พฤติกรรมการดูแลของพยาบาลในหอผู้ป่วยอายุรกรรม-ศัลยกรรม ประเทศกัมพูชา: การศึกษาเปรียบเทียบระหว่างการรับรู้ของผู้ป่วย พยาบาล และนักศึกษาพยาบาล

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วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาพยาบาลศาสตรมหาบัณฑิต
สาขาวิชาพยาบาลศาสตร์
คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2556

NURSES' CARING BEHAVIOR IN MEDICAL-SURGICAL UNITS, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES AND NURSING STUDENTS

Ms. Naryna Yel

A Thesis Submitted in Partial Fulfillment of the Requirements
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Thesis Title	NURSES' CARING BEHAVIOR IN MEDICAL-SURGICAL UNITS, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES AND NURSING STUDENTS
By	Ms. Naryna Yel
Field of Study	Nursing Science
Thesis Advisor	Assistant Professor Branom Rodcumdee, Ph.D, RN
Thesis Co-advisor	Associate Professor Sureeporn Thanasilp, DNS, APN, RN

Accepted by the Faculty of Nursing, Chulalongkorn University in Partial Fulfillment of the Requirements for the Doctoral Degree

……Dean of the Faculty of Nursing
(Associate Professor Pol. Capt. Yupin Aungsuroch, Ph.D, RN)

THESIS COMMITTEE

……Chairman
(Associate Professor Waraporn Chaiyawat, DNS, APN, RN)

……Thesis Advisor
(Assistant Professor Branom Rodcumdee, Ph.D, RN)

……Thesis Co-advisor
(Associate Professor Sureeporn Thanasilp, DNS, APN, RN)

……External Examiner
(Choosak Khampalikit, Ph.D)

นารีนา เยล : พฤติกรรมการดูแลของพยาบาลในหอผู้ป่วยอายุรกรรม-ศัลยกรรม ประเทศกัมพูชา: การศึกษาเปรียบเทียบระหว่างการรับรู้ของผู้ป่วย พยาบาล และนักศึกษาพยาบาล (NURSES'CARING BEHAVIOR IN MEDICAL-SURGICAL UNITS, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES AND NURSING STUDENTS) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: ผศ.ดร.ประนอม รอดคำดี อ. ที่ปรึกษาวิทยานิพนธ์ร่วม : รศ.ดร. สุรีพร ธนศิลป์, 151 หน้า

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อศึกษาและเปรียบเทียบการรับรู้ในพฤติกรรมการดูแลของผู้ป่วย พยาบาล และนักศึกษาพยาบาล โดยมีรูปแบบการวิจัยเชิงสำรวจพฤติกรรมการดูแล (The Caring Behavior Inventory: CBI) จากผู้ป่วยและพยาบาลในแผนกอายุรกรรม-ศัลยกรรม และนักศึกษาพยาบาลในสถานศึกษาของพยาบาล เครื่องมือที่ใช้ในการวิจัยประกอบไปด้วยแบบสอบถามข้อมูลส่วนบุคคล กลุ่มตัวอย่างประกอบไปด้วย ผู้ป่วย 105 คน และพยาบาล 57 คน จากโรงพยาบาล Khmer-Soviet Friendship และ Preah Kossamak และนักศึกษาพยาบาล 150 คน จากสถาบัน Technical School for Medical Care

ผลการวิจัยพบความแตกต่างอย่างมีนัยสำคัญทางสถิติระหว่างกลุ่ม (ผู้ป่วย พยาบาล และนักศึกษาพยาบาล) โดยพบว่าคะแนนเฉลี่ยการรับรู้ของผู้ป่วยเกี่ยวกับพฤติกรรมการดูแลต่ำกว่าคะแนนเฉลี่ยของพยาบาล และนักศึกษาพยาบาล ในทุกๆ ด้านของแบบสอบถาม CBI-42 แม้ว่าจะไม่พบความแตกต่างอย่างมีนัยสำคัญระหว่างการรับรู้ของพยาบาล และนักศึกษาพยาบาล แต่กลับพบว่าคะแนนเฉลี่ยของนักศึกษาพยาบาลมีค่าน้อยกว่าคะแนนเฉลี่ยของพยาบาลในทุกๆข้อคำถาม ยกเว้นในข้อสุดท้าย (ใส่ใจกับประสบการณ์ของผู้อื่น) ผลการวิเคราะห์ด้วย one way ANOVA พบความแตกต่างอย่างมีนัยสำคัญทั้ง 5 ด้าน ส่วนผลการวิเคราะห์ความแปรปรวนของกลุ่มตัวอย่างทั้ง 3 กลุ่ม พบว่าไม่มีความแตกต่างกันอย่างมีนัยสำคัญ โดยค่า F-value (98.358) มีค่ามากกว่าสมมติฐานกลาง จึงนำไปสู่การปฏิเสธสมมติฐานของค่าเฉลี่ยในกลุ่มที่มีคะแนนเท่ากัน การทดสอบด้วย Tukey HSD post-hoc เพื่อเปรียบเทียบความแตกต่างของการรับรู้เกี่ยวกับการดูแลของกลุ่มตัวอย่าง ในแต่ละด้านของแบบสอบถาม CBI พบว่าคะแนนของแต่ละข้อคำถามของผู้ป่วยมีความแตกต่างจากคะแนนของพยาบาลและนักศึกษาพยาบาลอย่างมีนัยสำคัญทางสถิติ ($p<.01$) ในขณะที่ไม่พบความแตกต่างเมื่อเปรียบเทียบระหว่างพยาบาลและนักศึกษาพยาบาล

การศึกษาในแผนกอายุรกรรม-ศัลยกรรม ประเทศกัมพูชาครั้งนี้ แสดงให้เห็นว่าการรับรู้ระหว่างผู้ป่วยนั้น มีความแตกต่างจากพยาบาลและนักศึกษาพยาบาล ซึ่งเป็นสิ่งสำคัญที่จะช่วยให้เกิดความเข้าใจในสิ่งที่ผู้ป่วย พยาบาลและนักศึกษาพยาบาลตระหนักถึงพฤติกรรมการดูแล อันจะนำไปสู่การลดปัญหาความขัดแย้งของพยาบาลกับผู้ป่วยได้

สาขาวิชา……..พยาบาลศาสตร์.....ลายมือชื่อนิสิต.....

ปีการศึกษา.....2556……. ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์หลัก.....

ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์ร่วม.....

5477170536: MAJOR NURSING SCIENCE
KEYWORDS: NURSE CARING BEHAVIOR / PERCEPTION / NURSES / NURSING STUDENTS / PATIENTS

NARYNA YEL: NURSES' CARING BEHAVIOR IN MEDICAL-SURGICAL UNITS, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES AND NURSING STUDENTS
ADVISOR: ASST.PROF. BRANOM RODCUMDEE, Ph.D, RN, CO-ADVISOR: ASSOC. PROF. SUREEPORN THANASILP, DNS, APN, RN, 151 pp.

The purpose of this study was to explore and compare the perception of the nurses' caring behavior among the patients, nurses and nursing students. This study used a descriptive survey design. The Caring Behavior Inventory (CBI) was used to explore and compare the perception among patients, nurses from medical-surgical units and nursing students from the school of nursing. In addition, the demographic data were also obtained. The participants included 105 patients and 57 nurses from Khmer-Soviet Friendship hospital and Preah Kossamak hospital and 150 nursing students from Technical School for Medical Care were included in this study.

The findings indicated statistically significant differences among the groups (patients, nurses and nursing students). The means of the patients on how they perceived the nurse caring behavior were lower than the means of the nurse and nursing students in every subscale of the CBI-42 items. Although there were no significant differences between the nurses' perception and the nursing students' on how they perceived nurses caring behaviors. However, the means score of nursing students were slightly lower than means of nurses in every subscales of except the last subscales (Attentive to Other's experience). The one way ANOVA was utilized to demonstrated significant different on all the five subscales. The result of the analysis of variance on total CBI-42 items scores. Since F-value (98.358) exceeded the null hypothesis of equal means among three groups then leading to rejection of equal means among the groups at ($p<.01$) level. Tukey HSD post-hoc test was then run to compare the differences perceptions among the groups in each subscale of CBI. All the significant value subscales of the patients differ to the nurses and nursing students ($p < .01$) while the nurse and nursing students showed no differences.

This study which carried out in the medical-surgical unit, Cambodia showed evidence that the perceptions between the patients were different to the nurses and nursing students. It is essential to understand what the patients, nurses and nursing students viewed as important caring behaviors so that the nurses can avoid conflict with the patients.

Field of Study : Nursing Science Student's Signature .....

Academic Year : 2013 Advisor's Signature .....

Co-Advisor's Signature .....

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CHAPTER I

INTRODUCTION

Background and significance of the study

Nursing is a profession that places high value on caring and it is the foundation of practice. Nurses are experiencing difficulties demanding them to balance activities of caring with the task determined by the working environment. The increased number of patients' admission, shortage of nurses, inadequate numbers of beds in the medical and surgical units, and early discharge have lead to nurse having doubts in their capacity to show caring behaviors for the patients. The risk in neglecting some patients occurs due to the increase workload of the nurses leading to prioritizing the more seriously ill patient (Baldursdottir & Jonsdottir, 2002). However, it is inadmissible to both patients and nurses.

Moreover, nurses perceived their caring behaviors through psychological skills and expressive caring behaviors as higher than instrumental and technical skills in which the patients perceived more as nurse caring behaviors ((Papastavrou, 2011). Thus, the interaction between the nurses and patients through many of these aspects may draw to the perception of caring behaviors.

As the largest group of healthcare providers, nurses are committed to care for all persons in society under any condition and any circumstance. Nurses must be able to develop caring relations which shows their caring behaviors with patients in order to express their professional identification. According to Roach (2002), caring is the human mode of being. Nursing is what been known as a caring profession. Caring is

what differentiates nursing from other professions. Caring is the locus of all attributes used to describe nursing. Nurses are prepared to be caring professionals by a curriculum based on holistic, integral humanism and caring environment (Roach, 2002).

Most individual that became a professional nurse because of their desire to care for other people (Vance, 2003). It has been considered that Caring and nursing are synonym. Caring as a main concept has led to the development of several caring theories. Two well known theories were developed in the 1970's, Leininger's Theory of cultural care and Jean Watson's Theory of human caring (McCance et. al, 1999). Caring behaviors are evidenced by nurses in caring for patients (Vance, 2003). According to Watson (1985), "Caring is the process by which the nurse becomes responsive to another person as a unique individual". Watson defines these caring behaviors as carative factors and these behaviors are evidenced by nurses in caring for patients, refer to those physical, emotional and spiritual interactions of the nurse as perceived by the patient that result in the satisfaction of certain human needs (Watson, 1979).

The original work of Watson (1979) incorporated ten carative factors which stand as a framework to concentrate on the nursing phenomena. Carative factors are still use as the current terminology for the guide for the "core" of nursing (Watson, 2008). Carative factors are evolving to "Clinical Caritas" of transpersonal caring. The carative factors honor the human dimension of nursing's work and the inner life world and subjective experiences of the people being serve however, what differs in the "Clinical Caritas" framework is that it have a greater spiritual dimension in the new processes. It originates from the Greek vocabulary meaning "to cherish and to give

special loving attention" (Watson, 2008). However, the researcher in this study had use the original theory of Watson (1979) because carative factors are still the core for nursing practice and Caritas Processes have a wider spiritual dimension. Since there is no instruments for the "Caritas Processes" yet in measuring the nurse caring behaviors, the researcher used the (Caring Behavior Inventory 42-times) that is still being used currently and still have a high reliability and content validity. Watson (2001) had mentioned that it is improper to presume that instruments used to measure the carative factors can also be used to measure the "clinical caritas processes", particularly given the "decidedly spiritual dimension".

On the other hand, the role of nursing education is to provide an academic and clinical experience that enables the student to thus develop as a nurse, and as a person. It also expected that the student nurse will use their knowledge gained through studying in the academic environment as a platform to develop their own caring behaviors. This must coincide with a mentality for compassion and a propensity to provide care. As the student progresses, thus does the nurturing process, enabling the students to learn how to behave in a caring, yet professional manner. Therefore it is also important to study the nurses' caring behaviors from the perception of the nursing students (Wilkes and Wallis, 1998; Karao¨z, 2005). If student who do not adopt professional values such as caring during their pre-professional studies are unlikely to integrate them in the future (Fassetta, 2011).

Duffy (2009) describe the relationship between nurse caring behaviors and patient fulfilled needs as having a high correlation as it benefit both the carer and the one being cared for. When the nurse is being able to help a patient feel better and cared for, the reward is fulfillment and joy. The ultimate reasons many nurses chose

the nursing profession are these rewards that they received from caring the patients. Fostering caring behavior should be a continuous practice for all nurses and nursing students.

Watson's theory have describe that caring can be effectively demonstrated and practiced only interpersonally (Watson, 1979). Thus the relationship between the patients and nurses constructs the basis for nursing practice. An examination of both the patient's and nurse's interpretations of caring must be achieved. To be meaningful, the caring of nursing must be based upon mutual agreement between nurses and patients as what constitutes *nurse caring behaviors* (Zamanzadeh et al, 2010). Nurses cannot be certain that their behaviors are consistent with patients' perceptions of their care (Holroyd et al, 1998). Also, nurses cannot assume that patients perceive caring efforts as they are intended. To avoid these problems, it is imperative that nurses validate with the patients that the patients' care needs are being met (Widmark-Petersson et at., 2000).

