).

The literature is replete with recommendations on effective management of

patients with chronic heart failure who frequent the emergency department. Specifically,

this management calls for the understanding of the perspectives of the patients and care

givers by health care personnel and nurses in particular. Patients with heart failure who

visit the ED require complex therapeutic regimens as well as the caring support of health

care providers and their significant. With a focus on enhancing the quality of life for

patients and their caregivers, nurses must take the lead developing and implementing

strategies to improve care outcomes with the goal of promoting continuity of care and

maintaining optimum quality of life for these patients. Jurgens, Dumas, & Messina

(2007) described patient centered heart failure management as that by which the patient

and members of his social network, including health care providers, work collaboratively

to improve self care, reduce hospitalization episodes, and reduce the cost of care.

Improving quality of life through ensuring adherence to an evidence- based standard of

care for heart failure patients requires the understanding of patient's support system, as

well as commitment for caring support that patients can perceive and appreciate.

Impact of Support and Caring for CHF Patients

Chronically ill patients and heart failure patients admitted in the emergency

department are especially vulnerable as they undergo emotional distress and anxiety

related to the care processes and unpredictable treatment outcome. While it is known that

people in distress fare better with caring support especially during illness exacerbation,

the high vulnerability of heart failure patients places them in a position of greater demand

for caring support.

In a review of the literature on the importance of social support on outcomes in

patients with heart failure, Luttik et al. (2005) concluded that focused study was needed

to understand the characteristics of heart failure patients needing social support, as well

as how the support can be provided effectively. As mentioned earlier in the literature

review, a lack of social support was a strong predictor of hospital readmissions and

mortality in heart failure patients. A lack of social support has been found to be

associated with reluctance to seek care (Jurgens et al, 2009). Fewer ED visits were found

to result from the shared medical appointment mode, previously described (Lin,

Cavendish, Boren, Ofstad & Seidensticker, 2008).

A mixed method study investigation into the reasons elderly patients with heart

failure often delay response to symptoms of heart failure found multiple factors including

lack of social support to be associated with the decision to seek health care (Jurgens et al,

2009). Although the study reported that social factors were not the predominant reason

the 77 heart failure patients, 65 years and older, ignored their symptoms, several of the

participants reported reluctance to seek care because of social and family-related issues.

Specifically, the study cited instances in which family members were instrumental in

initiating access to the medical centers for consultation and treatment. While the aim of

the study was to raise awareness of the importance of involving patients and their

significant others in the education about disease process and management, the importance

of positive social support by immediate family members and others was also

demonstrated.

A pilot study to test the efficacy of shared medical appointment (SMA) model

was confirmed the importance of social support among patients with heart failure.

Designed by a group of cardiology medical practice centers that included physicians,

dieticians, pharmacists, nurses, and social service personnel, this study prospective

enrolled 56 heart failure patients with class III (marked limitation of activity) or class IV

(only comfortable at bed rest) following a recent hospitalization related to heart failure

(Lin, Cavendish, Boren, Ofstad, & Seidensticker, 2008). Thirty three patients completed

the six months' pilot program that involved weekly two-hour sessions with six to eight

patients and their significant other per session. Topics on disease process, treatment

regimen, use and side effects of medications, dietary restriction, and self-care were

addressed in an interactive manner participated by patients, their significant others, and

the interdisciplinary team members. Patients had significantly fewer sub-specialty and

emergency department visits, as well evidence of improved self-care, medication

compliance and improved satisfaction. Although the pilot study was aimed at improving

self care, reducing cost of care, and improving overall treatment outcomes among heart

failure, social support was identified as a component of its process.

Sayers et al. (2008) investigated the effects of structural and functional aspects of social support among patents with heart failure on self care, including medication adherence, dietary adherence, and heart failure symptom monitoring functions. Structural support was defined as the availability of support through one's social circumstances or social network; functional support was defined as the degree to which one perceives that others are emotionally and/or practically supportive. The researchers hypothesized that patients with relatively high levels of social support would report higher levels of self-care, as functional and structural support were associated with self-care in simultaneous models predicting self-care. Of the 214 heart failure patients that met the research inclusion criteria, 74 completed the study questionnaire form and interview.

The study findings support available literature reports citing that social support by patients' immediate close relatives such as spouses increases the likelihood of the availability of others and the involvement of others in various medical care tasks. Emotional support was found to be consistently related to medication and dietary adherence among heart failure patients. Conversely, support from significant others was found to be inversely related to self care confidence. The researchers suggested that this finding could be due to the fact support from significant others may undermine a patient's perceived abilities. In their discussion, the researchers highlighted the link between the emotional aspects of family relationship and self care and how this link serves the broader goal of understanding how social relationships may influence clinical outcomes and mortality. The researchers concluded that enhancing social relationships as a way to

maximize self care is crucial to efforts for improving outcomes of patients with

cardiovascular diseases

In summary, social support theories describe social networks as including

significant others to an individual, including health care professionals and members of

social groups. By virtue of their professional role, nurses' therapeutic relationship with

patients can serve as an invitation to patients' social network. Heart failure patients

without supportive family and those who live alone are often socially isolated and

vulnerable to poor self-care practices (Dunbar et al., 2008). While family influences have

been positively associated with self-care ability and overall treatment outcomes in

patients with heart failure, these patients often require complex treatment regimen that

places demands on the patients and their care givers in terms of knowledge, cooperation,

and active participation (Evangelista & Shinnick, 2008). Nurses are in an excellent

position to assist heart failure patients to cope with their disease process and manage their

symptoms in order to achieve good outcomes.

Summary and Critique of the Literature Reviewed

The Quality-Caring model has been well tested and fits with this study's purpose

and design.. Caring, a major concept in this study is extensively presented in the nursing

literature. The concept of caring is the core of what nurses do and without which nursing

care is deemed simply as robotic. A number of studies related to nurse caring and on the

impact of multiple factors in emergency nursing including technological advances, staff

burnout, high acuity, and overcrowding have been done. Yet little has been published

regarding ED nurse caring and especially of vulnerable CHF patients in the ED.

Patient satisfaction is known to be a critical quality measure in patient care settings including the emergency department. Patient satisfaction is also known to be influenced by multiple factors including provider related issues, patients' intrinsic and extrinsic factors perception of caring and social support system, as well as issues specific to the emergency department environment of care. Uncovering the combined effect of these variables remains a challenge as patient satisfaction studies available in the literature tend to focus on care outcomes, compliance with medical regimen, and loyalty to the hospital of care.

Social support, while described over the last three to four decades by the disciplines of Psychology, Sociology and Social Work as an important factor in health and recovery, has not been addressed with respect to its relationship to nurse caring, from the patients' perspective. The role social support status plays on how CHF patients perceive nurse caring and patient satisfaction in the emergency department has not been adequately studied and is the focus of this investigation. Although other groups of patients can benefit from studies that seek to improve the quality of life among the chronically ill, improving care of CHF patients as a vulnerable and frequently distressed group in the emergency department may improve overall quality of life and yield cost savings.

This study is aimed at filling the knowledge gap on the relationship of social support to the perception of nurse caring and patient satisfaction among heart failure patients admitted to the emergency department.

CHAPTER III

METHODOLOGY

Purpose

The purpose of this study is to explicate the influence of social support on the perception of nurse caring and patient satisfaction. The emergency department was selected as the study setting because little research has addressed patient satisfaction and nurse caring in this setting. Heart Failure patients were chosen as the study sample because of their frequent visits to the emergency department and the research on the influence of social support for these individuals. Social support has also not been studied regarding its influence on patient satisfaction and nurse caring. The study also explored the Quality Care Model (Duffy & Hoskins, 2003) used as the framework for this study.

Design

This study utilized a quantitative non-experimental design to investigate the relationship of social support, nurse caring and patient satisfaction. Data were obtained on the dimensions of caring perception as described in the revised Caring Assessment Tool (Duffy & Hoskins, 2009) and on emergency patient's satisfaction as described in the Consumer Emergency Care Satisfaction Scale (Davis et al., 1997). Data on factors of chronic illness perceived by CHF patients as having significant impact on their quality of life were obtained using a demographic survey designed by this researcher.

Population, Sample Selection, and Study Setting

The study location was the emergency department of a New York metropolitan area hospital network. The study population was comprised of a convenience sample of heart failure patients admitted through the emergency department and who had experienced nursing care in the emergency department holding area over a period of six hours or longer while awaiting inpatient bed assignment. The study sample was planned to include a minimum of one hundred heart failure patients who had at least one previous hospital admission through the emergency department within the past one year for problems related to heart failure.

To ensure an adequate focus on nurse-patient interaction that would allow for perception of caring or lack thereof, patients with heart failure admitted through the emergency department who had received nursing care for a minimum of six hours while waiting for inpatient bed assignment comprised the study sample. This group of patients was selected for their high illness vulnerability that predisposed them to frequent emergency department visits, hospital readmissions, and the need for caring support by healthcare providers and nurses in particular. The selection was also based on the knowledge that admitted patients are often housed in the ED holding area with dedicated nurses administering inpatient care while these patients waited for an inpatient bed assignment. Patients' assessment of satisfaction with nursing care focused on general satisfaction and perception of caring among holding area nurses in all shifts.

Inclusion criteria were:

- Adult heart failure patient admitted in stable condition as determined by physician and with no obvious signs of distress such as shortness of breath

- History of heart failure requiring previous hospitalization

- Ability to read and write English language

- Voluntary agreement of participation in the study

Exclusion criteria were:

- Patients with new diagnoses of heart failure as noted in their medical history who had no prior history of hospital admission for heart failure

- Patients who declined participation for any reasons at any point during the study

- Heart failure patients who were unable to read and write English

- Heart failure patients who were in obvious distress, including those with breathing difficulties and/or on mechanical ventilator support.

The patients' admission time and length of stay in the emergency department holding area were tracked using the emergency department electronic patient tracking system that is currently used in the emergency department.

Theoretical and Operational Definitions of Study Variables

Key variables in this study include: social support, nurse caring, and patient satisfaction. **Social support** is defined as the interpersonal supportive transaction or behaviors that involve giving and receiving assistance from others throughout the course of life (Cobb, 1976;, Khan, 1979). In the Quality Caring Model, and within the Process

component, the patient, his family, and the nurse are engaged in an interdependent relationship utilizing the informational component of social support as one process or intervention that is critical in this relationship. **Nurse caring** in the emergency department is defined as deliberate, competent, and humane nursing actions or behaviors in which the identification, validation, and alleviation of the patient/significant other's concerns is the primary focus. **Patient satisfaction** is identified as an outcome or an end result of care within the Quality Caring Model. Patient satisfaction as a terminal result is impacted by positive changes in patients' behaviors, emotions, perceptions, or knowledge that result from the interaction between the patient/family, the health care, and the system. Also in this model, patient satisfaction subsequently impacts future patient expectations.

The **history of illness and demographic variables** are factors such as age, length of time with heart failure, living arrangement, and number of times in the ED. These factors may affect social support, nurse caring and patient satisfaction.

Study Variables

Social support. Social Support was defined as the interpersonal supportive transaction or behaviors that involve giving and receiving assistance from others throughout the course of life (Cobb, 1976; Khan, 1979). For this study, social support was measured using the Medical Outcomes Study survey tool (Sherbourne & Stewart, 1991).

Perception of nurse caring. For this study Perception of Nurse Caring was defined as deliberate, competent, and humane nursing actions or behaviors in which the

identification, validation, and alleviation of the patient/significant other's concerns is the

primary focus (Duffy & Hoskins, 2003). Perception of nurse caring in this study was

measured using the Caring Assessment Tool (Duffy & Hoskins, 2003).

Patient Satisfaction. For this study Patient Satisfaction is defined as the extent to which

patients' expectations of care matched the actual care received for a specified aspect of

care (Laschinger et al., 2005). Patient satisfaction in this study will be measured using

the Consumer Emergency Care Satisfaction instrument (Davis et al., 1997).

Human Subjects' Protection

This researcher recognized the potential vulnerability of chronically ill patients and

heart failure patients in particular who serve as subjects of research studies. As part of

the effort to protect patients who volunteer to participate in the study, this researcher

served as the sole recruiter of the study subjects. The need for knowledge and

competency in the topics relevant to this research was acknowledged. To this end, the

researcher took all necessary measures to ensure self-training on issues related to

management of heart failure patients, including assessment and recognition of signs and

symptoms of CHF such as, severe weakness, shortness of breath, and dizziness, which

could impact patients' abilities to participate in the study. As necessary, this researcher

consulted the interdisciplinary team for clarifications. Following the acquisition of

Adelphi University's and the participating hospitals' IRB approvals, all subjects who

agreed to participate were asked to sign a written consent and were informed of the right

to opt out at any time during the study (See Appendix A). To ensure timely data

collection, the researcher remained on site while administering the study questionnaires

to patients who agreed to participate and sign the informed consent. The researcher collected the completed   forms at each encounter. Data collection allowed for capturing most patients who were admitted through the hospital ED who agreed to participate in the study. The timeline for the study, including the survey of patients and data analysis was estimated at four months. Predicated on the subjects' preferences, condition, and patient flow issues, data collection occurred in the emergency department, holding area or assigned unit.

Study Instruments

Four study instruments, the Medical Outcomes Study (MOS) Social Support Survey (Sherbourne & Stewart, 1991), the Caring Assessment Tool (Duffy & Hoskins, 2009), the Consumer Emergency Care Satisfaction Scale (Davis, 2005), and a socio-demographic instrument were used for this study.   All but the socio-demographic survey instrument have been validated and used in other studies. Although each instrument has separate instructions for use, all instruments were collated into a booklet for ease of use.

The Medical Outcomes Study (MOS) Instrument

The Medical Outcomes Study MOS Social Support Survey (Sherbourne & Stewart, 1991) is a 20-item tool developed from a two-year observational study of 2,987 patients with various chronic conditions. The tool was designed to measure perceived availability of functional support, believed to be more important aspect of social support. Dimensions of social support measured with the MOS survey include emotional support described as involving caring, love, and empathy; instrumental support involves provision of tangible assistance; informational support involves provision of guidance or feedback that can

yield solution to a problem; appraisal support is described as involving information relevant to self-evaluation; social companionship is described as involving spending time with others in leisure and recreational activities (Sherbourne & Stewart, 1991).

The MOS instrument development process included multitrait scaling analyses of a pool of functional support items that yielded the final 19 related health and social support items including, physical functionality, role limitations, effects of pain, pain severity, mental health, loneliness and others hypothesized to measure the dimensions of social support. The tool also includes a single-item measure of structural support by close friends or relatives. The items withstood tests of several types of validity including, construct, factorial, and discriminant validity both at the initial phase and at one year following the tool development. Internal-consistency reliability and one-year stability coefficients for the support subscales using Cronbach's coefficient averaged 0.91.

Caring Assessment Tool (CAT)

The revised Caring Assessment Tool (Duffy & Hoskins, 2009) which is a blend of quality and human caring indicators and developed from the Quality-Caring framework. This tool is comprised of indicators that reflect aspects of quality care and has been used for measuring the caring competencies of nurses who work in acute care environment. This instrument is deemed appropriate for this study as it employs the familiar structure-process-outcome quality measures that are used for measurement of quality care across healthcare settings. The instrument has been validated in nursing education, nursing administration, and select clinical settings although not used in emergency department studies. This study provided an opportunity for the tool use in a complex practice

environment such as the emergency department where quantification of caring behaviors has proven difficult.

The Caring Assessment Tool (Duffy, Hoskins, & Seifert, 2007) provides a comprehensive nurse-psychometric measurement of nurse-caring and is grounded in Watson's (1988) 'carative' factors that describe interpersonal behaviors that characterized nurse caring. The instrument was originally developed in 1990 to assess patients' perception of nurse caring behaviors and has been revised a number of times since then. The current tool (version IV, 2007) emerged from a factor analysis and factor loading to consolidate a previous version. The use of factor analysis resulted to the tool changing from a 100-item to a 36-item 5-point Likert-type scale questionnaire that fit under 8 caring factors that were matched for theoretical consistency and empirical evidence. Multiple nurse caring theories of Watson, Peplau, Roach, Swanson, Leininger, Johnson, King, Orem, Henderson and Roy yielded the eight summative caring factors that were matched . The eight factors included mutual problem solving, attentive assurance, human respect, encouraging manner, appreciation of unique meanings, affiliation needs, and basic human needs.

The CAT revision involved 557 general medical/surgical patients from five acute care hospitals, 365 of who completed the 36-item questionnaire on the frequency of occurrence of each caring behavior. The internal consistency for the shortened tool was validated using Cronbach's alpha coefficient value of 0.96; construct validity was established by the use of factor analysis. Further validating the tool were the tests for internal validity of each independent factor which ranged from 0.757 to 0.917. Using mean substitution for patients who had one to ten percent of the items missing, reliability

for the 522 patients was found to be 0.96 with the scale mean of 142.64 and standard

deviation of 27.70. Although the original tool has been used in many previous studies,

use of the revised tool in any study is limited.

Consumer Emergency Care Satisfaction Scale (CESS)

The Consumer Emergency Care Satisfaction Scale originally developed by Davis,

Bush, & Thomas in 1997 and revised in 2005 will be utilized as a second instrument for

this study. The CESS was designed for measuring satisfaction with nursing among

urgent and non-urgent patients discharged from the emergency department, and is

comprised of a 19 item scored on a 5-point Likert-type scale ranging from completely

agree (5) to completely disagree (1). The instrument was based on two dimensions of

nursing care, discharge teaching and caring and included items such as, "the nurse

performed her duties skillfully, and the nurses seemed to know something about my

illness".

For reliability, the discharge teaching and caring scales demonstrated internal

consistency ranging from 0.84 to 0.94 and 0.87 to 0.95 respectively. In addition,

Cronbach's alpha coefficient for the discharge teaching scale scored an alpha coefficient

of 0.88, and the caring scale had an alpha coefficient of 0.97. Using a study of 468

participants, construct validity was tested by convergence in multiple groups factor

analysis of 4-factor matrix of psychological safety, discharge teaching, information

giving, and technical competence was reduced to 2-factor matrix of caring and discharge

teaching. Another validity testing of CESS using 616 participants from five researchers

in Australia, Slovenia, and Austria also supported the 2-factor matrix of caring and

discharge teaching (Davis et al., 2005). The CESS is self-administered and is recommended for studies measuring patient satisfaction in the ED because of its repeated testing and supported validity. Unlike several widely used patient satisfaction instruments such as Press-Ganey, CESS provides a measure of patient satisfaction that is specific for nurse behavior in a given patient care environment.

Demographic and History Form (DHF)

A demographic and history form (DHF) (Appendix B) developed by the researcher was used to collect participants' illness history, the number of times admitted to hospital with CHF, and related issues with seeking hospital care. Demographics collected using this form include age, gender, marital status, race/ethnicity, level of education, employment status, income level, home living condition, change in living status, admissions specific to ED, and admissions to past EDs, the number of times admitted to hospital with CHF, and related issues with seeking hospital care. The form is also designed to capture relevant aspects of chronic heart failure that may determine patient's response to the illness such as change in living status or delay in seeking treatment.

Hypotheses

To explore the influence of social support on nurse caring and patient satisfaction, the following statistical hypotheses will be tested:

- Social support scores using the MOS will positively correlate with the scores on perception of caring using the CAT.

- Social support scores using the MOS will positively correlate with the scores on patient satisfaction using the CESS.

- Demographic and illness history data will be associated with social support, caring perception, and patient satisfaction.

Data Collection Methods

Following approval by Institutional Review Board of both Adelphi University and the hospital study site, the researcher contacted and met with the emergency department administrators, including nurse managers as well as mangers of the inpatient units that house CHF patients. The meeting served to explain the study purpose, timeframe, and logistics and to address any questions and concerns. The researcher also arranged a meeting with the nurses to explain the study purpose and to answer relevant questions. Once clearance was received, the researcher prepared a time table for the study. The researcher asked for nurse volunteers to contact her as potential candidates were identified. The researcher visited the ED as frequently as possible to recruit study candidates and to collect data.

Prospective candidates deemed suitable for the study were given an explanation of the study, including the purpose, anticipated risks and benefits, the course of the study, and the required measures in place to maintain their confidentiality, privacy and safety. CHF patients who, after being briefed on the study purpose and process and who met the inclusion criteria and consented to participate in the study, were asked to complete the survey forms. Data collection took place after the patient had settled following bed assignment. Each subject was given an overview of the content of the forms and

instructions on how to complete them. The researcher answered any questions the

subjects may have. The estimated time frame for completion of a study packet forms was

30 minutes. The estimated time frame for data collection was 2 months.