Significant differences were found between patients and nurses in their perception of nurses' caring behaviors in many reviewed studies. These results, repeatedly reported in the research literature, indicate that nurses may not accurately assess patient perceptions of caring and that patient care is not congruent to the patients' preferences or individual needs (Amendolair, 2007). Empirical studies on caring behavior related to nursing have focused on nurses' perceptions of what constitutes caring for the patient, patient's perceptions of what is important in making them feel cared for, and comparisons of patients' and nurses' perceptions of what constitutes essential nurse caring behaviors (Greenhalgh et. at, 1998). Many of these

studies have generally demonstrated significant differences in patient's and nurse's perceptions of nurse caring behaviors (Von-Essen, 2003).

Many factors could shape the nurse caring behavior as perceived by the nurse and patients. The patients' demographic data such as gender, age and educational level showed significant difference. Female scored higher than men and the higher the patients' age, the greater the nurse caring behaviors. Thus, scoring of the patients that have low education levels were significantly higher (Baldursdottir and Jonsdottir, 2002). There are also similarities and differences found in a study where the patient's rating on caring behaviors are higher when the nurse is female and lower if the nurse is male thus it can be assume that gender stereotype maybe affect how they perceived nurses' caring behaviors (Eksrom, 1999).

Such information is valuable because the responsibility of nurses is centered on providing high quality nursing interventions leading to positive outcomes (Suhonen et al. 2008). This study suggest that the nurses and nursing students should not assume that their intended caring behaviors and demonstration of skill competency are significant to the patient's perception but understand the specific behaviors that patients perceived to be most important and compare their caring behaviors with patients' so that they may learn to effectively care for their patients. Caring can be conceptualized and individualized in a numerous of ways. Nurses need to know what patients view as essential so they can meet their need. Identification of caring behaviors by nurses has the potential to bridge the gaps in the fragmentation of the health care delivered.

Samples that included a mixed variant of patients, and hospital setting often presented a lack of perceived agreement, which ultimately disfavor the theory that

perceptions of caring were influenced by the context in which the interaction took place (Christopher & Hegedus, 2000). The findings show that it is not possible to draw a conclusive analysis when conducting studies on different sample groups, i.e. patients or nurses, using alternate instruments, and in different care settings.

Studies investigating the perceptions of nurses and patients simultaneously in one care setting using the same instrument may produce more conclusive results. Such studies would determine the extent of agreement/disagreement between nurses' and patients' perceptions of the importance of nurse caring behaviours (O' Connell E., & Landers M., 2008).

Therefore, the present study is designed to determine patients', nurses' and nursing students' perceptions of nursing care behaviors from one subspecialty area and the two main government hospitals in Phnom Penh, Cambodia. Medical-surgical patients, medical-surgical nurses and fourth year nursing students who have been trained at the medical-surgical ward will be selected as the target population.

The medical-surgical unit is a conglomeration of all kinds of nonpregnant adults having all sorts of health problems behavior (Plauntz, 2007). Thus in the Medical-Surgical Units from both of the hospitals in this study showed a high rate of patients admitting with accident health problems and non-communicable diseases especially in diabetes and heart diseases.

The nurses at the medical-surgical unit render a broad range of nursing care for patients with acute and chronic illness supporting the nursing and medical needs of patients with various degrees of complexity of needs. Patients at the medical-surgical unit are typically in the condition which requires a moderate degree of technological support and the average length of stay is 2.7 days at least, which can

allow time for the patient to evaluate the caring behaviors of the nurses and nurses (Amendolair, 2007). Thus, given the wide range of nursing care activities that nurses in this specialty perform, the medical-surgical nurses and medical surgical patients are a suitable population for studying and exploring the nurses' caring behaviors from their perception.

Therefore, nurses on such a unit must be versatile and on their toes at all times. Because of the regular interactions between the nurses and the medical-surgical patients, thus allow for frequent observation for the effect of their enacted behavior (Plauntz, 2007). Hence, these patients, because of their diagnosis and treatment modalities, are often in frequent contact with nurses and are mostly adult patient's which enable them to answer to all the concrete questions appropriately and may therefore be better able to formulate their perceptions of what nurses behaviors constitute caring to them.

In this respect, such studies increases knowledge on the caring nature of medical-surgical nursing can facilitate a plan of nursing care based on priority caring behaviors identified by medical-surgical patients and identifies the degree to which this sample of medical-surgical patients and nurses agree on priority caring behaviors. There is currently a considerable emphasis on the provisions of patient-centered care in all aspects of health care. What is most important is to make clear what the patients' perception of nursing care is in order to improve quality of nursing care.

In spite of that, there aren't adequate studies on nurses' and patients' perceptions in regards to nursing care of these patients in African and Asian countries (Zamanzadeh, 2010) and there is none in Cambodia. There is also no literature statistic regarding the information in the Medical-Surgical unit in the two Nation

hospitals that was selected in this study. As such, it is important to investigate the perception of nurse caring behaviors of medical-surgical patients, nurses and nursing students.

Cambodia is one of the developing countries in Southeast Asia which has roughly 14 million people and an estimated of 6,000 nurses (Allaboutone, 2012), which leads to the nurse-patient ratios of 1:2333. Currently, in the Kingdom of Cambodia has the public sectors of health facilities such as 8 National Hospitals, 24 Municipal and Provincial Health Departments, 77 Operational Districts, 79 Referral Hospitals, 1010 Health Centers, and 122 Health Posts (in remote area). It also has many private hospitals, Clinics, Consultation Cabinets and NGOs centers, (Prak et al., 2011). However, there is no statistic regarding the number of the Medical-Surgical Unit in all those health care facilities.

The two hospitals that this study has selected were the 2 National Hospitals among the 8 National Hospitals which aren't the Maternal, Pediatric or Communicable diseases hospital among the 8 national hospitals. Those hospitals are Khmer-Soviet Friendship Hospital and Preah Kossmak Hospital.

Most of the nurses in Cambodia have only 1 to 3 years of nursing education post their secondary education and provide basic technical skills under the direction and supervision of physicians (Allaboutaone, 2012) . However, in this study the nurses at the Medical-Surgical Unit at the Khmer-Soviet Friendship Hospital and Preah Kossmak Hospital all have their 3 years Diploma Nursing Program. The curriculum of the Bachelor of Science in Nursing in Cambodia was only developed in 2008 (Cambodia Council of Nurses, 2007). The lack of accurate statistics, surveys and researches makes planning for the development for the health care system as well

as the nursing system difficult. However, there is a strong desire on the part of Cambodia nursing faculty to advance the knowledge and skills of the nurse (Allaboutaone, 2012). Thus this study can be a small step to provide some details about patients, nurses and nursing students in Cambodia and further more improve the nursing systems and as well the nursing education systems.

Phnom Penh is chosen to be the place to conduct the research as Phnom Penh is the capital city and center of Cambodia with more patients and nurses to study compare to the provinces or rural areas. The health staffs such as doctors and nurses find numerous advantages such as attractive employment opportunities for professional development, and higher quality education and other amenities for their families from practicing in the city, and prefer to stay there (MOH, 2004). Hence, the hospitals in Phnom Penh have a higher percentage of patients than the rural areas as the patient come from all over the country to the city to seek for reliable Medical-Surgical care from Nation's Hospitals which is only located in Phnom Penh. Therefore, there are more nurses and patients in Phnom Penh to conduct the research.

Furthermore, the school of nursing is in Phnom Penh and it covers the students from all over the 24 provinces who are studying nursing. The hospitals that are chosen in this study are where the students are being sent for their clinical training as well as their medical-surgical practice as those hospitals could provide enough cases for them (Prak, 2011). The school or nursing in Phnom Penh is the first to introduce the new curriculum of the Bachelor of Science in Nursing in Cambodia in 2008 (Cambodia Council of Nurses, 2007). The objectives of the new Bachelor of Science in nursing curricula in the nursing school in Cambodia just as other nursing school always incorporate caring and more advanced knowledge which is different from the old

diploma curriculum. The student nurses are expected to be able to apply their nursing knowledge in promoting health, preventing illness, caring, and rehabilitating the health of individuals (Technical School of Medical Care-Curriculum, 2006). Thus, this new curriculum has started to produce baccalaureate prepared nurses with the aim to improve the quality of nursing care in Cambodia. Therefore, it is essential to study the comparison of the perceptions among the patients, nurses and nursing students.

So the aim of this study is to explore and compare if there is any differences between patients' perception, nurses' perception and nursing students' perceptions of nurse caring behaviors in Cambodia since there are many reviewed studies in other countries that showed significant differences between the patients' and nurses' perception on how they perceived nurse caring behaviors. Thus this can be a new knowledge and findings for Cambodia nurses and health personnel.

Research questions

For the purpose of this investigation the following questions were developed:

1. What are the nurse caring behaviors as perceived by the patients?
2. What are the nurse caring behaviors as perceived by the nurses?
3. What are the nurse caring behaviors as perceived by the nursing students?
4. Are there any differences among the patients' perception of nurse caring behavior?

Purposes of the study

1. To explore the nurse caring behavior in Medical-Surgical units, Cambodia as perceived by the patients.
2. To explore the nurse caring behavior in Medical-Surgical units, Cambodia as perceived by the nurses.
3. To explore the nurse caring behavior in Medical-Surgical units, Cambodia as perceived by the nursing students.
4. To compare the nurse caring behavior among the perception of patients, nurses and nursing students.

Reasons and Hypotheses

Significant differences were found between patients and nurses in their perception of nurses' caring behaviors in many reviewed studies. These results, repeatedly reported in the research literature, indicate that nurses may not accurately assess patient perceptions of caring and that patient care is not congruent to the patients' perception (Amendolair, 2007). Empirical studies on caring behavior related to nursing have focused on nurses' perceptions of what constitutes caring for the patient, patient's perceptions in making them feel cared for, and comparisons of patients' and nurses' perceptions on nurse caring behaviors showed differences (Greenhalgh et. at, 1998). Many of these studies have generally demonstrated significant differences in patient's and nurse's perceptions of nurse caring behaviors (Von-Essen, 2003).

In this study, the following research hypotheses were formulated:

There will be significant difference among the perception of the patients', nurses' and nursing students' regarding the nurses' caring behaviors.

Scope of the study

This study explored and compared the perception of patients, nurses and nursing students' with regard to nurses' caring behaviors. The variable in this study is the nurse caring behaviors. The aspects look into nurses caring behaviors as perceived by patients, nurses and nursing students and compare those perceptions among the groups. The study was carried out at the medical-surgical unit of the two main government hospitals and the government school of nursing in Phnom Penh the capital city of Cambodia.

Definitions of terms

Nurse caring behaviors are behaviors evidenced by the nurses in the medical-surgical units in Cambodia when caring for patients. The nurses communicate the caring behaviors through saying or doing. These caring behaviors are categorized into five: assurance of human presence (formation of a humanistic-altruistic system of values, instillation of faith-hope, and cultivation of sensitivity to one's self and to others), respectful deference (development of a helping-trusting relationship and promotion and acceptance of the expression of positive and negative feelings), professional knowledge and skill (systematic use of the scientific problem-solving method for decision making and promotion of interpersonal teaching-learning), positive connectedness (provision for a supportive, protective, and/or corrective mental, physical, socio-cultural, and spiritual environment) and attentive to other's

experience assistance with the gratification of human needs and allowance for existential-phenomenological forces) (Wolf, 1986; Wolf et.al,1994; Brunton & Beaman, 2000). The perception of nurse caring behaviors were computed using the total scores of the Caring Behavior Inventory (Cambodian translated version) developed by the researcher herself which was originally developed by Wolf, et.al., (1994).

Nurses refer to the person whom are registered and qualified by the nursing school to practice nursing and are currently working at the medical-surgical units in Phnom Penh, Cambodia.

Nursing students are whom under taking the four year baccalaureate nursing program at school of nursing, Technical School for Medical Care, University of Health Science.

Patients are the person over the age of 18 and under the age of 60 who are currently admitted to Khmer-Soviet Hospital and Preah Kossamak Hospital with an illness or disease seeking for medical and surgical treatment in the medical-surgical unit.

Expected outcomes and benefits of the study

1. For nurse administrators: This study could influence nurse leaders and managers with respect to patient care planning and nursing practice decisions. The results can be used by the nursing staff to improve practice in many ways and continue their service. The administrators can also find new avenues of service that encourage exploration of what patients perceive as high nurse caring behaviors and

providing training for the nurses. This will also help the nurses in avoiding conflicts with the patients and reflecting their professional caring identity.

The patient will appreciate the value of nurse thus can develop caring relationship between them.

2. For nurse educators: Nurse Educators will understand more clearly the competencies of the future nurses, their strength and weakness when it comes to their caring behaviors. This will create a vision for the nurse academe to work comprehensively and devotedly to the needs of further enhancing nursing students' caring behaviors to assure better rendition of care in the nursing profession. They will be able to attend and focus on the improvement of nursing education with the emphasis on the carative factors students nurses must possess as early as possible.