Data Management and Analysis

The Statistical Package for Social Sciences (SPSS) software was used in

determining the relationship among the variables of social support, nurse caring and

patient satisfaction. The outcome of this study may yield further insights on managing

CHF in a manner that reduces illness burden and enhances quality of life among CHF

patients.

CHAPTER IV

PRESENTATION OF STUDY RESULTS

Overview of Data Collection and Analysis

This study examined the impact of Social Support on perception of nurse caring and patient satisfaction among patients with Heart Failure in the emergency department. In this chapter, the first section presents the study overview, the hypotheses, and the instruments used in data collection. The second section discusses sample description and the study settings. The final section presents the results of hypotheses testing. Throughout the chapter, several tables are used to describe the resulting statistical tests and findings

Four instruments were used in the study, Medical *Outcomes Study (MOS) Social Support Survey, Caring Assessment Tool (CAT), Consumer Emergency Care Satisfaction Scale (CESS)*, and a *Demographic History Form (DHF)*. All but the demographic history form have been validated and used in various studies. The demographic history form was developed to collect information on socio-economic profiles, including gender, age, marital status, race/ethnicity, employment status, occupation, level of education, number of household members, yearly household income, as well as illness related factors that may have influence on the study variables. The illness related factors considered in the

study included, the number of times admitted to the hospital in the past year, decision to delay seeking medical attention and the reason for such delay, individuals with whom participants lived, and what bothered the participants most when they were ill.

Hypotheses

To explore the relationship of social support, nurse caring and patient satisfaction, the following statistical hypotheses were tested:

1. Social support scores on the MOS instrument will positively correlate with the scores on perception of caring on the CAT instrument.

2. Social support scores on the MOS instrument will positively correlate with the scores on patient satisfaction using the CESS instrument.

3a. There will be an association between the study variables and socio-demographic variables

3b. There will an association between the study variables and illness variables.

Recruitment of Study Participants and Data Collection

As proposed, all participants were recruited from inpatient units directly following admission from the emergency department. The study settings included telemetry, coronary care, and medical-surgical units of the two hospital networks in the New York metropolitan of the United States, referred to in this study as hospital A and hospital B. Hospital A is a large 545 bed teaching and level 1 trauma designated hospital located in a densely populated area of the metropolis and serving a widely diversified

population. Hospital B is a 230 bed hospital located in a quiet residential area of the metropolis but also serving a culturally diversified population.

Following the Institutional Review Board approval at the researcher's university, the researcher sought permission from the hospitals to serve as the study setting. After several meetings with the appropriate administrative and clinical groups, IRB approval was sought and obtained from the study facilities. Following approval, meetings were held with the nursing staff, during which the study's purpose and process was explained, and the assistance of the nurses was requested for determining stability of qualified participants as well a request to solicit appropriate study participants. Data collection took place over a two month period.

Once information on the stability of prospective participants was determined, the researcher approached the participant, explaining the study purpose and process, including any risks and benefits. Each participant was informed that participation was voluntary and that refusal to participate would not impact his/her care. Prospective subjects were allowed ample time to ask questions before making a decision to participate in the study. Those who declined to participate were thanked and reassured that there would be no further action or effort to recruit them. Those who agreed to participate were asked to sign the consent form. The researcher then explained the contents of the research questionnaire package, consisting of the informed consent form and the four instruments for completion by participants. During completion of the instruments the researcher remained on the unit to answer any clarification questions the participants had. A total of 115 participants completed the questionnaire package.

The data collection took place between October 31st and December 31, 2013. Data

from the one hundred and fifteen (115) participants were first analyzed using descriptive

statistics. Each participant completed four one-page forms including, the *Demographic*

and History Form (DHF), the *Caring Assessment Tool* (CAT), the *Medical Outcomes*

Study (MOS) Social Support Survey, and the *Consumer Emergency Care Satisfaction*

Scale (CESS). The Demographic and History Form was used to collect information on a

socio-demographic profile including age, gender, race/ethnicity, marital status,

employment status, occupation, level of education, household yearly income, number of

household members, and disease-specific data including total number of hospital

admissions related to Congestive Heart Failure, number of hospital admissions for heart

failure within the past year, factors that influence the decision to seek medical attention

when ill, and greatest cause for concerns during hospitalization.

Description of the Sample

Demographics of the Sample

Of the 115 participants, 61.7 percent were male; 38.3 percent were female. The

median age was 60 years; 40 percent were married; 27 percent were divorced or

separated, while 38 percent were single or never married. Thirty percent were

Hispanic/Latino, 29 percent were African-American, 25 percent were white, 18 percent

were American Indian/Alaskan Native, and 13 percent were Asian/Hawaiian/Pacific

Islander. Forty-five percent were retired; 40 percent were either unemployed or disabled,

and 15 percent were employed. Forty-two percent of participants had an occupation

classified as non-professional; 25 percent as non-professional but skilled, 17 percent as

professional, and 11 percent as clerical. Twenty-six participants lived alone; the remainder lived with one or more individuals. Sixty-four percent completed grade/high school, 29 percent attained some college or technical school, while 8 percent had a post baccalaureate degree.

The yearly household income for 87 percent of the participants was below $30,000.00 with most of the participants receiving governmental financial assistance, while 13 percent reported an average income above $30,000.00. Because the demographic data form did not have a breakdown of income above $30,000.00, it was difficult to ascertain specific levels of income above $30,000.00.

Illness History Data of the Sample

The total number of hospital admissions for congestive heart failure among participants ranged from one to 5 times in the previous year, with 58 percent reporting an average of 2 times. Most participants lived with other family members (55%), including 25 percent who lived with their spouses; 29 percent lived alone. Responding to whether they delayed going to the hospital when ill, 87 participants or 76 percent responded "yes"; 28 participants or 24 percent responded "no". Answering the 'reason for delay' before seeking medical care, 82 percent stated that they were afraid of being kept in the hospital; the few others gave other reasons, including negative experiences with care in previous encounter. Responding to the question of what bothered them most while they were ill, 48 percent chose having someone to do their chores and errands, 24 percent chose having someone to help the with daily care, while others chose other reasons including fear of death and disability (see Appendix F).

Findings

Scores on Instruments

Medical Outcomes Study (MOS) Social Support Survey scores. (Appendix C)

In order to determine if an association existed between participants' perception of social

support and nurse caring and overall satisfaction with care, the *Medical Outcomes Study*

(MOS) instrument was utilized to collect information of social support indicators. The

MOS instrument is a 20 item questionnaire used to examine perceived social support.

Item number 1 of the instrument is numerically scored and used to capture the number of

close family members and friends in a person's support network. The remaining 19 items

of instrument are scaled from 1-5, ranging from none of the time, a little of the time,

some of the time, most of the time and all the time.

In response to the Medical Outcomes Study (MOS) instrument response on the

number close friends and relatives a participant had, 53 percent responded that they had

1-5; 23 percent responded that they had 6-10; 13 percent responded that they had 11-19;

13 percent responded that they had 20 or more, while 2 percent chose none (see

Appendix A). Responding to other questions that scaled the level of support and the

frequency of such support, 59 % of participants stated that they received support most or

all of the time, while 39% responded to getting support a little or some of the time. Less

than 2% stated that they had no support.

Caring Assessment Tool (CAT) To explore the association of nurse caring and social

support, the Caring Assessment Tool was used for capturing information of patients'

perception of nurse caring behaviors of the nurses in the emergency department. The tool

is comprised of a 27 item questionnaire on a scale of 1-4. The means and standard

deviation scores of the 27 items are rated (never, rarely, occasionally, frequently,

always). The majority of the participants chose 'frequently', giving a mean score of 3.8

of 4 (see Appendix D).

Consumer Emergency Care Satisfaction Scale (CESS) scores. The *Consumer*

Emergency Care Satisfaction Scale is a 17-item instrument that was utilized to capture

the level of patient satisfaction with nursing care in the emergency department. The

questionnaire items are scaled from 1-4, with the rating, completely agree, agree, neither

agree nor disagree, to disagree. Using this instrument, participants were asked to rate the

degree to which they agreed or disagree with aspects of care by the emergency

department nurses. Question numbers 5, 9, and 17 were asked and coded in reverse.

Appendix E shows details of the questionnaire as well as corresponding responses by the

participants.

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Hypotheses Testing and Statistical Results

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In this section, the findings from statistical analysis for the study hypotheses are

presented. The display of the analyses from correlations can be found in Appendix G.

Hypothesis #1

Social support scores on the MOS will positively correlate with the scores on the

perception of caring using the CAT instrument.

The alpha level for this hypothesis testing was set at $p < .05$. Using the Pearson

Product-Moment Correlation, no association was found between Social Support and

Caring perception, $r = .168$; $p = 0.079$; N = 110 (see Table1). From these analyses,

Hypothesis 1 was not supported (see Table 1).

Table 1
Correlation Coefficients (r) Among Study's Three Major Variables

	Social Support	Caring Perception	Satisfaction
Social Support	1.00	.168	-.139
Caring Perception	.168	1.00	-.555**
Satisfaction	-.139	-.555**	1.00

  * significance= p <0 .05
  ** significance = p < 0.001

Hypothesis #2

Social support scores on the MOS will positively correlate with the scores on

patient satisfaction using the CESS instrument. To determine the relationship of social

support and patient satisfaction, the Pearson Product-Moment Correlation was conducted

based on p <0.05. No association was found between social support and patient

satisfaction, $r = -.151$; $p = .110$; N =113 (see Table 1). Although not part of the study

hypotheses, an interesting association was noted between nurse caring and patient

satisfaction (see Table 1). This significant negative relationship between caring and

patient satisfaction ($r = -.555, p < .001$) is contradictory to the known and well reported

positive relationship between these two variables. A discussion of this finding is found in

Chapter V.

Hypothesis 3a and b

These hypotheses examined the association between both the study variables

(social support, caring perception, and satisfaction) and the socio-demographic and the

illness variables.

The socio-demographic variables were: age, gender, occupation, education level, income (ranges were provided as response choice), marital status, working status (working, retired), race-ethnicity, and number of people in household. The illness variables analyzed in relation to the study variables were: number of times admitted, whether treatment was delayed (yes/no), and reasons for treatment delay (multiple choices). Additional coding of some responses was necessary. For example, the reason treatment was delayed was coded as fear/no fear because the majority of the respondents indicated fear as a primary reason for delay. Hypothesis 3a and 3b results follow.

Hypotheses 3a. There are associations between the study variables and the socio-demographic variables.

Either Pearson Product Moment correlation or ANOVA was used to determine if an association existed between the scores on the study instruments (MOS, CAT, and CESS) and the scores of the variables on the socio-demographic instrument. Tables 2 and 3 present the summary of findings on the analyses of relationships. In Table 2, for the study variables age, marital status, occupation and number of household members an ANOVA was used. There was a significant association between social support and marital status as well as social support and number of household members.

Table 2: ANOVA Results of Study Variables and Age, Marital Status, Occupation Type and Number of Household Members

	Age (F)	Marital Status (F)	Occupation Type (F)	Number of Household Members (F)
Social Support	.022	4.764*	1.374	16.032**
Caring perception	.098	1.894	.608	1.634
Satisfaction	.018	.318	.593	.910

*significance = p<.05
**significance =p<0.001

A t-test was used to determine the association with the study variables of education level,

work status (retired or not), race-ethnicity, type of occupation and gender (Table 3.)

Social support and work status showed a significant association as did caring presence

and work status.

Table 3:
T-test Results of Study Variables and Select Demographic Variables

	Educ. Level	Work Status	Occupation	Race/ Ethnicity	Gender
Social Support	.154	3.140*	1.374	2.379	-1.737
Caring Perception	.693	4.260*	0.608	.134	-.553
Satisfaction	1.359	1.926	0.593	1.716	1.458

*=significance=p< 0.05
**significance=p<0.001

The findings of these analyses were mixed, with no significant association found between

social support, caring perception and satisfaction scores and the scores on age, gender,

educational level, income, race/ethnicity, and occupation. From the analyses however,

social support was found to be positively associated with being married, (marital status),

$F = 4.764; p = 0.004$. Social support was also noted to be associated with high number of

household members, $F = 16.032; p = <0.001$. See Table 2. A positive correlation was

found between work status and social support, $F = 3.140; p = 0.028$ and between caring

perception of nurses in the ED and being retired, $F = 4.260; p = 0.007$. Given these

findings, the hypothesis of a relationship between the study variables and the socio-

demographic variables was partially supported, indicating that the higher the number of

household members, the more support participants perceived. It also showed those who

are employed perceived more support than those who were unemployed and retired

individuals perceived more caring from nurses.

Hypotheses 3b

There are associations between the three study variables (social support, caring

perception and satisfaction and the illness variables (See Tables 4 and 5).

The second part of the hypothesis testing for H-3b examined the relationship

between the study variables and the illness variables, including the number of times

admitted in the previous year, whether decision to seek care was delayed, and the reason

for such delay. To determine if a relationship existed between illness data and the study

variables, the scores on the illness variables and the scores on the three study instruments

were analyzed using different statistical tests depending on the variable coding. An

analysis of the relationship between the illness variable, 'number of admissions for heart

failure in the previous year' with social support, caring perception of nurses, and patient

satisfaction using Pearson Product-Moment Correlation revealed no associations between

this illness variable and the scores from the caring perception and the satisfaction

instruments (see Table 4). A similar analysis of the relationship between the illness

variable 'who do you live with' and the study variables showed no significance for caring

perception and satisfaction (Table 4). However, there was a significant positive

relationship between social support scores and the variable 'who do you live with,

$r = .418$ $p = .001$. Of the 106 participants who responded to the question 'who do you live

with', 28(26%) chose 'alone', 25(23%) chose 'spouse', while 53 (50%) chose 'other

family'. Subsequently, analyzing the relationship between social support, caring

perception, and patient satisfaction using ANOVA, $F = 14.553$, $p < 0.001$, validated the

finding that the higher the number of household members, the more the participants felt

supported. The reason why participants who lived with larger number of household

members felt supported over those who lived alone or with less number of household

members was not clear.

Table 4
Correlation Coefficients (r) for Study Variables and
Who do you Live with and Times Admitted

	Who do you live with? (r)	Number of Times Admitted (r)
Social Support	.418**	.048
Caring Perception	.114	.077
Satisfaction	-0.97	-.60

* significance = p<.0.05
** significance =p< 0.001

To further examine the association between the study variables and the illness

variables, the mean score on the question about whether participants sometimes delayed

seeking medical help (yes/no) was correlated with the mean scores of the study variable

instruments using t-test and showed no association, t = 0.668 for social support, t = 0.685

for caring, and t = 0.601 for satisfaction (see Table 5). Ninety four participants (82%)

chose fear of being admitted to the hospital among other options for delay; others cited

other reasons for delay as not being happy with previous hospital experience (13.5%) and

not having someone to take them to the doctor (3.4%). Because a large number of

participants selected 'fear of being kept in hospital', the responses for this part of the

analysis were reduced to two categories, 'fear of hospitalization' and 'no-fear of

hospitalization' and correlated to the main three study variables. Treating the categories

as dichotomous variables, a t-test analysis was done and showed no significant

association between 'fear and social support, $t = 0.567$; fear and caring perception, $t = 0.773$; and fear and patient satisfaction, $t = 0.093$ (see Table 5).

The responses to the question of 'what bothers you most when you are ill' were reduced and treated as categorical since a significant number of participants chose the answer 'someone to do my chores and errands' over the five other options. Using t-test, 'doing my chores' versus 'not doing my chores' items were then analyzed for their relationship with the study variables and showed no association. Therefore, hypothesis 3b was only partially supported, showing that the higher the number of household members, the more social support participants perceived.

Table 5:
T-test Results for the Three Study Variables and Select Illness Variables

	Delayed seeking Treatment (yes/no)	Reason for Treatment Delay (fear of hospital admission) (yes/no)	What bothers you most (someone to do chores/errands)
Social Support	0.668	0.567	0.353
Caring Perception	0.685	0.773	0.307
Satisfaction	0.601	0.093	0.487

* significance=p< 0.05
** significance=p< 0.001

Summary of Chapter

The results of data analyses were presented in this chapter. The purpose of this study was to determine if associations existed between perceptions of social support, nurse caring, and satisfaction and to further explore if there were associations between the study variables, socio-demographic variables and illness variables among patients with heart failure admitted to the emergency department. Three hypotheses were tested using descriptive and inferential statistics. The analysis of the hypothesized associations

between Social Support and Caring Perception and between Social Support and Patient

Satisfaction using inferential statistical methods showed no significant correlation

between Social Support and Perception of Caring. There was equally no significant

association between Social Support and Satisfaction. While the analysis of the

relationships among the study variables did not support all the hypotheses, it revealed

other interesting trends and associations.

The analyses of association between the study variables and the scores on the

socio-demographic instruments showed partial support for the relevant hypothesis with

social support showing a positive relationship with increased number of household

members, as well as with being employed or being retired. In the second part of

Hypothesis, 3b, the relationship between the scores of the study instruments and the

scores for the illness data of the socio-demographic profile was also partially supported.

Individuals who live in larger households, that is, have more household members,

perceive having better support than those with fewer household members. Although not

part of the study hypotheses, an interesting trend emerged. There was a significant

negative correlation between Caring Perception and Patient Satisfaction. A discussion of

the study findings are presented in Chapter V.

CHAPTER V

SUMMARY, DISCUSSION, IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

Study Summary

This research study was undertaken to examine the relationship between social support and the perception of nurse caring, and patient satisfaction among patients with heart failure admitted to the emergency department. It was hypothesized that patients who perceived themselves as having strong social support would have positive perceptions of nurse caring, as well as positive satisfaction with their overall care. It was further postulated that the participant demographic and illness factors would be influenced by the study variables of perception of social support, nurse caring, and satisfaction. This chapter contains a discussion of the findings of hypotheses testing as well as other serendipitous findings. The implications of the study findings for nursing are discussed; recommendations for further research are presented.

The study utilized a descriptive correlational design to test the hypotheses. The sample was comprised of 115 patients admitted with congestive heart failure to two acute care hospitals in the New York metropolitan area of the United States. No significant association was found among the study variables. Mixed findings were noted on the association of the study variables and the socio-demographic and illness variables.

Study Limitations

There are limitations in this study and therefore the findings should be interpreted with caution. First there was a known vulnerability of the study subjects. The debilitating effects of congestive heart failure may have impacted how participants responded to the questionnaire; for example, while every effort was made to be sensitive to the subject's physical and emotional status, their illness predisposition may have interfered with their comprehension of the survey questionnaire. Another limitation was that some of the demographic data employed ranges and were designed for ease of use by the patients. Consequently, this format jeopardized the ability to collect more specific information on some of the socio-demographic variables such as income level. Finally, the subjects may have felt compelled to answer items favorably although assured their responses were anonymous and would not affect their care, and this may have influenced the study's results.

Discussion of Findings

This discussion will focus on the study findings and situate the findings within what is known about the hypotheses that were tested using both theoretical and reported research literature as a comparison.

Study Sample

Participants were recruited over a two-month period. Data collection took place as soon as patients were transferred from the Emergency Department to the medical, telemetry or Step Down units where patients with heart failure were admitted. Data were excluded from patients who were unable to complete all study questionnaires for any

reasons, even after signing the informed consent. The final sample size was 115, comprising 71 males and 44 females.

The age of the participants ranged from 25 to 96 years with the mean age of 65 years. Of the 115 participants, race/ethnicity distribution is as follows: 15.7 percent were American Indian/Alaskan Native, 11.3 percent were Asian/Hawaiian/Pacific Islander, 25.2 percent were Black/African American, 26.1 percent were Hispanic or Latino, while 21.7 percent were white/Caucasian. The sample's race/ethnicity distribution is in contrast with the admissions for both Hospitals A and B for the year 2013, which were reported by hospital statistical records as comprising 2 percent American Indian/Alaskan Native, 14 percent Asian/Hawaiian/Pacific Islander, 10 percent Black/African American, 3 percent Hispanic or Latino, 17 percent white/Caucasian, while 54 percent were of unknown race/ethnicity. The socio-economic variables of the participants including, employment status, occupation, number of household members, education level as well as yearly household income and number of individuals sharing residence with each participant can be found in Appendix D.

The review of literature which highlighted an association between illness variables and the study variables (Jurgens et al.; 2009) prompted the inclusion of illness history data as part of the socio-demographic data form. Participants' response to the number of times they had been admitted with heart failure related problems in the previous year, with whom they lived, whether or not they sometimes delayed seeking medical care and the reason for such delay, and what bothered them most when they were ill, were items included in the socio-demographic data form (Appendix D).