CHAPTER II

LITERATURE REVIEW

This chapter presents an integrative review of the nurses' caring behaviors in the medical-surgical unit, Cambodia as perceived by the patients, nurses and nursing students. The review covers the following topics:

1. Overview of the nursing education in Cambodia.
2. Cambodia health care system and nursing practice.
3. Theoretical perspective that guided the research.
4. Nurses' caring behavior
    - 4.1 The instruments in measuring the caring behaviors.
    - 4.2 Patients' perception of the nurse caring behaviors.
    - 4.3 Nurses' perception of the nurse caring behaviors.
    - 4.4 Nursing students' perception of the nurse caring behaviors.
5. Comparison of nurse caring behaviors between the groups.

1. Nursing Education in Cambodia

At the present Cambodia have five schools that offer nursing education. The Technical School for Medical Care (TSMC), based in Phnom Penh, it is one of the four faculties' schools of the University of Health Science (UHS). In July 2002, the University of Health Science became an autonomous institution. Under its new status, the TSMC could use half of their students' fee to pay to teaching staff and half of the

income, could be used for running cost, building/renovating facilities as well as purchasing some of equipments/reagents and training materials (Prak et. al., 2011).

TSMC has traditionally offers basic education and continuing education for nurse and midwife for students from the central provinces of Phnom Penh, Kampong Chhnang, Kampong Speu and Kandal. The TSMC cover the students from all 24 provinces by providing the Bachelor of Science in Nursing education, however, the Diploma nursing degree is still offered. Other courses that TSMC provide are education for Lab, Physiotherapy PT and Radiological Technology RT and some of post basic courses. Most of the clinical sites are National Hospitals and Centers and there are a quite small numbers of provincial hospitals and health centers that TSMC sent their students for clinical practice because those national health facilities could provide enough cases for student's clinical practice. The four Regional Training Centers (RTCs) have been funded through the Provincial Health Department in the province in which they are based and just have their own budget since last five years (Prak et. al., 2011). Different from the TSMC, the 4 RTCs offer basic and continuing education for nurse, midwife and other post basic education in different provinces under their coverage:

- Kampot RTC – located to the South and covering the provinces of Kampot, Kep, Kampong Som, Koh Kong and Takeo.
- Kampong Cham RTC – located to the East and covering the provinces of Kampong Cham, Prey Veng, Kampong Thom, and Svay Rieng.
- Battambang RTC – located to the North West and covering the provinces of Battambang, Siem Reap, Banteay Meanchey, Pursat, Pailin, and Oudor Meanchey

- Stung Treng RTC – located to the North East and covering the 5 provinces of Stung Treng, Preah Vihear, Rattanakiri, Mondulkiri, and Kratie (Prak et. al., 2011).

In 1950, the first nursing school was founded and a 2 years general nursing course was commenced. Later in 1960, the nursing training curriculum was expanded to be a 3 year diploma program. During the Khmer Rouge Regime in 1975, the nursing school closed down then later after the Khmer Rouge Regime was over in 1979, the primary nursing and midwife course was commenced. In 1980, a 2 year bridge course for primary nurse to secondary nurses started (Cambodia Council of Nurses, 2007). In 2000, several meetings were conducted at the University of Health Sciences on the new nursing education system and then later in the year of 2003, roles and functions of nurses, chief nurses and head nurses were commenced. In 2005, there was an establishment of the national policy to support nursing and midwifery practice.

Cambodia Council of Nurses was then established in 2007 which was endorsed by His Majesty the King of Kingdom of Cambodia, Norodom Sihamony. It was then in the year of 2008, the Curriculum of Bachelor of Science in Nursing, a 4-year program started. The nursing documents was developed and approved by the Ministry of Health. (Cambodia Council of Nurses, 2007).

The four years Bachelor of Science in offers training program in leading and serving the Nursing Society of Cambodia .The aim of the curriculum and all school systems is to produce quality education and steady health forces to promote the health care system in Cambodia. As such to maintain the slow growing pace of health care system in Cambodia and to facilitate the present health needs for the Cambodian. This

new curriculum emphasized more on caring than the previous program (Technical School of Medical Care, 2006)

2. Cambodia Health Care System and Nursing Practice

In the last decade, Cambodia has made progress in improving the nation health care system. Although Cambodia is currently content with the peace after more than 30 years of instability due to political conflict, Cambodia still remain one of the developing countries in Southeast Asia as well as in the health care field. Thus, Cambodia is still in the continuous challenges in the health care system as well as the nursing system.

Many illnesses could have been treated and death could have been prevented. However, unhealthy living practices occur continuously because of a lack of adequate water and sanitation. Moreover, there is still chronic poverty, a lack of insufficient knowledge of healthy living, home care, public health services and traditional beliefs in living practices. There are insufficient and weaknesses in many areas in the public health sector such as poorly equipped facilities, lack of trained staff and a weak referral system. VOS (Voluntary Service Overseas) volunteers are working to develop the quality, range in many health issues, nutrition services and teaching to adopt and practice a healthy living (McGrew, 2010).

However, the general quality health amongst the Cambodian people is improving. In 2010, the life expectancy has increase to 60 years for males and 65 years for females. There has been a major improvement since the year 1999 where the average life expectancy was only 49.8 for males and 46.8 for female respectively (Embassyofcambodia.org.nz, 2011). In order to improve the quality of health care in

Cambodia, the Royal Cambodia Government plans by increasing the awareness of malaria, HIV/AIDS, and other diseases amongst the health care workers and people. There is a 5.8% of the Cambodia's gross domestic product (GDP) corresponding to the government expenses on the health care in Cambodia ("Health in Cambodia," 2013).

There is no literature assessing the nursing practice in the medical-surgical unit, Cambodia, however according to the estimated number of the monthly admitted patients of 1666 in the medical-surgical unit from the Khmer-Soviet Friendship hospital and Preah Kossmak hospital and the total number of 68 nurses from those 2 hospitals, leading to the nurse-patient ratios of 1:24.5. An interviewed to a nurse at the medical-surgical unit has also been conducted by the researcher to understand the daily work as a nurse at the medical-surgical ward. Nurses must perform their duties such as providing, assessment, daily care, education and advice, as well as solving health problems. Assist physicians in performing treatments, take care of individuals' physically and mentally (Peov, J. email interview, March 22, 2013).

3. Theoretical Perspectives

Jean Watson's Theory of Human Caring is the theoretical concept that will guide this research. When Florence Nightingale published her theory of nursing in 1860, she reflected a caring philosophy in which caring implied a moral imperative in nursing. Since the development of today's nursing, care has been at the basis of nursing practice. Watson (2008) illustrates the principles of caring science and sacred science and what is believe to be the social, moral, and scientific that the health professional provide to mankind. Hence, the human development can be affected by

the nurses' ideal care to the patients. Moreover, Watson anticipates that within today's society it is imperative to support human caring ideals and practice with a caring ideology. However, the major advances in radical treatment and techniques specializing in care, are often implemented without due diligence regarding the monetary costs or impact upon humans.

Human caring is described by Watson as the consistence of transpersonal processes which are implemented to help an individual interpret the meaning of illness, pain, suffering and existence to help an individual gain insight into self-awareness, self-control, self-care, self-healing, and predominately inner peace (Oermann, 1991). The Human Caring theory relates to a system largely associated with ones respect for life, and an acceptance of a spiritual dimension to life, and an acknowledgement of the internal forces within the human caring process (Oermann, 1991). The theory dictates that individuals participating in the caring process must possess a deep, and valued regard for people, human life, human autonomy, and freedom of choice (Oermann, 1991).

The original work of Watson (1979) incorporated ten carative factors which stand as a framework to concentrate on the nursing phenomena. Carative factors are still use as the current terminology for the guide for the "core" of nursing (Watson, 2008). Carative factors are developing gradually to "Clinical Caritas" of transpersonal caring. The carative factors honor the human dimension of nursing's work and the inner life world and subjective experiences of the people being serve however, what differs in the "Clinical Caritas" framework is that it have a greater spiritual dimension in the new processes. It originates from the Greek vocabulary meaning "to cherish and to give special loving attention" (Watson, 2008). However, the researcher in this

study had use the original theory of Watson (1979) because carative factors are still the core for nursing practice and Caritas Processes have a wider spiritual dimension. Since there is no instruments for the “Caritas Processes” yet in measuring the nurse caring behaviors, the researcher used the (Caring Behavior Inventory 42-times) that is still being used currently and still have a high reliability and content validity. Watson (2001) had mentioned that it is improper to presume that instruments used to measure the carative factors can also be used to measure the “clinical caritas processes”, particularly given the “decidedly spiritual dimension”.

Carative has move to caritas which in an emerged model transpersonal caring. However, this new transcends elicit both the past and the future and this unify expanded perspective transcends both the “conventional industrial, static models of nursing” (Watson, 2001). For instance, modern nursing is still tied to Nightingale’s theory and uses it as guide to with human ethical service and appreciating the phenomena, subject and to whom we served. This is how love and caring is incorporate in work and life through discovering and confirming that nursing is not just a job like a teacher but has its own professional identity and saves peoples life for a lifetime career with continuous development and experienced (Watson, 2008).

Caritas process embody both art and science, and in the process of redefining, acknowledging a confluence between art, science, and spirituality. In the process of learning transpersonal caring theory, it is a challenge for one to question intent of it, the idea and how essential it is t life, nursing and theory (Watson, 2008).

Leading the idea back to the original theory of Watson that the researcher utilize, it is the belief of Watson (1979) that the aim of nursing is to help persons gain higher degree happiness within the mind, body and soul. This helps to generate self-

reverence, self-knowledge, self-healing, and self-care processes. It is possible that this aim might be achieved through ten carative interventions. The ten carative interventions are:

1. The formation of a humanistic-altruistic system of values.
2. The instillation of faith-hope.
3. The cultivation of sensitivity to one's self and to others.
4. The development of a helping-trusting relationship.
5. The promotion and acceptance of the expression of positive and negative feelings.
6. The systematic use of the scientific problem-solving method for decision-making.
7. The promotion of interpersonal teaching-learning.
8. The provision for a supportive, protective and/or corrective mental, physical, socio-cultural, and spiritual environment.
9. Assistance with the gratification of human needs.
10. The allowance for existential-phenomenological-spiritual forces.

Watson (1979) stated that the carative interventions are mutually dependent. She grouped the carative interventions based on their mutually dependent or that we called interdependent. Hence, the 10 carative interventions were combined and five carative categories were produced (Table 1). These carative categories go in any orders as they are not proceeding step by step. The five carative categories were interpreted conceptually in the work of Wolf (1986) and Wolf, Osborne, Ambrose and Giardino (1994).

The five categories includes “assurance of human presence”, “respectful deference”, “professional knowledge and skill”, “positive connectedness”, and “attentive to other’s experience”.

Assurance of human presence category fuses the three carative interventions which include “formation of a humanistic-altruistic system of values, instillation of faith-hope, and cultivation of sensitivity to one’s self and to others”. This category constitutes “helping the patient, talking with the patient, appreciating the patient as a human being and responding quickly to the patient’s call” (Brunton & Beaman, 2000).

Respectful deference category fuses the two carative interventions which include “development of a helping-trusting relationship and promotion and acceptance of the expression of positive and negative feelings”. This category comprises caring activities such as “being honest with the patient, showing respect for the patient and giving the patient information to make decisions” (Brunton & Beaman, 2000).

Professional knowledge and skill category fuses the carative interventions which include “systematic use of the scientific problem-solving method for decision making and promotion of interpersonal teaching-learning”. This category compose such caring activities as “watching over the patient, being confident with the patient, and paying special attention to the patient on the first visit” (Brunton & Beaman, 2000).

Positive connectedness category includes the carative intervention of “provision for a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment”. This category consist such activities as

"being hopeful for the patient, allowing the patient to express feelings and trusting the patient" (Brunton &Beaman, 2000).

Attentive to other's experience is the final category which composed of the two carative interventions of "assistance with the gratification of human needs and allowance for existential-phenomenological forces". The caring activities contained in this category are "relieving the patient's symptoms, putting the patient first and giving good physical care" (Brunton & Beaman, 2000).

Table 1
Five Carative Categories with the Corresponding Carative Interventions of Watson's Theory (Brunton & Beaman, 2000)

5 Carative Categories	**Corresponding Carative Interventions of Watson's Theory**
I. Assurance of Human Presence	• Formation of humanistic-altruistic system of values • Instillation of faith-hope • Cultivation of sensitivity to one' self and to others
II. Respectful Deference	• Development of a helping-trusting relationship • Promotion and acceptance of expression of positive and negative feelings
III. Professional Knowledge and Skill	• Systematic use of scientific problem-solving method for decision making • Promotion of interpersonal teaching learning

IV. Positive Connectedness	• Provision for a supportive, protective and/or corrective mental, physical, socio-cultural, and spiritual environment
V. Attentive to Other's Experience	• Assistance with gratification of human needs • Allowance for existential phenomenological spiritual forces

4. Nurse Caring Behavior

The definition of Caring Behaviors is evidenced by nurses caring for the patients. According to the nursing literatures, the top ten caring behaviors that is shown by the nurses are such as attentive listening to the patient, comforting, being honest with the patient, being patience with the patient, showing responsibility, providing information for the patient to make an informed decision, touch the patient to communicate caring, being sensitivity, showing respect, calling the patient by his/her preferred name (Vance, 2003).