Social Support and Perception of Nurse Caring

Hypothesis 1 tested the association between social support using scores on the Medical Outcomes Study (MOS) Social Support Survey instrument and nurse caring perception using the scores on Caring Assessment Tool (CAT). The results of this analysis showed no association between social support and perception of nurse caring. While the relationship between these factors was not supported in this study, each variable has been shown to impact chronic illness and heart failure in particular. A study that examined the challenges and caring processes related to heart failure identified lack of caring support from health care providers and social isolation as having the most negative impact on heart failure patients (Hopp, Thornton, & Martin, 2010). The lack of a significant association in this study could be attributed to a number of difficult to control circumstances surrounding the study, including patients' interpretations of the instruments. The majority of participants (80 percent) did rate experiencing nurse caring as frequently verses never, rarely, occasionally, or always, with a mean score of 3.8 out of 4.

A second explanation for the lack of significant association might be the fast paced nature of the emergency department as the environment of care for heart failure patients who often present in a significant amount of distress. Issues of care in the emergency department including overcrowding, high acuity, and inadequate resources continue to challenge care givers' ability to render personalized care that the heart failure patient requires (Kilcoyne & Dowling, 2007; McCraig & Burt, 2005; Pitts et al., 2008).

Under the circumstance of chaos that characterizes the average emergency department, the heart failure patient in distress may not be in the best of position to appreciate the nuances of social support in such an environment of care.

Another explanation for the finding of a lack of relationship between social support and perception of nursing caring might be the ambiguity of social support and caring frameworks and their lack of consistency in the definition and measurement of the concept of caring and social support. The scores on the Caring Instrument were relatively high, however, and it may be that social support was not well defined or understood within the instruments as used. While the influence of caring behaviors and social support on ameliorating hardship or stressful conditions has been well documented in the literature, the measurement of these concepts is complex and may mean different things to different individuals. Accordingly, studies that have explored the ways by which social support provides mediating response to illness or stress reported conflicting results, identifying multiple opposing variables such as cultural orientation that influence perception of social support (Hatfield et al., 2012; Karada et al., 2013). It might also be that existing theories on social support emanate from social sciences with little focus on health sciences (Finfgeld-Connett, 2007), and thus may not be a good fit for studies with health variables. Moreover, available instruments for measuring attributes of social support tend to focus on social variables and rarely on health/illness variables.

Theories of social support describe social networks as comprising significant others ranging from an individual, to multiple immediate family members, friends, other relatives, health care professionals, and members of other social groups such as churches and community groups (Norbeck & Tilden, 1988; Pagana, 1990). While there is

evidence that social support can reduce life stress, including mortality, psychosocial

stress, and stress from health hazards, the structure and processes by which social support

affects human health and well-being are not fully understood (House et al., 1998). This

obvious complexity in delineating how support alleviates human health and illness

conditions may contribute to the lack of clarity and in developing concise measurement

instrument for the concept of social support, thus influencing on the study's findings.

The complexity that is inherent in the explanation of the concept of caring might

have also affected a lack of support for the hypotheses. Perception of caring is subjective

and varies widely among individuals based on multiple factors such as cultural behavior

expectation and gender role ambiguity (Blackford, 2003; Hultsjo & Hjelm, 2005;

Leininger, 2002; Munoz, 2007; Socorro, Tolson, & Fleming, 2001). While the concept

of caring is said to embrace a number of attributes and behaviors, including expression of

empathy, clinical competence, presence, and reflexive reassurance, care recipients often

hold a narrow perspective of what constitutes caring (Duffy & Hoskins, 2003; Jonsdottir,

Litchfield, & Pharris, 2004; Morse et al., 1992). Because perception of caring may be

influenced by many variables, including culture, technology, condition of the patients,

and the care environment, caring perception can differ due to the beholder's perspective.

As such, development of an instrument that captures the true essence of caring from the

perspective of the multiple recipients of caring behaviors can be a challenge.

The quest to understand the abstract nature of the concept of caring has yielded

qualitative and quantitative instruments for measuring this variable; yet, these

instruments do not determine universal measures that reliably assess the attributes of

caring. The multiple perspectives of caring as well as the differing instruments for

measuring caring may have contributed to the lack of association between social support and caring perception in this study. Available instruments are rarely tested enough to give an assurance of good fit across differing samples and contexts. It is important to note that the Caring Assessment Tool that was used in this study had not used previously in the emergency department setting. Therefore its sensitivity, validity and reliability in this context may have influenced the study's results. In addition, the role of the emergency department as the environment of care for heart failure patients who participated in this study is not well understood. Typically, the emergency department is chaotic, involving multiple kinds of caregivers in contact with patients at different time periods. Although this study examined a subset of patients who experienced nursing care in the emergency department, it may have been difficult for the patients to discern the care that was rendered exclusively by nurses. Another intervening variable was the patients' physical and mental state at admission. The physiologic status of heart failure patients when they present to the emergency department may be such that they are not able to remember details of their care in the emergency department, thereby influencing their responses to the study questionnaire on caring.

Social Support and Patient Satisfaction

The relationship between social support scores on the MOS instrument and Patient satisfaction scores on the CESS was tested. Utilizing the Pearson Moment correlation, an association was sought between social support and patient satisfaction with overall care in the emergency room. The results showed no correlation between social support and satisfaction at $r = 0.139$ and $p < 0.14$.

While it was important to explore the association between social support and patient satisfaction, the finding of a lack of association was not totally surprising. Patient satisfaction with care has been a major indicator of the quality of care; yet, specific factors that determine individual satisfaction remain elusive (Lashinger et al., 2005). Satisfaction with nursing care, defined as the degree to which nursing care meets patients' expectations with regard to many variables, including the art of care (Davis & Bush, 2003; Mrayyan, 2006), is often subjective and prone to bias. A nursing model of satisfaction postulates that satisfaction is a product of an individual's intrinsic and the organization's extrinsic factors, (Comley & Beard, 1988). Intrinsic factors according to this theory include a person's demographic profile as well as illness type and severity. Extrinsic factors include nursing care delivery model, provider competence, service promptness, comfort and cleanliness of the environment of care. From this model's perspective, it is clear that factors which result in patient satisfaction are not totally under the control of nursing care providers, and tend to vary among individuals rating satisfaction.

The lack of a correlation between social support and patient satisfaction might also have been influenced by the lack of uniformity in conceptualizing patient satisfaction and the consequent lack of a universal instrument for measuring patient satisfaction. Commonly used instruments that measure satisfaction tend to focus on overall patients' experience with hospital care. An accurate measure of the impact of nursing care experience on patients requires an instrument that captures the technical as well as caring art of nursing. Currently, instruments that are nursing care-sensitive for measuring patient satisfaction are rare; those that are available differ in their identified attributes of

nurse caring behaviors that lead to patient satisfaction. Similar to the variables of nurse caring and social support, the multiple differing perspectives that are characteristic of patient satisfaction might have resulted in a lack of association between the variables.

It is interesting to note that while the study hypotheses did not include examination of the relationship between perception of nurse caring and patient satisfaction, an important trend was noted from the analysis. The analysis showed a negative association between caring perception and patient satisfaction. The findings are contrary to the literature that report that caring perception has been s positively associated with overall satisfaction with care (Clark, et al., 2007; Davis & Duffy, 1999; Elder et al., 2004; Hayes & Tyler-Ball, 2007; Henderson et al., 2007; Leong, Lao, S & Chio, 2013).

In a study exploring the correlation of nurse caring and patient satisfaction and gender differences among cardiac patients undergoing interventional cardiology procedures, Wolf, Miller & Devine (2003) found a positive relationship between nurse caring and satisfaction, however with no significant gender difference. Compared to the findings of another study in which patients' perception of quality care were found to be dependent on their subjective estimations of the importance of the various dimensions of care (Muntalin et al., 2006), the present study findings did not support association between patients' perception of nurse caring and satisfaction in the emergency department.

Relationship between the Study Variables and the Socio-demographic Variables

This study examined the socio demographic profile of participants for trends as well as determined if relationships existed between select socio-demographic data and the study variables: social support, perception of nurse caring, and patient satisfaction.

Appendix F shows the profile of participants' gender, age, marital status, race/ethnicity, employment status, occupation, number of household members, highest education completed, yearly household income, and the number of hospital admissions in the past year related to heart failure. The majority of the participants were males (71 percent); 40 percent were married. Age distribution of participants varied widely, ranging from 25 to 96 years; their race/ethnicity also varied widely (See Appendix F). Further exploration of this finding may be beneficial and may have influenced some of the study's findings. The association between select demographic variables and the study variables are presented next.

Study Variables and Select Demographic Variables

Using the Pearson Moment-Correlation statistic, the association between the study variables and select socio-demographic variables including age, gender, marital status, and education level was explored and determined not to be significant (see Appendix 6). Further analysis using ANOVA revealed a significant relationship between social support and marital status. Married subjects and those who were widowed scored higher that those unmarried or divorced. This finding is in alignment with literature reporting that people who live with family members tend to report more support than those who do not (Dunbar et al., 2008; Jurgens et al., 2009; Lin et al., 2008; Luttik et al., 2005; Sayers et al., 2008). From the same finding, an association with social support was noted among participants who reported living with large number of family members.

While the finding for marital status was supported by literature, it was not clear why those who were widowed had similar results as those who were married. It was

noteworthy however, that study participants who reported being widowed also reported living with other family members, further supporting the association found between social support and larger number of house hold members reported by subjects. The data analyses did not show significant association between caring perception and satisfaction, and any of the aforementioned socio-demographic variables.

Employment Status and the Study Variables

Preliminary analysis using the Pearson Product-Moment Correlation revealed a significant association between perception of social support and employment status, $r = -248$, $p = <.01$. (See Appendix G). A further analysis using the ANOVA computation supported the association between social support and work status, $F = 3.140$, $p = <.05$. Participants who were employed or retired had higher scores on the support instrument than did those participants who were unemployed. The relationship between employment status and perception of caring was noted, although inversely; participants who reported being employed also reported perceiving more caring than those who were unemployed. This finding is difficult to explain because it contradicts well accepted study findings that showed a positive correlation of perception of caring and satisfaction with care. Overall, the study findings seem to suggest that poor economic status that is evidenced by poor employment status and lower income levels would account for the low perception of social support. It is equally difficult to compare these findings with reported literature because similar studies that have explored the same demographic variables focused on different factors and utilized different statistical analyses.

Relationship Between the Study Variables and Illness Variables

The study revealed associations between select illness variables and the study variables of social support, caring perception, and patient satisfaction study instruments (see Table 2). The analysis of the part of the socio-demographic profile that addressed illness variables, including the number of times the participant had been admitted to the hospital with heart failure within the previous year, who the participant lived with, whether participants sometimes delayed seeking medical care and the reason for such delay, as well as what bothered them the most when they were ill, revealed some interesting points noted in the following discussion section.

Study Variables and number of hospital admissions for heart failure

Using the Pearson Product-Moment correlation analysis, no trends or significant association were found between social support, caring perception, and patient satisfaction on the question that asked the number of hospital admissions related to heart failure in the previous year. This finding is refuted by existing literature that states that lack of social support is a strong predictor of readmissions in patients with heart failure (Luttik, et al., 2005).

Study Variables and 'With Whom Subjects Lived'

A significant correlation was found between social support and the response to the question on the number of people with whom participants lived using Pearson Product-Moment correlation analysis (see Table 3). Specifically, participants who reported living with larger numbers of people in the household also reported perceiving more social support, $r = 0.418$; $p < 0.001$. This finding is in alignment with literature reported in

which heart failure patients who lived alone report feeling socially isolated and

vulnerable to poor self-care practices (Dunbar et al., 2008; Evangelista & Shinnick,

2008). Although it is different from Sayles' (2008) finding that living with family

members did not improve self-care. There were no significant relationships noted

between caring perception and satisfaction and the number of household members.

Study Variables and 'Delay Seeking Medical Care and Reason for Delay'

The analysis of association between social support, caring perception, and satisfaction

and the 'yes' or 'no' choice responses to the question on whether participants delayed

seeking medical care when ill, using the t-test revealed interesting findings. Seventy five

percent of participants chose 'yes' to delaying seeking medical assistance with no

significant trend of pattern. Because 82% of the participants who responded 'yes' to

delaying medical assistance also chose fear of being admitted to the hospital as the reason

for the delay in seeking medical assistance, the response fear to being admitted to the

hospital was treated as a dichotomous variable and analyzed to determine if an

association existed between this response and the scores on social support, caring

perception, and satisfaction instruments; however no significant association was found.

This finding is in contrast with findings from a similar study in which a group of elderly

patients with heart failure had reported different social support related factors, including

over-dependence on the family members and others, as the reason for delaying seeking

medical care promptly (Jurgens et al., 2009). The reason for the lack of association

between these variables is not clear; however, one might speculate that the issues related

to the use of the study instruments in the ED and the lack of sensitivity and clarity of

items on the social support (MOS) instrument discussed earlier may have influenced

these results.

Study Variables and 'What Bothered You the most During Illness'

Using t-statistics, the mean score of participants' responses to the question 'what

bothers you the most when ill' and the mean scores on social support, caring perception,

and satisfaction were analyzed for association. Although the majority of participants

chose 'finding someone to do my chores and errands' as bothering them more that the

other options, no significant association was found between the study variables and the

responses to this illness variable. No relevant research literature could be located about

this finding and thus further explanation of it by comparison is not possible. However,

this was one item on an instrument developed by the researcher and only one of five

items on illness history.

Quality Caring Framework

The use of the Quality Caring model with its structural, process and outcome

components was useful for explaining the rather complex relationships between the

variables in this study. The robust nature of the framework allowed for flexibility in

capturing different complex care situations from the perspective of care recipients,

especially as they relate to quality care and patient satisfaction. Specifically, this theory

highlighted the effect of social support on an individual's response to illness and illness

variables. The framework's components encompassed the interplay of the environment,

the actions of care providers and the response of care recipients. Because the

framework's design is based on a quality assessment model, its use to explore the study variables which serve as frequently monitored quality care indicators was a good fit.

The quality caring theory examines the severity of illness as part of the patient/family structure of the model and as such influenced the questions about the severity of heart failure as it is lived in admissions to the emergency department. The process part of the model guided the choice of instruments focusing on family aspects of social support as well as the dimensions of nurse caring. Another piece of the process model within the theory emphasizes collaborative caring relationships in multidisciplinary teams. These teams were not part of the investigation and their absence may have influenced the results. Finally, the outcome dimension of the quality nursing care theory emphasizes nurses' role in preventing readmissions which in turn supported asking about number of admissions as it is known that readmissions are linked to a lack of social support in this population. The quality caring model also holds patient satisfaction as one of its key terminal outcomes for patients. The theory influenced the study design by placing the focus of the exploration on the interdependent relationships of social support, nurse caring and patient satisfaction.

Implications

Understanding the factors that influence individuals' responses in illness conditions can provide insights to effective care outcomes, measured by enhanced consumer engagement in self-care, reduced cost of care, improved quality of life, and consumer satisfaction with care. While the mediating effects of social support in illness and stressful conditions is well documented in the literature, the type of support that

works best in various illness situations and the source of such support need to be better understood. More work is needed to understand the various perspectives of consumers on social support, nursing caring behaviors, and patient satisfaction, as well as on the development of standardized measurement instruments for these constructs, especially in meeting the national goals of provision of patient-centered care (IOM, 2001).

Implications for Nursing Practice

In an era when preventative health care is emphasized, the need to support self-care behavior among consumers is well recognized. Nurses are in the best position to identify sources of social support that are appropriate for the various levels of prevention: primary, secondary, and tertiary. Incorporating the assessment of clients' social support networks and eliciting available support systems at the start of care can help nurses in planning appropriate intervention for their clients, including education and counseling. In addition, understanding what it means to be caring from the perspective of patients will undoubtedly strengthen care partnership between nurses and clients and helps to focus nursing on patient-centered care and outcomes of practice. This may consequently promote continuity of care and improve care outcome and satisfaction.

Implications for Nursing Education

While the relationship among social support, nurse caring, and patient satisfaction was not found to be significant in this study, these concepts have been known to relate in many ways and to contribute to positive care outcomes. The design of academic nursing curricula should focus on these constructs from the inception of basic nursing education programs. It is equally important that academic curricula include an emphasis of practice

skills competency as a critical component of human caring behavior. Transitioning these attributes to the practice environment through facility-based education is the key to successful implementation. Nurses are accountable for educating the public on what nurses do. Attending to the needs of clients in a manner that is humane, and providing assistance in their responses to illnesses is central to nursing's role. Nurses need to be taught to identify themselves to patients and to describe the kind of help they are offering to them, in terms of specialized knowledge and abilities. This help may involve monitoring technology, medications and safeguarding patients from fatigue, falls or emotional upset. When nurses are able to describe these actions to their patients more of central and multi-faceted role of caring is explicated.

Implications for Nursing Administration

Nurse administrators, especially those in the emergency department, have the challenge of ensuring the delivery of quality nursing care to a diverse group of chronically-ill patients with multiplicity of needs present to the emergency department on a frequent basis. Nurse administrators also have the role for ensuring the competency, engagement, and satisfaction of nurses as a way of enhance and maintaining good care outcomes. The complex nature of the emergency department warrants that nurse administrators provide an enabling practice environment in which the nursing staff are culturally and technically competent as well as empowered to provide supportive nursing care even in the presence of the challenging circumstances of the emergency department. An exploration of relationship-based care models such as the quality caring nursing model that nurtures partnership between the nursing staff, patients, and their significant others is beneficial. Administrators must make a commitment that the care of patients

who frequently use the ED due to the chronic nature of their illness need to be viewed in

a special way by the nursing staff, with compassion and understanding for their needs for

caring and support. They can begin their understanding and advance that understanding

of others by examining constructs like social support and caring. The role of the family in

these constructs must move to the foreground of the emergency room environment

starting with the administrative policy leaders. In turn nursing staff who perceive support

from their nurse leaders are more likely to express satisfaction and may be more likely to

be perceived as caring and supportive by their clients, the essence of patient satisfaction.

These nurses will also recognize the importance of the role of family members in the ED

setting as sources of social support and assist in making them not only welcome but

partners in care.

Implications for Community Health Nurses

Community health nurses play a significant role in health-illness continuum,

ensuring health maintenance and preventing exacerbation of chronic illness conditions.

Effective health maintenance requires a caring commitment to understanding social

support systems of the diverse community, as well as provision of appropriate education

and guidance. To remain relevant to the health of their clientele, community health

nurses must win the trust of their clients through caring presence, an integral part of in-

depth assessment and care of clients in a manner that is supportive and non-judgmental.

Recommendations for Further Research

As previously noted, much of the current research on social support has been done by the disciplines of Psychology, Sociology, and Social Work. Accordingly, available instruments for measuring social support are broad-based and often not specific to nursing care situations. While the work of these disciplines is very valuable in understanding social support, there is a need to discover the meaning of the concept of social support from the perspective of nursing science. This may provide the desired clarity to the concept, as well as aid in the development of standardized measurement instruments. Once this is accomplished, research should be focused on uncovering the different types of social support that are appropriate in ameliorating the stress of illness for different individuals. This may be understood through using qualitative research such as grounded theory to examine the process of social support.

The act of caring applies to all humans and has been said to be the hub of nursing practice (Leininger, 1988). Yet, the construct of nurse caring remains elusive and often difficult to measure. More research is needed to understand the attributes of nurse caring in order to separate nurse caring from the caring by others. As the definition of nursing caring behaviors are refined, new instruments will be necessary in order to capture the new areas of interest. Qualitative research here, too, may provide a lens into the experience of being cared for in an emergency setting.

Consumer satisfaction with nursing care is another area that requires further research. While it is evident that satisfaction with nursing care continues as a key indicator of satisfaction with overall hospital care (Palese et al., 2011), discerning the behaviors of nursing from that of other health care workers in interdisciplinary work

environment remains a major challenge. Research is needed on how to identify and propagate nursing actions that are satisfying to patients. Studying the impact and relationship of social support, nursing caring, and patient satisfaction especially in nurse-managed environment of care will highlight the role of nursing and further provide clarity to the public on what nurses do.

Conclusions

While the hypotheses on the associations between social support, perception of caring, patient satisfaction, demographic, and illness variables could not be substantiated in their entirety, the study's intent to uncover trends and association between these variables remains relevant. The findings support our knowledge that the management of heart failure remains a challenge to nurses, healthcare providers, patients and their significant others. Its management requires a multidimensional approach and partnership between care providers, patients, and members of their social network.