Watson (1979) defines these behaviors as carative factors and these behaviors are evidenced by nurses in caring for patients, refer to those physical, emotional and spiritual interactions of the nurse as perceived by the patient that result in the satisfaction of certain human needs.

According to Watson (1985) caring occurs every time a nurse comes into contact with a patient and can be observed through the behaviors of the nurse while rendering care for the patient. Caring behaviors include, but are not limited to: actions, words, cognition, body language, feelings, thoughts, intuition, movement, gestures, looks, acts, procedures, information and touch. Through these caring

behaviors, patients experience being cared for. Leininger (2001) addresses the idea that caring behaviors vary with features of the social structure in any designated culture. In addition, caring behaviors have been reported to be beneficial both to nurses and patients.

The research literature on nurse caring behaviors is growing. Raising the consciousness of caring behaviours can help nurses to develop themselves and nursing practice. In some of the past studies (Kyle, 1995; von Essen & Sjoden, 1995, Lea & Watson, 1996) examine nursing care behaviours and nurses' perception of effective behaviours as well as patients' perception of effective nurse caring behaviours. These are defined as acts, conduct and mannerisms enacted by professional nurses that convey concern, safety and attention to the patient. The assumption is that the sensation by patients of feeling cared for results from nurses' caring behaviours (Larson & Ferketich, 1993).

Baldursdottir and Jonsdottir's (2002) study revealed clinical competence as the most important caring behavior. Watson's theory of caring and the Caring Behavior Assessment (CBA) were used in this study. CBA uses seven subscales instead of the ten as described by Watson. This study was the first international study to use the CBA. Three hundred patients who were admitted to a University hospital in Iceland during one month were mailed the questionnaire with 60.7% return rate (N=182). The ten most important caring behaviors were (ranked from highest to lowest), know that they are doing; know when it is necessary to call the doctor, know when to give shots, IVs, etc, know how to handle equipment, answer my question clearly, treat me as an individual, give me treatments and medications on time, do what they say they will do; be kind and considerate; and check my condition very

closely. Rating for the CBA subscales were given “Human needs assistance” was the most important subscale followed by supportive/protective/corrective environment: teaching/learning; humanism/faith-hope/sensitivity; helping/trust, existential/ phenomenological/spiritual forces, and expression of positive/negative feelings.

4.1 Instruments in measuring the caring behaviors

In her book *Assessing and Measuring Caring in Nursing and Health Science,* Watson (2002) acknowledged the need for quantitative methodologies in order to promote the science of caring. On the other hand, she stated that “some deep philosophical/ontological dimensions of caring cannot be measured” (Watson, 2002). Watson continued by presenting an overview of the major tools on caring developed and reported in the nursing literature from the past several decades. The synopsis of each tool included the year developed, author and contact information, year of publication, what the tool measured, description of the tool, reported validity and reliability, as well as citations of tool usage in the nursing literature. The caring tools measurements identified a variety of aspects consists of nurse caring behaviors as perceived by both the nurses and patients, the identification of the nurse caring behaviors, assessing and evaluating the nurse caring behaviors, the perception of the nurse caring behaviors by the nurse educators and organizational characteristics of caring and many other more aspects. By having various instruments to assess caring, Watson acknowledged that there are more opportunities for the development of awareness and knowledge regarding caring thus addressing and learning more about the benefit that the patients, nurses and systems may gain.

Since the early stages of the research of caring, data had been complied exclusively by using the Q-methodology and Care-Q instrument which was developed

by Larson (1984) and this strategy remained to influence research for many years. This review literature showed 18 out of the 23 research studies used the Q-methodology or a modification and the remaining used different instruments such as the Caring Behavior Inventory (CBI) (Moyle et al. 2005), the Caring Behaviour Assessment (CBA) (O'Connel & Landers 2008) and the Caring Dimensions Inventory (CDI) (McCance et al. 2009). One study used the NCQ and PCQ (Nurse and Patient Caring Questionnaire) that consists of two parts, which differ on the instructions, the first part asking nurses to state their preference about the importance of caring items and the second to report on caring work actually performed (Ekstrom 1999). However, studies exploring the views of nurses separately of those of patients used a variety of caring instruments although there is a slight preference for using the Care-Q. There is also a tendency to use caring instruments in combination with other measures like patient anxiety and depression (Larsson et al. 1998, Widmark-Petersson et al. 2000), the health and quality of life of the patient (Widmark-Petersson et al. 2000), or pain scales (Chang et al. 2005). The majority of the studies examined the most and least important nurse caring behaviors whether patients and nurses differ in their ranking of those behaviors and if a statistically significant relationship between nurses' and patients' perceptions of nurse caring behaviors exists.

Care-Q

The CARE-Q (Larson 1981) was developed for use with Q-methodology to identify nurse caring behaviors that are perceived as important. In the Q-methodology only a certain number of cards can be placed in each designated pile so that a normal distribution is formed. The CARE-Q consists of 50 caring behaviors categorized into the following six sub-scales: accessible (six items), explains and facilitates (six

items), trusting relationship (sixteen items), and monitors and follows through (eight items).

Each of the 50 CARE-Q items is printed on a separate card resulting in a deck of 50 cards. Subjects are asked to sort the 50 cards into seven different piles ranging from most important to not important. The instructions ask subjects to put only one item as most important, four items as fairly important, 10 items as somewhat important, 20 items as neither important nor unimportant, 10 items as somewhat unimportant, four items as unimportant, and one item as not important.

To develop the items on the CARE-Q, Larson (1987) conducted (a) a Delphi survey of practicing nurses on caring behaviours and (b) a study of patient's perceptions of nurse caring behaviours which resulted in the identification of 69 nurse caring behaviours. The content validity assessed by an expert nurse panel of graduate nursing students. The expert panel agreed on 60 items and nine items were then verified by a panel of patients and nurses from an oncology unit. Ten additional redundant items were identified by this panel and were deleted. The remaining 50 items comprised the CARE-Q.

Larson (1987) assessed the test-retest reliability (30 days part) of the CARE-Q with a sample of 82 nurses randomly selected from the membership of an oncology nursing national organization. For the five most important caring items the test-retest reliability was 79% and for the five least important caring items it was 63%.

The CARE-Q has been used to measure caring behaviours with various other types of nurses and patients, such as psychiatric patients and nurses (von Essen & Sjoden, 1993), nursing home residents and nurses (Smith & Sullivan, 1997), coronary care patients and nurses (Rosenthal, 1992), patients and nurses in rehabilitation

hospital (Keane et al. 1987), home care patients and nurses (Smit & Spoelstra, 1991), oncology patients and nurses (Mayer, 1986, 1987; Larson, 1987; von Essen et al. 1994), and nursing students (Mangold 1991). None of these studies reported on the reliability of the CARE-Q.

Care Satisfaction Questionnaire

Larson & Feketich (1993) incorporated the 50 items of the CARE-Q into a VAS and renamed it the Care Satisfaction Questionaire (CARE/SAT). Twenty-one additional items were developed and added to the questionnaire to assess overall satisfaction with nurse caring behaviours in each of the six sub-scales. The sample for the initial testing of the CARE/SAT included 268 hospitalized adult medical-surgical patients ready for discharge within 48 hours. Patients placed an 'X' on the 100-centrimetre line next to the item statement to indicate the degree to which they agreed or disagreed to indicate the degree to which they agreed or disagreed that they experienced that specific nursing action while they were here hospitalized. Cronbach's alpha for the total CARE/SAT was 0.94. Alpha coefficients for each sub-scale exceeded 0.80. Larson and Ferketich reported that a Pearson correlation coefficient ($r = 0.80$) between the CARE/SAT and the Risser Patient Questionnaire (Hinshaw & Atwood, 1982) provided evidence of construct validity.

There is a three-factor solution that the factor analysis revealed. Factor 1 consisted of 12 items and accounted for 34.8% of the variance. This factor was called Assistive and referred to basic nursing care behaviours such as 'checked on me frequently' and 'created a sense of trust'. Benign neglect was Factor 2 and it consisted of 11 items on the CARE/SAT. The second factor accounted of 7.3% from the

variance. The third factor, Enabling was composed of six items and accounted for 4.8% of the variance,

Andrew et al. (1996) used the CARE/SAT with 26 nurse administrators and reported the five highest and five lowest ranked caring behaviours. The highest ranked behaviour was 'Encouraged me to call' and the lowest ranked behaviour was 'Checked on me frequently'.

Caring Behavior of Nurses Scale

The Caring Behaviours of Nurses Scale (CBNS) (Hinds 1988) is a 22-item VAS. Each item has a possible response range of 0-100 points. Scoring is interpreted as the higher the score the higher the patient's perception of being cared for by nurses. Twenty-five adolescents receiving inpatient treatment for substance abuse completed the CBNS at two points in time. The first data collection point was 24048 hours after admission and Time 2 occurred 96-120 hours before discharge. Hinds reported that Cronbach's alpha for the CBNS was 0.86 for both Time 1 and Time 2.

Caring Behaviour Checklist and Client Perception of Caring Scale

The Caring Behaviour Checklist (CBC) measures the presence or absence of specific actions of caring (McDaniel, 1990). The CBC was designed to be used in conjunction with the Client Perception of Caring Scale (CPCS) (McDaniel, 1990) to measure the caring process in a hospital setting. The CBC consists of 12 items denoting behaviours indicative of caring. The range of scores for the CBC is from 0 to 12. The CBC is scored by a trained observer while he/she observes a nurse-patient interaction for a 30-minute period. To help reduce subject reactivity, no data are recorded for the first 10 minutes.

The CPCS measures the client's responses to the caring behaviours of the nurse (McDaniel, 1990). It is a 10-item Likert scale rated on a 6-point summative rating scale ranging from 1 (not at all) to 6 (very much). The CPCS is administered to the client following the observation period. The range of scores for the CPCS is 10-60.

Content validity of the two instruments was assessed by two doctorally-prepared nurse researchers with expertise in the field of caring. The reported content validity index for the CBC was 0.80 and for the CPCS 1.00. Data from 21 different nursing student-patient interactions were used to determine reliability and construct validity. Overall interrater reliability for the CPCS was calculated at 0.81.

To assess construct validity, the scores on the CPCS were correlated with scoaers on the LaMonica Empathy Profile (LaMonica, 1981). McDaniel (1990) hypothesized that because empathy was conceptually close to caring, the instruments measuring these two concepts should be significantly correlated. There was, however, no significant correlation reported between these two tools thus indicating a difference in tehse two concepts. Another caring instrument would have been a more appropriate choice to assess construct validity. No additional studies were located in the literature reviews which have used the CPCS or the CBC.

Caring Behaviors Assessment Tool

The Caring Behaviors Assessment Tool (CBA) is based on Watson's (1985) carative factors. Cronin & Harrison's (1988) CBA consists of 61 nursing caring behaviors grouped into seven sub-scales. It is written at the sixth grade level. Participants rate on 5-points Likert scale, the degree to which each nurse behaviors reflects caring to them. Content validity of the CBA was assessed by four experts

familiar with Watson's caring theory. With a sample of 22 coronary care patients, Cronin and Harrison assessed the CBA's internal consistency. Hugins et al. (1993) also assessed the CBA's reliability with their sample of 288 ambulatory patients treated in an emergency room. The CBA has also been used to measure caring behaviors with 19 surgical patients (Parsons et al. 1993) and with 46 adults with AIDS or HIV (Mullins 1996).

Caring Dimensions Inventory

The Caring Dimensions Inventory (CDI) is a Likert scale designed to measure nurses' perception of caring (Watson & Lea 1997). It is composed of 41 questions. The first nine questions refer to demographic characteristics. The next four questions focus on how important the nurses feel caring in nursing is and how aware they are of the literature o caring in nursing. The 25 core questions obtain information on perceptions of caring by having nurses indicate their level of agreement of disagreement with statements regarding nursing practice that they consider to be caring such as 'listening to patient' and 'keeping relatives informed about a patient'. The four themes on nurse-patient relationship, nursing interventions, nursing attitudes, and communication, were used to classify the CDI questions. The final three questions are designed to obtain information on the sources of the nurses' caring knowledge.

Content validity of the CDI was addressed by a thorough review of the caring literature. The initial reliability of the CDI was assessed with a sample of 1430 nurses and nursing students in the United Kingdom. A mail survey was used to collect data and a 47% return rate was achieved. The Cronbach's alpha coefficient for internal

consistency reliability was reported to be 0.91. No other studies were located which used the CDI.

Caring Behaviors Inventory

The Caring Behaviors Inventory (CBI) originally contained75 items. Wolf et al. (1994) revised the CBI which now contains 43 items. Subjects are asked to rate caring words and phrases on a 4-point Likert scare. Test-retest reliability on a sample of 278 nurses and 263 patients was 0.96. An expert panel of four nurses helped establish the content validity. Known groups' technique was used to assess the construct validity. Scores of 278 nurses and 263 patients were compared and yielded significantly different results. An exploratory factor analysis revealed that the CBI consisted of the following five dimensions of nurse caring: respectful deference to others; assurance of human present; positive connectedness; professional knowledge and skill; and attentiveness to the other's experience.

Andrews et al. (1996) had 26 nurse administrators complete the CBI. The top three highest ranked caring behaviors reported were 'shows respect for the patient', 'allows patient to express feelings' and treats patient information confidentially.

This instrument will be utilized in this study because since late 1990s, CBI has been recommended as the most suitable tool for dual assessment by patients and nurses (Beck, 1999). It is a user-friendly time-saving tool, with good psychometric properties, based on the well- known Watson's Transpersonal theory (Andrews, Daniels, & Hall, 1996; Coulombe, Yeakel, Maljanian, & Bohannon, 2002; Wu, Larrabee, & Putman, 2006). The CBI-42 is easy to understand, has been used worldwide and is valuable in determining perceptions of caring in both nurses and patients (Andrews et. al, 1996). This is the most frequently used empirical tool for

measuring caring in nursing research and, for this reason, its reliability and validity is the best established. On the other hand, this research using *Jean Watson's Theory of Human Caring* as the theoretical concept to guide this research, so this CBI-42 is very suitable as it is based on Watson's theory.

The CBI-42 items have five subscales (Beck, 1999; Kyle, 1995; Wolf et al., 1994). The five subscales are listed below with corresponding survey question, number, number of items, and alpha coefficients:

1. Respectful deference to other (courteous regard for the other)
    a. (1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 15, 27, 28) 12 items
    b. Cronbach's alpha = 0.89
2. Assurance of human presence (investment in the other's need and security)
    a. (16, 18, 26, 29, 30, 31, 32, 33, 34, 35, 36, 37) 12 items
    b. Cronbach's alpha = 0.92
3. Positive connectedness (optimistic and constant readiness of the part of the nurse to help the other)
    a. (5, 6, 12, 13, 14, 17, 21, 23, 25) 9 items
    b. Cronbach's alpha = 0.85
4. Professional knowledge and skill (proficient, informed and skillful nurse)
    a. (19, 20, 22, 24, 38) 5 items
    b. Cronbach's alpha = 0.82
5. Attentiveness to other's experience (appreciation or and engrossment in the other's perspective and experience)
    a. (39, 40, 41, 42) 4 items
    b. Cronbach's alpha =0.82

4.2 Patients' Perception of the Nurse Caring Behaviors

An exploratory comparative survey by Schultz, Bridgham, Smith and Higgins (1998) examining the perceptions of nurse caring behaviors of the hospitalized long-term antepartum patient and the short-stay postpartum patient. The purpose of the study was to identify differences between the groups regarding what nurse caring behaviors were most and least important. The study was conducted at a 40-bed maternity unit that serves as a high-risk referral center for the state. Following approval from the hospital institutional review board, a non-probability convenience sample of antepartum and short-stay postpartum patients were recruited to participate. The Caring Behaviors Assessment tool was the instrument used for this study and was given to the antepartum patients during their stay in the hospital. There were no statistically significant differences in the mean age of the antepartum participants (M = 27.2, SD = 6.03) as compared to the postpartum participants (M = 29.7, SD = 3.7) or in the average number of years of education. There was a significant difference in marital status between the groups, with 19 married women in the postpartum group as compared to only 13 married women in the antepartum group. The antepartum participants reported and average of 2.9 pregnancies as compared to the postpartum participants who's average was 2.5 pregnancies. This was the first pregnancy for 10 of the participants.

Computations of mean scores and standard deviations for each item showed no statistically significant differences in total mean scores between the groups. Individual item scores ranged from means of 2.29-4.9. There were no significant correlations between the total score for the CBA and age, years of education, para, or gravida of the respondents. There was not a statistically significant difference in the

total mean CBA score of married women (M = 267.1, SD 23.5 and unmarried women (M = 258.5, SD = 23.4). The subscale scores also showed no significant difference between the groups and items in the Human Needs Assistance subscale ranked highest as seen in previous studies. Schultz et al. suggest that since items in this subscale reflected the nurses' level of knowledge; patients may equate caring with competence. Items in the Existential/Phenomenological/Spiritual group ranked the lowest for both groups. Limitations to the study included use of a small sample size and the length of the CBA tool.

An identification of the behaviors that rendered by the staff nurses as important indicators of caring according to the perception of the older adults that resided in the institutional settings by a pilot study (Marini, 1999). The framework in this research study was Watson's Theory of Human Caring and the instrument to interview the residents was Caring Behavior Assessment (CBA). The nurse's technical competency was analyzed and revealed as the highest indicator of nurse caring. As part of the study it was identified that there was a majority gender-specific perception of caring, this might be attributed to the differences in communication styles between gender, and the personal expressions in which people express care. Humanistic caring –treating the patient with respect and as a human being" – was the second most important indicator of care. Among the elderly, care which focuses and enhances the individual dignity of the patient is considered a priority (Marini, 1999). The evidence presented in this literary review highlights the fact that patients perceive caring in relation to the nurses' deliverance of safe and competent care. It is imperative to patients that the nurse delivers a proficient service with regards to care. They must be able to display their knowledge and understanding through the methods

they implement care. It is also important that nurses treat all their patients with dignity, and respect regardless of their social status or wealth whilst providing satisfactory technical care.

Dorsey, Phillips, and Williams (2001) conducted a descriptive correlational study to explore differences in adult patients' perceptions of nurse caring behaviors between a group of patients with sickle cell disease (SCD) and a group of patients with general medical conditions. They also examined the differences of perceptions of nurse caring behaviors between men with SCD and women with SCD. A modified version of the Caring Behaviors Assessment tool (CBA) was used to identify patients' perception of the degree of caring behaviors demonstrated by healthcare providers. The seven subscales of the modified version yielded a Cronbach's coefficient alpha range of = .88 to .94. Demographics reported with regards to socio- economic levels of the adults with SCD appeared to be similar. Data analysis using descriptive statistics was calculated for each demographic variable. Independent t-tests were performed for each of the research questions. Mean scores for the total CBA was 234 (SD=49.2) for adults with SCD and 258 for adults with other medical conditions. Adults with SCD reported a lower perception of nurses' caring behaviors than adults with other medical conditions. The mean score calculated for females with SCD was 216 (SD = 44.) and the mean score calculated for males with SCD was 262.7 (SD =34.3). Men with SCD reported a greater perception of nurses' caring behaviors than women with SCD. Limitations to the study included a small sample size, inability of the patient to distinguish nurses from other healthcare providers such as nurse aids, and participants' responses were retrospective of previous admissions.

Baldursdottir and Jonsdottir (2002) identified nurse caring behaviors that were perceived by patients in an emergency room as important indicators or caring. Watson's theory of caring and the CBA were used in this study. CBA uses seven subscales instead of the ten as described by Watson. The study was the first international study to use the CBA. Three hundred patients who were admitted to a University hospital in Iceland during one month were mailed the questionnaire with 60.7% return rate *(N* = 182) study revealed clinical competence as the most important caring behavior in the emergency room. Nurse caring behaviors were grouped by relative importance in relation to demographic variables and the illnesses that the patient perceived. Cronin and Harrison's CBA (Watson's theory) with a 61 item questionnaires was used and the results indicated that patient (N = 182) scored the items, "know what they are doing," "know when it is necessary to call the doctor," "know how to give shots, IVs, etc," and "know how to handle equipment" as the nurse caring behaviors that is the most important "physical care".

Seven subscales that measure nurse caring behaviors were compared with perceived illness and 4 demographic variables: gender, residence,age, and education. The results of a Mann-Whitney U test on the subscales, in relation to gender and residence, demonstrate that women score significantly higher than men in subscales 1,2, 3, 5, and 6 (Table V) and that no significant residential differences were found with respect to any of the subscales. The results of the Kruskal-Wallis one way analysis of variance on the subscales in relation to age, educational level, and how the subjects perceived their illness showed significant age differences for every subscale (ie, the higher the age of subjects', the greater the importance of nurse caring behaviors). Significant educational differences were found for subscales 1, 3, 4, and 7.

Subjects with low educational levels scored significantly higher on these 4 subscales. No significant differences were found for subscales 1 to 7 with respect to how sick the patients perceived themselves to be (Baldursdottir and Jonsdottir, 2002)

4.3 Nurses' Perception of the Nurse Caring Behaviors

Brunton and Beaman's (2000) study dealing with nurse practitioners' perception of nurse caring behavior used a modified Wolf Caring Behavior Inventory based on Watson's (1988) carative factors. The study explored the nurse practitioners' perception of their own caring behaviors, the relationship between socio-demographic variables, and environmental factors The Caring Behavior Inventory (CBI), developed to measure caring by staff nurses (Wolf, et al., 1994), was revised for use in this study CBI items were revised to remove references to bedside care and to reflect the primary care of the nurse practitioner (NP) with a total of 40 items scored.

The most frequently reported behaviors as perceived by the NP toward the client were (out of a possible score of six): appreciating as a human being (M = 5.86), showing respect (M = 5.83), being sensitive (M = 5.82), talking with the patient (M =5.79) and maintaining confidentiality (M = 5.76). Group rankings were similar with mean values of the items as follows: (a) respectful deference to others (M = 5.60), (b) assurance of a human presence (M = 5.35), (c) positive connectedness (M = 5.12), (d) professional knowledge and skill (M =5.14), attentiveness or the other's experience (M = 3.94). The significant relationship between the socio-demographic variables of the NP and perceptions or his/her caring behaviors using Pearson's correlation demonstrated that the longer the participant had been in practice, the more frequently he/she reported behaviors in the caring dimension or the positive connectedness. The two most common were being empathetic and cheerful with patients.

Watson et al. (2003) compared and contrasted perceptions of caring in nursing between UK (United Kingdom) and Spanish nurses. They employed the CBI-25 (Caring Behavior Inventory), an instrument with previously accepted psychometric properties (Cronbach's =0.91; P = 0.92). The 25 question inventory with a five-point Likert scale response was gathered from 1,430 UK nurses and 224 Spanish nurses in a teaching hospital. Mokken Scaling Procedure, Pearson's correlation coefficient, independent t test was used for analysis of the data. The study showed that there were noticeable and differences in perceptions of caring between Spanish (N = 224) and UK (N= 1,430) nurses. Eleven of the items were identical on both Mokken scales derived from the data collected. The 11 items were explaining a clinical procedure to a patient; being with a patient during clinical procedure, listening to a patient; consulting with the doctor about a patient, instructing a patient about an aspect of self care, measuring the vital signs of a patient, being technically competent with a clinical procedure, involving a patient with his or her care, giving reassurance about a clinical procedure, providing privacy for a patient , and observing the effects of a medication on a patient.

Watson et al. (2003) speculate why there are similarities and differences in the perceptions of caring in the two different cultures. The reasons maybe the cultural differences concerned with prevailing values in society, aspects learned as part of nurse education and training or as a result of the organizational culture where they work.

Green's (2004) descriptive study determined the relationship between nurse practitioners' demographics and their percept ions of their own caring behaviors in the state of Louisiana. The Caring Behaviors Inventory (CBI) was used by the nurse

practitioners, CBI mean scores and subscale mean scales were round to be high for all 348 NPs participating in this study. Ranking CBI scores (1 to 6) were (a) respectful deference to the other (12 items: *M* = 5.64, SD = .32); (b) assurance of human presence (12 items: *M* = 5.48, *SD* = .35); (c) positive connectedness (9 items: M= 5.16, *SD= .45),* (d) professional knowledge and skill (6 items *M* = 5.39, *SD* = .45), and (e) attentiveness to the other's experience (3 items: *M*= 5.46, *SD* = .41). Cronbach's coefficient alpha for the 42 items on the CBI was .94. ANOVA was used to determine if the CBI total mean scores differed according to the NPs' demographics Total mean scores of a NP's gender and area of practice (urban and rural) were not statistically significant when comparing gender *F* (1, 340)= 0.76, *P* = 3.8 and practice area, *F* (1,340) = 0.30, *P* = 59. Green's (2004) study or nurse practitioners in Louisiana indicates that they perceive themselves as very caring primary health care providers.

4.4 Nursing Students' Perception of the Nurse Caring Behaviors

A phenomenological research study designed by Simonson (1996) presents the discovery in a nursing education program, associate degree of nursing of how caring was taught. There were three principle questions that were asked: What is the meaning of caring to the faculty and students, how do the faculty communicate this meaning to the students; and how does this meaning shape the experience of the students. Semi-structured interviews with the entire faculty and a selection of students, the documents were reviewed and an observation of the classroom. According to the data analysis it is interesting to find the explanation of the definition of caring, how it is being taught and what are the things that the students learnt from caring. Watson's Theory of Human caring has developed four carative factors as a

descriptions for the main themes and assisted with the explanation of caring and how caring and the essential of caring were impart in the nursing program. It is very important to know the meaning of caring to give the identity of nursing and the verbal of caring from the nurses and behaviors of the faculty and nursing students. Faculty member were able to integrate and communicate caring into the classrooms and teaches the students the values of it. The suggestions implying from this research study is to give an idea for the nursing faculty on how to be caring as it can be a reflection to the students. Hence, they can communicate caring as the important aspects of nursing (Simonson, 1996).

A phenomenological study by Kosowski (1995) reports the purpose of the study to discover, describe and analyze nursing education can assist the nursing students in learning caring as a professional nurse. For the data collection, 18 female baccalaureate nursing students were interviewed. The nursing students recite how they learnt caring through enumerating their knowledge of how they establish caring with patients. By providing the patient care interactions through discussion then they had the ability to answer the research questions in regard to how they learned caring in the clinical practice. Two essential patterns were established which are creative caring and learned caring. The nursing students understand that they continuously acquire and learn caring which they can exhibit with their experience in caring for the patient through acting, thinking and feeling (Kosowski, 1995).