The inherent complexity of the emergency department as the study environment may have contributed to the challenge in determining an association between the concepts of social support and perception of nurse caring. Individual patient perspectives are yet another possible source of bias in exploring the association between perception of social support and perception of nurse caring. Socio-economic variables and individual opinion often differ; what one patient defines as assistance could well be the opposite for another patient. It will be worthwhile to continue to explore patient-related or endogenous factors that influence the recognition of social support, the perception of nurse caring behaviors as well as patient satisfaction with care.

Summary of Chapter V

As a discipline that guides human response to illness and stressful conditions, the nursing profession is obligated to continually engage in research efforts to uncover best nursing practice that are evidence-based and scientifically sound. It was upon this premise that this research was conceived and future work recommended. This chapter presented the summary of findings from the study, and a discussion of the choice of the theoretical framework for the study, implications for nursing practice, nursing education, and nursing administration. Recommendations for further research were also presented.

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Appendix A
Adelphi University Informed Consent

IRB Protocol Title: The influence of social support on perception of nurse caring and patient satisfaction among patients with heart failure in the Emergency Department.

Principal Investigator: Agatha Anosike, RN, MS, PhD candidate

Research Purpose

The purpose of the research is to determine the effect of social support on both nurse caring and patient satisfaction in patients who visit the ED due to heart failure.

Description of the Research

If you consent to being part of this study you will be asked to fill out four surveys. Each one represents a part of the study that I am completing for my PhD studies. The surveys measure Social Support, Caring, Patient Satisfaction and Personal/Medical History. You will be asked to fill them out only if you feel well and strong enough and you meet the criteria of having been admitted once before for treatment of heart failure. Access to your medical record will be needed in order to determine the stage of HF you are experiencing.

Potential Risks

There are minimal risks to your health in filling out the surveys. Your nurse and the study investigator will determine that you are stable enough to fill these forms out and that they will not cause you to become tired. If these surveys bring up questions that upset you in any way, you may stop the study and that will not affect your care in anyway. In fact, you may decide to stop filling out the forms and being part of the study at any time. The principal investigator is an experienced emergency nurse who can readily intervene if a referral is needed for additional support. Ms. Anosike is available at 516-384-8590.

Potential Benefits

You are welcome to learn about the results of the study and if you choose to do so, you may receive the benefits of increased knowledge about your illness.

Costs/Compensation

There are no costs and there is no compensation for being part of the study.

Contact Persons

If you have any questions, at any time, about this research, please contact **Agatha Anosike at telephone number—516-384-8590 or through email at agathanosike@mail.adelphi.edu.**

Confidentiality

The records will be kept in a locked box in the home of the investigator, Agatha Anosike. Your identity as a participant in this research study will be kept confidential in any publication of the results of this study. The information obtained during this research (research records) will be kept confidential to the extent permitted by law. However, this research record may be reviewed by government agencies (such as the Department of Health and Human Services), the agency sponsoring this research, individuals who are authorized to monitor or audit the research, or the Institutional Review Board (the committee that oversees all research in human subjects at Adelphi University) if required by applicable laws or regulations. The material will be maintained for **up to 7 years**.

Voluntary Participation

Participation in this study is voluntary. If you decide not to participate, this will not affect your care in the hospital or the emergency room in any way. Any new information that develops during this study, which might affect your decision to participate, will be given to you immediately. A signed copy of this consent form will be given to you.

Institutional Review Board Approval

This research has been reviewed and approved by the Adelphi University Institutional Review Board. If you have any questions, concerns or comments, please contact Dr. Julie Altman, 516-877-4344 or altman@adelphi.edu.

Signature

Person Obtaining Consent

Print Name_____Signature_____Date_____

Study Participant

Print Name_____Signature_____Date_____

Appendix B. Socio-Demographic Profile

Subject # _____

Today's Date: _____   *# of all Hospital past admissions for HF:*
_____

Please list your heart failure stage if you know
it. _____

Please read and place "X" in the box that best answers the question or fill in the blanks

1. Gender [ ] male [ ] female   2. Age: _____

3. Marital status: [ ] married   [ ] Divorced [ ] Separated [ ] Never married [ ] Widowed

4. Race/Ethnicity:
[ ] American Indian/Alaskan Native
[ ] Asian/Hawaiian/Pacific Islander
[ ] Black or African-American
[ ] Hispanic or Latino
[ ] Two or More Races
_____
[ ] White

5. Employment Status:
     [ ] Employed
     [ ] Retired
     [ ] Homemaker
     [ ] Unemployed
     [ ] Other (specify)

6. Occupation: _____   7. # of household members:
_____

8. Highest education completed
    [ ] Grade school/ High school

    [ ] Some college/Technical school
    [ ] Post Baccalaureate degree

9. Yearly Household income:
    [ ] Less than 30,000

    [ ] Above 30,000
    [ ] Receiving disability

10. # of times you were admitted to hospital with heart failure in the past one year:
_____

11. Who do you live with [ ] Alone [ ] Spouse [ ] Other family [ ] Friends [ ]
Shelter/homeless

12. Do you sometimes delay seeking medical help or going to the doctor when you are
ill?
      No [ ] Yes [ ]. If yes please choose all of the following reasons that apply.

[ ] Not having someone to take you to the doctor/ hospital
[ ] Afraid that they might keep (admit) me in the hospital
[ ] Not happy with my previous hospital care
[ ] Others (please specify) (i) _____ (ii)

_____

13. What bothers you the most when you are ill?
[ ] Finding someone to take care of my pets
[ ] Having someone to help me with my daily care
[ ] Finding someone to do my chores and errands
[ ] Having someone to chat with
[ ] Others (please specify) (i) _____ (ii)

_____

Thank you.

Appendix C
Medical Outcome Study (MOS) Social Support Survey

1. About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?							
Write the number of close friends and close relatives							
	None	1-5	6-10	11-20	More than 20	Mean	SD
	N (%)	N (%)	N (%)	N (%)	N (%)		
# of close friends	2 (1.7)	61 (53)	26 (22.6)	423 (20)	3 (2.6)	1.69	0.902

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Mean	SD
	N (%)	N (%)	N (%)	N (%)	N (%)		
2.Someone to help you if you were confined to bed...	2 (1.7)	6 (5.2)	31 (27)	47 (40.9)	29 (25.2)	3.83	0.93
3. Someone you can count on to listen to you when you need to talk...	1 (0.9)	8 (7)	34 (29.6)	49 (42.6)	23 (20)	3.74	0.889
4. Someone to give you good advice about a crisis...	1 (0.9)	7 (6.1)	42 (36.5)	41 (35.7)	24 (20.9)	3.70	0.900
5. Someone to take you to the doctor if you needed it...	2 (1.7)	7 (6.1)	39 (33.9)	42 (36.5)	24 (20.9)	3.69	0.932
6. Someone who shows you love and affection...	2 (1.7)	8 (7)	39 (33.9)	41 (35.7)	25 (21.7)	3.69	0.949
7. Someone to have a good time with...	2 (1.7)	8 (7)	42 (36.5)	39 (33.9)	24 (20.9)	3.65	0.946
8. Someone to give you information to help you understand a situation...	1 (0.9)	10 (8.7)	41 (35.7)	41 (35.7)	22 (19.1)	3.63	0.921
9. Someone to confide in or talk to about yourself or your problems...	1 (0.9)	9 (7.8)	43 (37.4)	38 (33)	24 (20.9)	3.65	0.928
10. Someone who hugs you...	2 (1.7)	10 (8.7)	37 (32.2)	40 (34.8)	25 (21.7)	3.67	0.975
11. Someone to get together with for relaxation...	1 (0.9)	11 (9.6)	39 (33.9)	41 (35.7)	22 (19.1)	3.63	0.934
12. Someone to prepare your meals if you were unable to do it yourself.	1 (0.9)	12 (10.4)	38 (33)	40 (34.8)	24 (20.9)	3.64	0.957
13. Someone whose advice you really want...	1 (0.9)	8 (7)	41(35.7)	43 (37.4)	22 (19.1)	3.67	0.896
14. Someone to do things with to help you get your mind off things...	1 (0.9)	10 (8.7)	41(35.7)	40 (34.8)	23 (20)	3.64	0.929
15. Someone to help with daily chores if you were sick...	1 (0.9)	11 (9.6)	35 (30.4)	42 (36.5)	26 (22.6)	3.70	0.955
16. Someone to share your most private worries and fears with...	2 (1.7)	10 (8.7)	37 (32.2)	44 (38.3)	22 (19.1)	3.64	0.948
17. Someone to turn to for suggestions about how to deal with a personal problem	1 (0.9)	10 (8.7)	36 (31.3)	45 (39.1)	23 (20)	3.69	0.921
18. Someone to do something enjoyable with...	1 (0.9)	8 (7)	39 (33.9)	43 (37.4)	24 (20.9)	3.7	0.908
19. Someone who understands your problems...	1 (0.9)	9 (7.8)	31 (27)	50 (43.5)	24 (20.9)	3.76	0.904
20. Someone to love and make you feel wanted...	1 (0.9)	10 (8.7)	27 (23.5)	50 (43.5)	27 (23.5)	3.8	0.929