Caring is an essential component in nursing that must be affirmed and nurtured. They completed a phenomenological study of faculty-student caring interactions by exploring the perceptions of faculty caring behaviors as experienced by students at the practical nurse and nurses' aide levels. Their study replicated a

previous phenomenological study of baccalaureate nursing students. The results indicated that the participants perceived caring as recognition of their unique individuality and the sharing and giving of self and time by the faculty. The authors of this study believe that the knowledge acquired in this study could be utilized by nursing faculty in order to reinforce or enrich caring interactions with students (Dillon and Stines, 1996).

An establishment of significant of baccalaureate nursing students' experience in the caring and not-so-caring interactions with the faculty was reported in a study (Hanson and Smith, 1996). An interviewed was conducted with 17 baccalaureate nursing students from the private liberal arts college and another 15 from the public university. A Giorgi's technique was used to analyze the transcripts. Themes were obtained and abstracted into the categories of recognition, connection, and confirmation. The meaning units were acquired and the significant statements were established. The descriptions of the phenomena of a caring and not-so-caring interaction were formed. There were implications from the study for the nurse educators. Positive feeling and self-esteem of the students can be enhanced through caring environment which not only aid humanistic values but also improve the motivation of the students in studying and learning, thus supporting the students' decision in choosing nursing as a profession (Hanson and Smith, 1996).

Watson, Deary and Lea (1999) completed a longitudinal study with nursing students to determine if their perceptions of caring changed over time, throughout nursing school. Another purpose of their study was to determine if the Caring Dimensions Inventory (CDI) instrument could detect any changes in the students' perceptions of caring. The CDI was developed in 1997 and consists of 25

operationalized statements of nursing actions. Subjects are asked to indicate their agreement that each statement constitutes caring by using a 5-point Likert scale (1=strongly disagree to 5=strongly agree). The instrument focuses on two dimensions of caring – the "psychosocial" (emotional) and the "professional and technical" (physical). The psychosocial dimension includes listening to the patient and sitting with the patient. The professional and technical dimension includes taking vital signs and reporting on a patient's condition. The sample consisted of student nurses in Scotland between 1994 and 1996.

There were three parts of participations and the first time the questionnaire were given to 168, the second time at 12 months to 124 and the final to 90 at 24 months. This study presents the population of the nurses and nursing students in Scotland. There is an expanded of study over the years relating to the perception of caring in nursing students relating to the professional and technical aspects of caring. On the other hand, there was no expansion of study found in other extent of study such as psychosocial, being cheerful with a patient and inappropriate dimensions of nursing. A suggestion were given by the authors to do a further investigation with the nurses in the clinical ground to proof if there is any increase of caring presents in the individuals after they have completed with their nursing education and have become less "task oriented" (Watson, Deary, and Lea, 1999).

Watson et al. (1999a, b, 2001) found that nursing students after 12 months of education lost some of their idealism about caring, and after 24 months they became more influenced by professional and technical aspects of caring in a longitudinal study; however, as the nursing education programme proceeded, the psychosocial aspect seemed to be more apparent. In another study, students explained caring as

having technical knowledge and being able to help patients manage vital bodily functions (Kapborg 2000).

The most important nurse caring behavior as viewed by the nurses and nursing students were listening to the patients as present in a study by Mangold (1991). Professional nurses gave the least importance to 'is professional in appearance' while nursing students chose 'puts the patient first no matter what happens' as the least important behavior. Wilkes and Wallis (1998) presented a model of professional nurse caring from the students' perspective. In this model 'compassion' as the core of caring was actualized in the students' nursing of patients by communicating, providing comfort, being competent, being committed, having conscience, being confident and being.

A longitudinal study by Simmons and Cavanaugh (2000) was conducted with the registered nurses on the development of caring ability. A resurveyed was performed again with the female nursing graduates' baccalaureate program at the nursing school of the United States three years later. The goal of this research was to evaluate the caring ability through the factors that helped with the development of the "professional caring ability". There different instruments in this study, firstly the Caring Ability Inventory was to measure the caring ability, the Parental Bonding Instrument was used to measure the maternal and paternal care and the School climate Profile was used for the assessment of the caring climate of the nursing school. The results showed significantly increased in the Caring ability scores after entering into the clinical practice, paired student's t-test, $P<.001$. The caring ability scores was $r=.58$, $P<.001$, which reported as the strongest predictor of their caring ability. School climate scores became the highest predictor of the postgraduate caring ability with the

score of (r=.17, P<.05) when student caring ability scores were excluded as a potential predictor. This came to a conclusion that the school environments that have caring contribute in the development of the professional caring ability. Moreover, upon the entry into the clinical practice, a prediction of the student caring ability developed (Simmons and Cavanaugh, 2000).

Caring as perceived by the nursing students that were reviewed in the literature inclined not to look at distinctive characteristics, rather how caring is communicate within faculty-student interactions and the school's environment. In general, the study stated that the most influenced factor on the student's perception of caring is the experienced they gained with the faculty and the nursing school. The literature has also indicated that the levels of stress may precipitate to burnout where it is a positive or negative level of caring. Therefore, study should look into the concepts of both caring and burnout.

Turkish students in a qualitative study perceived caring as professional/helping relationship and technical competency. Major themes were respect, concern, compassion, communication and comfort (Karaoz 2005).

First year nursing students, in a study in Norway, used the word 'care' as they knew about it from daily life. Third year students considered nursing as a caring science which contains knowledge for practicing professional nursing (Granum 2004).

There was no statistically significant influence on the nursing students' perception of the caring behaviors with regard to gender. However, age and programme year showed statistically significant on 'Explains and facilitates' (Khademian and Vizeshfar, 2007). A reported in a cross-sectional comparative design examines caring behaviors of ninety nursing students reflecting a 75% response rate.

The nursing students answered to Caring Assessment Questionnaire (Care-Q) questionnaire composed of 55 caring behaviors items and the behaviors is a Likert-type scale (5-point). There were seven subscales for the caring behaviors: 'accessible', 'monitors and follows through', 'explains and facilitates', 'comforts', 'anticipates', 'trusting relationship' and 'spiritual care'. Iran was where the data were collected and in the year 2003 where 'monitors and follows through as the most and 'trusting relationship' as the least important subscales as perceived by the nursing students. Thus the most and least important caring behaviors were 'To give patient's treatments and medications on time' and 'to do voluntarily little things…' sequentially.

5. Comparison of Nurse Caring Behaviors between the groups

There is a possibility that variables such as older population age and cultural heritage may have affected the perception of touching as nurse caring behavior (Smit and Spoelstra, 1991). Their study demonstrated that home care nurses' and their patients' perceptions of nurse caring behaviors varied. The CARE-Q (Caring assessment instrument) was given to 38 nurses at a home care agency and to 28 randomly selected agency clients in Michigan. The CARE-Q instrument requires the ranking of 50 indentified caring behaviors from most important to least important and uses the Q sort method. The Q sort technique calls for individuals to sort cards in order of importance. Each card lists a nurse caring behavior. Nurses assigned high ranking to behaviors such as listening while patients assigned high rankings to a nurse's clinical judgment and technical skill. Patients also ranked high nurse timeliness, accessibility, cheerfulness and professional appearance. The item that

differed significantly was “touches the patient when he/she needs comforting.” Nurses ranked it number two while patients ranked it 47 out of 50.

The result of a study by Widmark-Petersson, von Essen, and Sjoden, (2000), suggests that staff may enact patient care and interventions from their own points of view instead of the patients' point of view. This Sweden research study in a large university hospital oncology ward used three versions of the CARE Questionnaire in their study. It was used to determine patients’ and staffs’ perceptions of the importance of caring behaviors. The three versions were (a) patient perceptions of the importance of caring behaviors (CARE-P); (b) staff perceptions of the importance of caring behaviors (CARE-S), and (c) staff view of the patient perceptions of the importance of caring behaviors (CARE-SP). The CARE Questionnaire versions P, S, and SP are all extensions of the CA RE-Q instrument. In the original CARE-Q, the behaviors were ranked in seven categories from most important to least important in a forced choice format. In the revised versions, the participants assign a score between one (being low importance) and seven (being high importance). The sample consisted of 20 women and one man. The mean age was 33 years. Patients ranked “explains and facilitates” as the highest caring behaviors followed “anticipates, monitors, and follows through.” The staff ranked “anticipates, and then monitors and follows through, and comforts.” In the CARE-SP version, staff ranked highest nurse caring behaviors as “anticipates, then monitors, follows through and comforts.”

A contribution to the nurse professional identity is exhibit through the power in controlling their environment where nurses can display and render their caring behaviors. Caring behaviors are evidence by the nurses’ presence. A study by Von-Essen and Sjoden (2003) reported significant different between the nurses and

patients in the prioritizing the caring behaviors. However, both the nurses and patients accede that the important of care is through showing caring by listening, being there for, attentive attitude, doing for, respect behavior, supporting and providing competent skills and knowledge of care. Believing in the caring ability must be within the nurses by being able to influence the environment so that they can display their caring behaviors and reaching the needs and desire patient care. There is a belief that an empowerment control of the nurses in the healthcare is through fostering one's ability to complete the job and self-efficacy (Manojlovick, 2005a). There are continuous challenges in the health care environment, thus nurses need to able practice their self-influence to shape the social systems in order to control an expected occurrence or situation productively (Manojlovick, 2005a).

Important differences were found between patients and nurses in their perception of caring behaviours in many of the reviewed studies. The Q-methodology revealed marked differences between nurses and patients in the ranking of how important different nurse caring behaviours are considered to be. Patients appear to value the instrumental, technical caring skills more than nurses do and perceive behaviours that demonstrate competency on how to perform nursing activities ('know how') as more important. On the other hand, nurses perceive their psychological skills and expressive or affective caring behaviour as more important than patients do, leading to the conclusion that nurses may misperceive the necessity of the emotional aspect of caring in comparison with patient judgments. These results, repeatedly reported in the research literature, indicate that nursing staff may not accurately assess patients' perceptions of caring and that patient care is not congruent to the patients' preferences, expectations, or individual needs (Papastavrou, 2011).

Summary

Nurse caring behavior is an important concept in the healthcare system and should not be underemphasized. No studies have been conducted in Cambodia regarding the nurses' caring behavior from the perception of the patients, nurses and nursing students. Many reviewed studies have revealed significant differences between patients and nurses in their perception of caring behaviors. From the literature reviews, Patients appear to value the instrumental, technical caring skills more than nurses do and perceive behaviors that demonstrate competency on how to perform nursing activities ('know how') as more important. However it is interesting to note patients do not perceive psychological skills and expression of carative behaviors as important as nurses do. This potentially might induce nurses to miscomprehend the level of emotional and caring compassion required by the needs of the patient (Papastavrou, 2011). The overall goal of this study is to explore and compare the nurses' caring behavior among the perception of the patients, nurses and nursing students. Such information is essential because the professional responsibility of nurses is centered on rendering high quality nursing interventions leading to positive (Suhonen et al, 2008). Thus, the results from this study can help improve the health care system as well as the nursing systems in Cambodia. It is important to take into account the patients' perspective to link nursing interventions with patient outcome.

CHAPTER III

Methodology

This chapter describes the methodology used in the present study. In this chapter, the research design, population and sample, instrumentation, protection of the rights of human subjects, tryout study, data collection, and data analysis are detailed.

Research design

A descriptive survey research design was used to study and explore patients' perceptions, nurses' perception and nursing students' perceptions of the nurses' caring behavior by using the Caring Behavior Inventory by Wolf (1994). There is no research regarding nurses caring behaviors being conduct in Cambodia so the purpose of this study is to determine how nursing caring behavior are perceived in a survey report between these three groups in Cambodia. According to Burn and Grove (2005), a descriptive design is used to describes and examine the differences in variables in two or more groups that occur naturally in the setting (Burn & Grove, 2005). This study explored and compared the nurses' caring behaviors in the medical-surgical unit from the perception of the nursing students at the Technical School for Medical Care, University of Health Science and the nurses and patients at the Khmer-Soviet Friendship Hospital and Preah Kossamak Hospital. This approach is appropriate for this study of examining patients', nurses' and nursing students' perceptions of nurses' caring behaviors at the medical-surgical unit.

Descriptive studies are a way of discovering new meaning, describing what exists, determining the frequency with which something occurs and categorizing

information (Burns & Grove, 2001). In this case, it applies to the frequency of the caring behaviors that the nurses and nursing students provides and interact with the patients. This descriptive survey design was used in this study to explore, examine and compare if there is difference perceptions among the patients, nurses and nursing students. The design was suitable in this study because it examines and describes different in a variable in three groups that occur naturally in the setting; it provides an accurate portrayal of a particular event for the purpose of describing what exists and determining the means, ways and frequency with which an event occurs (Burns & Grove, 2001).

Population and sample

Population

The populations in this study were (1) the fourth year nursing students at the Technical School for Medical Care, University of Health Science where it is the only one government nursing school in Cambodia that covers the students from all over the 24 provinces, (2) the nurses at the Medical-Surgical Units, and (3) the patients at the Medical-Surgical Units at Khmer-Soviet Hospital and Preah Kossamak Hospital as both are one of the main government hospitals in Phnom Penh under the Ministry of Health, Cambodia. These sites were selected because they are tertiary hospitals with large number of patients at the medical-surgical aside from other hospitals in Cambodia. Cambodia is a developing country where most of the patients from all over the provinces come to these two hospitals for cheaper medical-surgical care and higher standard of treatment. Other hospitals that weren't included are Maternal,

Pediatric, Center for Communicable diseases, Private hospitals, Non-Government Organization hospitals or different standards and settings hospitals.

Sample

1. Patients who had been admitted to the medical-surgical unit within the period of the data collection. All the participants from the two medical-surgical units of the two selected hospitals who met the inclusion criteria were approached and requested to participate into the study. The inclusion criteria were as follows:

(1) Above the age of 18 and under the age of 60.

(2) Conscious and coherent.

(3) Admitted for at least 3 days.

(4) They were able to understand and communicate in Cambodian language.

(5) They were willing to participate in this study.

2. Nurses who are currently working at the medical-surgical units of the two hospitals in this study. The inclusion criteria are the nurses who have worked in these settings for at least a year as they have more experienced and have adjusted to the medical-surgical settings environment and were willing to participate in this study.

3. Fourth year baccalaureate nursing students at the Technical School for Medical Care, University of Health Science who were willing to participate in this study. The inclusion criteria were the total number of the fourth year nursing students as they are in their final semester so they have already completed with their training at the medical-surgical units and were willing to participate in this study.

Sample size

The total number of the fourth year nursing students in the year of 2013 is 156 from the Technical School of Medical Care, University of Health Science. The total number of the nurses at the medical-surgical unit from both of the hospitals is 68. The approximate total numbers of patients at the medical-surgical unit from both of the hospital is 20000.

(1) All the 156 nursing students from the Technical School for Medical Care, University of Health Science were recruited.

(2) All the 68 nurses at the medical-surgical unit from both of the hospital were all recruited.

(3) The sample size for the patients was selected using purposive sampling. indicates that purposive samplings pertain to certain sites or participants that will most suit the researcher's problem and questions, thus they must be willingly to make apparent and share the knowledge. Thus in this study, the researcher have targeted only the patents who have met the inclusion criteria and met the researcher's purpose of study during the month period of the data collection and came up with a sample size of 105 patients Creswell (2003).

Instrumentation

The instruments in this study consisted of: 1) the demographic data questionnaire, 2) the Caring Behavior Inventory (CBI). A description of each instrument is presented as follows:

Demographic data questionnaire

The data elicited from the patients were gender, age, marital status, education level, number of admissions to hospitals in the last 5 years and number of days in hospital during the last admission.

The data elicited from the nurses were gender, age, marital status and number of years working in Medical-Surgical unit.

The data elicited from the nursing students were gender, age and grade point average (GPA).

Caring Behavior Inventory (CBI)

The Caring Behavior Inventory (CBI) was used to explore and compare the nurses' caring behaviors among the perception of the patients, nurses and nursing students. Since late 1990s, CBI has been recommended as the most suitable tool for dual assessment by patients and nurses (Beck, 1999). It is a user-friendly time-saving tool, with good psychometric properties, based on the well- known Watson's Transpersonal theory (Andrews, Daniels, & Hall, 1996; Coulombe et. al., 2002; Wu, Larrabee, & Putman, 2006).

The Caring Behaviors Inventory developed in 1994 by Wolf et al., second version the 42-items will be used in this study. In measuring caring, CBI is viewed to be the second generation instrument. It is one of the earlier to be developed with clarity of conceptual-theoretical basis, along with on-going testing and refinement of instrument (Watson, 1940). This is the most frequently used empirical tool for measuring caring in nursing research and, for this reason, its reliability and validity is the best established. The content of such tools tend to vary with the frameworks underpinning their construction. The conceptual-theoretical basis of the Inventory was

derived from caring literature in general, and Watson's Transpersonal Caring Theory in particular. Caring is directed towards the welfare of patients and takes place when nurses respond to patients in a caring manner. This instrument defines five dimensions of caring: respectful deference to others; assurance of human presence; positive connectedness; professional knowledge and skills; and attentiveness to the experiences of others (i.e. this description of caring includes skills and personal relationships).

Validity and Reliability

The final 42 items were tested on 541 subjects, including 278 nursing staff and 263 patients. The internal consistency reliability was 0.96 after testing according to Wolf (1994). As compared to Kyle (1995), "attentive listening" was ranked as the highest caring behavior. After the 1994 study, the Likert scale of the CBI was revised to increase the variability of responses, increasing the scale from a 4-point to a 6-point Likert, with Then retesting CBI-42 with the Cronbach's alpha of 0.95 (Wolf et al., 2003).

This CBI was translated into Cambodian language by personal translation experts from the World Health Organization as they are the experts relating with official translation and international journals publication. There were no experts in Cambodia nursing who is qualified to back translate the instruments as there is still lack of journals publication from the nurses in Cambodia. The first ever journals for the nurses and midwifes in Cambodia "Cambodian Journal of Nursing and Midwifery (CJNM)", former Health Messenger were only launched in June 2012 during the 50th Issue Anniversary (Jubilee) of Health Messenger. However, Health Messenger is a Cambodian NGO that publishes since 1999, the medical scientific journals. The

purpose of these both peer-reviewed journals is to support the Ministry of Health to improve the capacity development and skills of health professionals and the quality of health services in Cambodia. The main target audience of CJNM is nurses, midwives and health workers; and the readers of CJM is medical doctors and medical assistants in public and private health facilities, hospital and community based in Cambodia and in the world (Huy, 2013).

In the current study, the researcher assessed the content validity of the translated instruments. The instrument was then assessed by four experts, including three doctors and one health officer who are all experts with health research and has international recognized published journals and researches. Regarding the content validity, all of the experts rated each item of CBI 4 (from 1 = not relevant to 4 = very relevant), which met the criteria for content validity (Polit and Hunger, 1999: 419). A content validity index (CVI) score of .80 or more is generally considered to have a good content validity (Polit and Hungler, 1999: 419). In this study, the CVI had a full score of 1 (see Appendix D). In addition, Cronbach's alpha correlation coefficient was used for internal consistency of reliability of this measurement in this study with the score of 0.96 in 30 patients, 0.94 in 30 nurses and 0.93 in 30 nursing students.

Scoring

In early versions of the CBI tool, subjects rated caring phrases and words on a four point scale: one = strongly disagree: two = disagree: three = agree, four = strongly agree. The scaling or CBI version was changed to six response choices to increase the variability of responses. The following six-point scales are the response choices included in the CBI: one = never; two = almost never; three = occasionally, four = usually, five = almost always; and six = always. This instrument originally

contained 75- items and later was decreased through psychometric processes to 42 final items (Beck, 1999; Kyle, 1995; Wolf et al., 1994). The CBI scores ranged from 42 to 252. The mean score of the CBI is rated by using the levels of the rating six-point scales (never, almost never, occasionally, usually, almost always, always).

Protection of the rights of human subjects

An approval from the National Ethics Committee for Health Research, Cambodia had been obtained prior to the beginning of the investigation. After the approval, permission to conduct the study were sought and obtained from the head of the two hospitals and the nursing school.

Ethical principles were followed to ensure the protection of informed consent and confidentiality of the participants. Participants were asked to sign the consent forms before the data collection. The participants were also informed of the purpose of the study and their rights to decline participation and that there were no harm to the participants in this study. Participants were encouraged that if any time they felt discomfort, they were able to discuss the importance of the question with the researcher and they can refuse to answer any question or the researcher. The participants were assured that their names and addresses would be kept strictly confidential and would not be reported with the study findings. Instead, a code number would be used to ensure confidentiality. Results of the study will be reported as a total picture. The participants were also assured that the study data collected from them would be stored in a secure place and would not be accessible to any other person without their permission.

Finally, the researcher explained that there was no harm to the participants in this study and it would take approximately 10-15 minutes to complete all the questionnaires, with the researcher being readily available by mobile phone for all participants to reach if they needed to ask any questions about the study. After completing the questionnaire, each questionnaire were put in an envelope and sealed.

Tryout Study

A tryout study could be conducted to develop and refine a research treatment, a data collection tool or the data collection process (Burns & Grove, 2003). A tryout study is also used to refer to the pretesting, or trying out, of a particular research instrument or research procedures (Baker, 1994: 182-183). Additionally, the trying out study helped ensured the research instrument in avoiding misleading, inappropriate, or redundant questions. It was carried out at the medical-surgical outpatient department of the Khmer-Soviet Friendship Hospital and Preah Kossamak Hospital and at the Technical School for Medical Care, University of Health Science.

The trying out study was conducted after permission was granted by the directors of Khmer-Soviet Friendship Hospital, Preah Kossamak Hospital and Technical School for Medical Care, University of Health Science. The researcher made appointments to meet the head of each of the medical-surgical outpatient department, nurses and the head instructor of the classroom. At the meeting, the researcher introduced herself and informed the health care professionals and head instructor of the objective of this study. Then the researcher asked for their cooperation and collaboration with the nurses to select the patients for the study participants and the nurse themselves and the nursing students.

The participants were adult patients who met the inclusion criteria, any nurses that were available and willing to participate and the 3rd year nursing students who have been trained and completed their practice at the medical-surgical unit like the fourth year nursing students since the total fourth year nursing students were already selected for the sample size. After the participants were identified, the researcher explained the objective of the study. They were informed of their rights to decide to participate or reject to participate in the study. The participants who agreed in the pilot study were asked to sign a consent form and complete the questionnaire and evaluate the clarity and appropriateness of the questions. The time spent on the completion of the questionnaires, any issues related with the questionnaire and the suggestions for improvements were recorded. The participants received a bathing product as a token of appreciation for their participation.

The results of the CBI were then examined for internal consistency using the Cronbach's alpha reliability coefficient. The reliability coefficients of the instrument are shown in Table (3.1). The overall scales of the Cronbach's alpha coefficient ranged from 0.93 to 0.96. On the overall, the measurements had acceptable psychometric properties. The results of this trying out study showed that the participants understood the items of the all the questionnaires. The interview took about 10-15 minutes to complete the instruments. Thus, this instrument was considered appropriate for the patients, nurses and nursing students.

Table 3.1: Psychometric properties of the Caring Behavior Inventory (CBI) used in the tryout study (n = 90)

Group	Number	Cronbach's alpha coefficient Tryout study (n = 90)
Patients	30	0.96
Nurses	30	0.94
Nursing Students	30	0.93

Data Collection

Permission to conduct the study was obtained from director of the hospitals and the director of the school of nursing. Following that, the researcher met the head nurses and nursing staffs during the day shifts of each unit to discuss the nature of the study and the data collection process. Most of the head nurses worked during the day which was more convenient for the researcher to ask the permission during their day shifts and to conduct the study with the nurses and patients at the same time because we can't bother the patient during the night. However, since the whole nurses from the Medical-Surgical Units were the target of the study, the nurses who worked different shifts and rotations and that the researcher didn't hand out the questionnaires personally, it was given to the head nurses to help distributed.

The patients who met the inclusion criteria were approached in their room at the hospitals and the nurses were approached in their working area or the nurses' room when they were free. As for the nursing students, they were approached in their classrooms.

If the patients, nurses and nursing students expressed a desire to participate in the study they were given a consent form to sign and an explanation with the information sheet were given to them. They were also encouraged to ask questions anytime during the study. The consent form also assured them that their anonymity were protected and that all documents associated with the study were remain confidential with only the researcher having access to them. They were informed that their decision to participate or not participate wouldn't affect themselves in any way and that they have the right to withdraw from the study at any time. Patients, nurses and nursing students whom signed the consent form were asked to complete a two part self-administered questionnaire.

For the patient, they were given privacy in their care area so that they can concentrate on the questionnaire and the patients who couldn't read and write were interviewed and assisted with the questionnaires. However, there is some uncontrolled distraction due to the overload patients in the settings. About 65 patients (62%) of the patients were interviewed and assisted by the researcher since most of the patients only have less than 6 grade educational level or have never been to school. Questions were repeated for the patients who did not understand the questionnaires or answer choices until they were clear and able to respond individually. The researcher did not assist the patients in selecting/rating the answers, however if they couldn't answer, it was treated as missing data. The first part of the patients' questionnaire were elicited demographic information including age, sex, marital status, education level, number of admissions to hospitals within the last five years and number of days in the hospital during the last admission.

For the nurses, due to their busy and heavy load work, they were given the questionnaires package at their medical-surgical unit during their free time or break and allowing them for a week so that they could spend their free time from their work in order to for them to concentrate on the questions and return the answers back. However, as mentioned above, the questionnaires were also given to the head nurses to help distribute to the nurses who weren't on duty or have different shifts. The first part of the nurses' questionnaire provided information on sex, age, marital status and number of years working at the medical-surgical unit.

For the nursing students, since they have two sections, the researcher approached them in their classrooms different times. The researcher had asked permission from each classroom lecturers to inform the student not to leave after the class end so that the researcher can approach, discussed and distribute the questionnaires to them. They were then given the questionnaires package at the nursing school in their classrooms within their free time allowing them to concentrate and answer the questions and which took most of them only 15 to 20 minutes. The first part of the nursing students' questionnaire provided information on sex, age and educational achievements.