Appendix D
Caring Assessment Scores

Since I have been a patient here, the nurse/s:							
	Never	Rarely	Occasionally	Frequently	Always	Mean	SD
1. Help me to believe in myself			18 (15.7)	92 (80.0)	5 (4.3)	3.89	0.435
2. Make me feel comfortable as possible			19 (16.5)	89 (77.4)	7 (6.1)	3.90	0.466
3. Support me with my beliefs			19 (16.5)	89 (77.4)	7 (6.1)	3.90	0.466
4. Pay attention to me when I am talking		1 (0.9)	21 (18.3)	85 (73.9)	8 (7)	3.87	0.522
5. Help me see some good aspects of my situation			20 (17.4)	86 (74.8)	9 (7.8)	3.90	0.495
6. Help me feel less worried		1 (0.9)	23 (20)	78 (67.8)	13 (11.3)	3.90	0.583
7. Anticipates my needs			25 (21.7)	77 (67)	13 (11.3)	3.90	0.568
8. Allow me to choose the best time to talk about my concerns			25 (21.7)	76 (66.1)	14 (12.2)	3.90	0.577
9. Are concerned about how I view things			26 (22.6)	77 (67)	12 (10.4)	3.88	0.564
10. Seem interested in me		2 (1.7)	26 (22.6)	74 (67.3)	13 (11.3)	3.85	0.625
11. Respect me		1 (0.9)	21 (18.3)	81 (70.4)	12 (10.4)	3.90	0.562
12. Are responsive to my family		1 (0.9)	24 (20.9)	75 (65.2)	12 (10.4)	3.88	0.587
13. Acknowledge my inner feelings			26 (22.6)	77 (67)	12 (10.4)	3.88	0.564
14. Help me understand how I am thinking about my illness		1 (0.9)	25 (21.7)	77 (67)	12 (10.4)	3.87	0.585
15. Help me explore alternative ways of dealing with my health problem(s)		2 (1.7)	23 (20)	78 (67.8)	12 (10.4)	3.87	0.600
16. Ask me what I know about my illness		3 (2.6)	21 (18.3)	78 (67.8)	13 (11.3)	3.88	0.623
17. Help me figure out questions to ask other health care professionals		2 (1.7)	23 (20)	78 (67.8)	12 (10.4)	3.87	0.600
18. Support my sense of hope		2 (1.7)	25 (21.7)	77 (67)	11 (9.6)	3.84	0.601
19. Respect my privacy		2 (1.7)	18 (15.7)	83 (72.2)	12 (10.4)	3.91	0.571
20. Ask me how I think my health care treatment is going		1 (0.9)	23 (20)	78 (68.7)	13 (11.3)	3.90	0.583
21. Treat my body carefully		1 (0.9)	20 (17.4)	83 (72.2)	11 (9.6)	3.90	0.546
22. Help me with my special routine needs for sleep			22 (19.1)	80 (69.6)	13 (11.3)	3.92	0.548
23. Ask me what I know about my illness		2 (1.7)	24 (20.9)	77 (67)	12 (10.4)	3.86	0.605
24. Help me deal with my bad feelings		2 (1.7)	24 (20.9)	77 (67)	12 (10.4)	3.86	0.605
25. Know what is important to me		2 (1.7)	24 (20.9)	79 (68.7)	10 (8.7)	3.84	0.586
26. Talk opening to my family		2 (1.7)	23 (20)	81 (70.4)	9 (7.8)	3.84	0.571

27. Show respect for those things that have meaning to me		2 (1.7)	23 (20)	80 (69.6)	10 (8.7)	3.85	0.581

Appendix E:
Emergency Care SatisfactionConsumer Action Scale (CESS)

Question The nurse:	Completely Agree	Agree	Neither Agree nor Disagree	Disagree	Completely Disagree	Mean	SD
1. The nurse performed his/her duties with skill	18 (14.8)	84 (72.2)	14 (12.2)	1 (0.9)		1.97	0.545
2. The nurse seemed to know something about my illness/problem	17 (15.7)	83 (73)	12 (10.4)	1 (0.9)		1.99	0.554
3.The nurse knew what treatment I needed	20 (17.4)	78 (67.8)	15 (13.0)	2 (1.7)		1.99	0.614
4. The nurse gave me instructions about caring for myself at home	17 (14.8)	80 (69.6)	18 (15.7)			2.01	0.554
5. The nurse should have been more attentive that he/she was		44 (38.3)	29 (25.2)	38 (33.0)	4 (3.5)	3.02	0.927
6. The nurse told me what problems to watch for	15 (13)	81 (70.4)	19 (16.5)			2.03	0.545
7. The nurse told me what to expect at home	15 (13)	82 (71.3)	18 (15.7)			2.03	0.537
8. The nurse explained all procedures before they were done	18 (15.7)	83 (72.2)	14 (12.2)			1.97	0.529
9. The nurse seemed too busy at the nurses station to spend time talking with me		47 (40.9)	38 (33)	29 (25.2)	1 (0.9)	2.86	0.826
10. The nurse explained things in terms I could understand	21 (18.3)	78 (67.8)	16 (13.9)			1.96	0.568
11. The nurse was understanding when listening to my problems	20 (17.4)	79 (68.7)	16 (13.9)			1.97	0.561
12 The nurse seemed genuinely concerned about my pain, fear, and anxiety	19 (16.5)	79 (68.7)	17 (14.8)			1.98	0.562
13. The nurse was as gentle as he/she could be when performing painful procedures	18 (15.7)	82 (71.3)	15 (13)			1.97	0.537
14. The nurse treated me as a number instead of as a person	10 (8.7)	49 (42.6)	13 (11.3)	43 (37.4)		2.77	1.052
15. The nurse seemed to understand how I felt	18 (15.7)	81 (70.4)	16 (13.9)			1.98	0.546
16. The nurse gave me a chance to ask questions	17 (14.8)	83 (72.2)	15 (13)			1.98	0.530
17. The nurse was not very friendly		61 (53)	25 (21.7)	28 (24.3)	1 (0.9)	2.73	0.862
18. The nurse appeared to take time to meet my needs	18 (15.7)	80 (69.6)	17 (14.8)			1.99	0.554
19. The nurse made sure that all my questions were answered	19 (16.5)	79 (68.7)	17 (14.8)			1.98	0.562

Appendix F
Socio-Demographic and Illness Profile

Gender	Number	Percent
male	71	61.7
female	44	38.3
Total	115	100.0

Age	Number	Percent
40 and less	4	3.5
41-50	8	7.0
51-60	34	29.6
61-70	31	27.0
71-80	22	19.1
81 and above	16	13.9
Total	115	100.0

Marital status:	Number	Percent
married	46	40.0
Divorced/ Separated	31	27.0
Never married	19	16.5
Widowed	19	16.5
Total	113	98.3
Missing	2	1.7

Race/Ethnicity:	Number	Percent
American Indian/Alaskan Native	18	15.7
Asian/Hawaiian/Pacific Islander	13	11.3
Black or African-American	29	25.2
Hispanic or Latino	30	26.1
White	25	21.7
Total	115	100.0

Employment Status:	Number	Percent
Employed	17	14.8
Retired	52	45.2
Unemployed	23	20.0
Other (specify- Disabled)	23	20.0
Total	115	100.0

Occupation	Number	Percent
Non-Professional	48	42.1
Non-Professional Skilled	29	25.4
Clerical	12	10.5
Professional	19	16.7

Work at home	6	5.3
Total	114	100.0

# of household members	Number	Percent
Alone	30	26.1
2	35	30.4
3-4	39	33.9
5 and more	11	9.6
Total	115	100.0

Highest education completed	Number	Percent
Grade school/ High school	73	63.5
Some college/Technical school	33	28.7
Post Baccalaureate degree	9	7.8
Total	115	100.0

Yearly Household income:	Number	Percent
Less than 30,000	100	87.0
Above 30,000	15	13.0
Receiving disability		
Total	115	100.0

Illness Profile

# of times you were admitted to hospital with heart failure in the past one year:	Number	Percent
1	7	6.1
2	58	50.4
3	26	22.6
4	18	15.7
5 +	6	5.2
Total	115	100.0

Who do you live with	Number	Percent
Alone	29	25.2
Spouse	25	21.7
Other family	55	47.8
Friends	5	4.3
Shelter/homeless	1	0.9
Total	115	100.0

Do you sometimes delay seeking medical help or going to the doctor when you are ill?	Number	Percent
No	28	24.3
Yes	87	75.7
If yes please choose all of the following reasons that apply.		
Not having someone to take you to the doctor/ hospital	3	3.4
Afraid that they might keep (admit) me in the hospital	73	82.0
Not happy with my previous hospital care	12	13.5
Others (Specify- Don't want to bother my daughter)	1	1.1
Total	89	100.0

What bothers you the most when you are ill?	Number	Percent
Finding someone to take care of my pets		
Having someone to help me with my daily care	27	23.5

Finding someone to do my chores and errands	55	47.9
Having someone to chat with	11	9.6
Others (please specify)**	22	19.1
*Nothing/ not worried***	*2*	*1.7*
*When to be well***	*2*	*1.7*
*How to be well/ getting better***	*16*	*13.9*
*Not able to work***	*1*	*.9*
*Afraid of death***	*1*	*.9*
Total	114	99.1
Missing	1	0.9

Appendix G
Correlations of Social Support, Caring Perception, Patient Satisfaction, and Socio-Demographic Variables

		Caring assessment	Satisfaction scale	Social support	Age	Marital Status	Employment status	Highest education completed	Gender
Caring assessment	Pearson Correlation	1	-.555**	.168	.098	.038	-.110	.004	.053
	Sig. (2-tailed)		.000	.079	.305	.688	.249	.968	.579
	N	112	112	110	112	112	112	112	112
Satisfaction scale	Pearson Correlation	-.555**	1	-.139	.018	-.061	.060	.152	-.142
	Sig. (2-tailed)	.000		.141	.845	.517	.522	.104	.129
	N	112	115	113	115	115	115	115	115
Social support	Pearson Correlation	.168	-.139	1	.022	-.033	-.248**	-.052	.161
	Sig. (2-tailed)	.079	.141		.813	.733	.008	.585	.089
	N	110	113	113	113	113	113	113	113
Age	Pearson Correlation	.098	.018	.022	1	.034	-.310**	-.158	.159
	Sig. (2-tailed)	.305	.845	.813		.718	.001	.092	.089
	N	112	115	113	115	115	115	115	115
Marital Status	Pearson Correlation	.038	-.061	-.033	.034	1	.029	-.149	.282**
	Sig. (2-tailed)	.688	.517	.733	.718		.760	.112	.002
	N	112	115	113	115	115	115	115	115

Employment status	Pearson Correlation	-.110	.060	-.248**	-.310**	.029	1	-.168	.044
	Sig. (2-tailed)	.249	.522	.008	.001	.760		.072	.640
	N	112	115	113	115	115	115	115	115
Highest education completed	Pearson Correlation	.004	.152	-.052	-.158	-.149	-.168	1	-.240**
	Sig. (2-tailed)	.968	.104	.585	.092	.112	.072		.010
	N	112	115	113	115	115	115	115	115
Gender	Pearson Correlation	.053	-.142	.161	.159	.282**	.044	-.240**	1
	Sig. (2-tailed)	.579	.129	.089	.089	.002	.640	.010	
	N	112	115	113	115	115	115	115	115

**. Correlation is significant at the 0.01 level (2-tailed).

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