The second part of the questionnaires were given in the questionnaires package with the first part of the questionnaire and it contained the instrument to measure the perception of the nurse caring behaviors which utilized the CBI that contained 42-items (Wolf et al., 1994).

Then the researcher collected the questionnaires by herself when it has been completed by the participants and put it in envelopes.

Data Analysis

The surveys were hand coded and data were entered into a statistical program (SPSS Inc., (Chicago, IL, USA) by the researcher. Preliminarily, CBI-42 was rated by the experts for the content validity and when the criteria was met, the try-out was performed and Cronbach's α were calculated to assessed the internal consistency. Demographic data were analyzed using descriptive statistics, such as frequencies, percentages, mean and standard deviation (SD). For the purpose of analysis, the 6 Likert-type scales ranging from 1 to 6, with 6 indicating the highest rating 'always' and 1 the lowest rating 'never'. The descriptive statistic of mean and rankings were used to explore the nurse caring behaviors as perceived by the groups. The ten most important caring behaviors as perceived by the groups using the CBI were ranked from highest to lowest according to the mean.

A one-way ANOVA was used to compare whether there were statistically significant differences among the patients, nurses and nursing students in their perception of the nurse caring behaviors. After the results revealed statistically significant differences among the groups, the Tukey HSD post-hoc was run to compare the differences in the groups in each subscale of the CBI. The mean scores were also calculated for each of the five subscales among the groups. The results were then presented in narrative form in Chapter IV.

CHAPTER IV

RESULTS

This chapter presents the findings of the study including the demographic characteristics of the participants derived from descriptive statistical analysis. Patients variables are gender, age, marital status, number of admissions to the hospital in the last five years and number of days in the hospital during the current admission and the variables for nurses are gender, age, marital status, and number of years in nursing and the variables for nursing students as gender, age and grade point average of their last semester were studied to see if there were any significant differences. The CBI total score and subscales were utilized to determine if there was a statistically significant difference in perceptions of the patients, nurses and nursing students.

Characteristics of the study participants

Demographic characteristics of the participants

A total sample of 105 patients (100% response rate) completed the CBI and demographic tool. A total of 68 nurses who are working at the medical-surgical unit were selected in this study and 57 nurses (84% response rate) completed the CBI and demographic tool. A total of 156 nursing students were selected in this study and 150 nursing students (96% response rate) completed the CBI and demographic tool. This study was completed at the two main government hospitals and at the school of nursing, Phnom Penh, Cambodia. The findings regarding demographic characteristics of the study participants are summarized in the Tables below.

Patient sample

Table 4.1: Demographic characteristics of Patients (n=105)

Characteristics	Mean	SD	Number	Percentage
Gender	-	-		
Female			42	40.0
Male			63	60.0
Age	39.75	13.39		
18-30			34	24.8
31-40			18	13.1
41-50			29	21.2
51-60			24	17.5
Marital Status	-	-		
Single			27	19.7
Married			63	46.0
Divorced			3	2.2
Widowed			1	8.8
Educational Level	-	-		
1-6 grade			27	19.7
6-9 grade			29	21.2
9-12 grade			14	10.2
1-2 years university			3	2.2
3-4 years university			8	5.8
Other (never been to school)			24	17.5
Number of Admissions to the Nation Hospital in the last 5 years	1.37	.49		
- First time			66	62.9
- More than once			39	37.1

Table 4.1 (Continuous)

Number of days in hospital during the current admission	8.23	7.56		
3-10			82	78.1
11-20			14	13.3
21-30			9	8.6

Table 4.1 illustrate the summarized demographic characteristics of the 105 patients. The patient participants were primarily male (60%), age ranged from 18 to 60 years of age with a mean age of 39.75 years old and standard deviation of 13.39, married (46%) and had six to ninth grade secondary education or less or never been to school at all.

Nurse sample

Table 4.2: Demographic characteristics of Nurses (n=57)

Characteristics	Mean	SD	Number	Percentage
Gender	-	-		
Female			33	57.9
Male			24	42.1
Age	32.14	8.83		
23-32			38	66.7
33-42			9	15.8
43-52			7	12.3
53-59			3	5.3
Marital Status	-	-		
Single			21	15.3
Married			36	26.3
Number of Years experienced in the Medical-Surgical	7.12	7.49		
1-10 years			45	32.8
11-20 years			7	5.1
21 to 30 years			5	3.6

Table 4.2 illustrate the summarized demographic characteristics of the 57 nurse participants. The nurse participants were marginally more female (58%), married (63%), and have experienced in the medical-surgical for 10 years or less (79%). Nurses' ages ranged from age 23 to age 59 with a mean of 32.14 years old and standard deviation of 8.83.

Nursing Students sample

Table 4.3: Demographic characteristics of Nursing Students (n=150)

Characteristics	Mean	SD	Number	Percentage
Gender				
Female	-	-	96	64.0
Male	-	-	54	36.0
Age	23.07	1.49		
20-23			102	68.0
24-28			48	32.0
Grade Point Average	3.39	.578		
1.50-2.00			3	2.0
2.01-2.50			7	4.7
2.51-3.00			28	18.7
3.01-3.50			46	30.7
3.51-4.00			66	44.0

Table 4.3 illustrate the summarized demographic characteristics of the 150 nursing student participants. The nursing student participants were primarily female (64%), ages ranged from age 20 to age 23 with a mean of 23.07 years old and standard deviation of 1.49. Grade point average of 3.51 to 4.00 and were obtained from the registrar office.

Findings of research questions and hypothesis

The findings that answered the research questions and the results of the hypothesis are enumerated as following:

Table 4.4: Top 10 Nurse Caring Behavior as perceived by the Patients (n=105)

Rank	Caring Behavior Inventory Item	M	SD	Nurses Rank	Nursing Students Rank
1	Knowing how to give shots, IVs, etc	4.65	.97	3	4
2	Treating patient information confidentially	4.65	.90	5	1
3	Including the patient in planning his or her care	4.58	.89	9	27
4	Returning to the patient voluntarily	4.57	3.93	22	26
5	Appreciating the patient as a human being	4.54	3.93	10	31
6	Relieving the patient's symptoms	4.51	3.92	29	16
7	Being patient or tireless with the patient	4.44	3.63	13	36
8	Calling the patient by his or her preferred name	4.41	.69	1	7
9	Managing equipment skillfully	4.29	.81	24	30
10	Using a soft, gentle voice with the patient	4.26	.64	14	10

Table 4.4 demonstrates the mean, standard deviation and top ten caring behaviors as perceived by the patients and the rankings of the nurses and nursing students. The top ten nurse caring behaviors as perceived by patients using the CBI were ranked from highest to lowest; Knowing how to give shots, IVs, etc, treating patient information confidentially, including the patient in planning his or her care, returning to the patient voluntarily, appreciating the patient as a human being, relieving the patient's symptoms, being patient or tireless with the patient, calling the

patient by his/her preferred name, managing equipment skillfully, using a soft, gentle voice with the patient. There items had means rating greater than 4.26 which illustrate the nurse caring behavior as perceived by the patient as usually present.

Table 4.5: Top 10 Nurse Caring Behavior as perceived by the Nurses (n=57)

Rank	Caring Behavior Inventory Item	M	SD	Patient Rank	Nursing Student Rank
1	Calling the patient by his/her preferred name	5.74	.58	8	7
2	Showing respect for the patient	5.68	.57	19	5
3	Knowing how to give shots, IVs, etc	5.67	.58	1	4
4	Being hopeful for the patient	5.65	5.25	35	12
5	Treating the patient information confidentially	5.61	.62	2	1
6	Giving the patient's treatments and medication on time	5.54	.66	11	13
7	Giving instructions to the patient	5.40	.82	33	20
8	Giving the patient information so that he or she can make a decision	5.33	.99	39	38
9	Including the patient in planning his or her care	5.39	.80	3	27
10	Appreciating the patient as a human being	5.28	.86	5	31

Table 4.5 demonstrates the mean, standard deviation and top ten caring behaviors as perceived by the patients and the rankings of the patients and nurses. The top ten caring behaviors as perceived by nurses using the CBI were ranked from highest to lowest; calling the patient by his/her preferred name, showing respect for the patient, knowing how to give shots, IVs, etc, being hopeful for the patient, treating the patient information confidentially, giving the patient's treatments and medication on time, giving instructions to the patient, giving the patient information so that he or she can make a decision, including the patient in planning his or her care, appreciating the patient as a human being. These items had means rating greater than 5.28 which illustrates that the nurse caring behaviors as perceived by the nurses as almost always present.

Table 4.6: Top 10 Nurse Caring Behavior as perceived by the Nursing Students (n=150)

Rank	Caring Behavior Inventory Item	M	SD	Patient Rank	Nurses Rank
1	Treating patient information confidentially	5.56	.67	2	5
2	Helping to reduce the patient's pain	5.11	5.11	28	27
3	Putting the patient first	5.45	4.92	22	35
4	Knowing how to give shots, IVs, etc	5.43	.79	1	3
5	Showing respect for the patient	5.37	.78	19	2
6	Being honest with the patient	5.37	3.33	24	23
7	Calling the patient by his/her preferred name	5.36	.92	8	1

Table 4.6 (Continuous)

8	Supporting the patient	5.23	.88	12	12
9	Encouraging the patient to call if there are problems	5.22	.95	23	15
10	Using a soft, gentle voice with the patient	5.22	.91	10	14

Table 4.6 demonstrates the mean, standard deviation and top ten caring behaviors as perceived by the patients and the rankings of the patients and nurses. The top ten nurse caring behaviors as perceived by nurses using the CBI were ranked from highest to lowest; treating patient information confidentially, helping to reduce the patient's pain, putting the patient first, knowing how to give shots, IVs, etc, showing respect for the patient, being honest with the patient, calling the patient by his/her preferred name, supporting the patient, encouraging the patient to call if there are problems, using a soft, gentle voice with the patient.

These items had means rating greater than 5.22 which illustrates that the nurse caring behaviors as perceived by the nursing students as almost always present.

Data analysis and interpretation

Table 4.7: Mean and Standard Deviation of the Total CBI Score (n= 312)

Total CBI	Patient	Nurse	Nursing Student
Mean	16.36	19.85	25.91
SD	1.75	2.18	2.09

Table 4.7 illustrates the mean and standard deviation of the total CBI among the group (patients, nurses and nursing students).The results from the table showed that the mean score and standard deviation of patients is lower than the nurse and nursing students. However the nursing students' mean is only slightly lower than the mean of the nurses. The result is carrying on ANOVA comparison of group mean on the Total score CBI in the following table 4.8.

Table 4.8: ANOVA Summary Table on Total CBI Score (n= 312)

CBI Total score					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	94223.723	2	47111.861	98.358	.01
Within Groups	148005.816	309	478.983		
Total	242229.538	311			

Table 4.8 demonstrates the result of the analysis of variance on total CBI-42 items scores. Since F-value (98.358) exceeded the null hypothesis of equal means among three groups then leading to rejection of equal means among the groups at ($p<.01$) level. The analysis is carrying on pairwise comparison of group mean in the following table 4.9.

Table 4.9 Tukey Pairwise of Total CBI Score

Group	Group	Mean Difference	Std. Error	Sig.
Patient	Nurse	-42.64912*	3.60069	<.01
Patient	Nursing Student	-33.63333*	2.78477	<.01
Nurse	Nursing Student	9.01579*	3.40535	.023

*. The mean difference is significant at the 0.05 level.

Table 4.9 illustrate the Tukey pairwise of the total score CBI items. The finding of pairwise among group means according to total score CBI items show a distinguished on the group mean. The mean difference on the perception of nurses caring behaviors were group into three (patient nurses nursing students). The mean of the patients perceived on nurses caring behaviors were lower than means of nurses and nursing students on the total CBI score. The results leading to a compute of mean and standard deviation of the CBI five subscales among the groups in the following table 4.10.

Table 4.10: Mean and Standard Deviation of the five subscales in the three groups of participants (n=312)

	Patient		Nurse		Nursing Student			
SUBSCALE	Mean	SD	Mean	SD	Mean	SD	F	P
Respect deference	50.55	3.86	63.56	9.11	60.24	5.19	83.06	<.01
Assurance of Human Presence	49.31	7.45	61.79	11.86	59.27	7.32	42.42	<.01
Positive Connectedness	36.63	4.56	45.47	5.28	43.22	7.04	65.08	<.01
Professional Knowledge and Skill	21.56	2.72	26.64	3.41	25.44	2.47	70.35	<.01
Attentive to Other's Experience	16.94	4.15	20.18	5.70	20.46	2.67	18.16	<.01
Total Score	35.00	15.46	43.53	19.80	41.73	18.51	55.82	<.01

The results from Table 4.10 show the following conclusions:

1) Means of patients perceived on nursing caring behaviors are lower than means of nurses and nursing students in every subscale.

2) Means of nursing students are slightly lower than mean of nurses in every subscale except the last subscale (Attentive to other's experience).

3) All F-test rejected null hypothesis of equal means in every subscale.

4) The results leading to compute pairwise among group mean by Tukey-method and the result is on the following Table 4.11.

Table 4.11: Turkey HSD post-hoc test results of the five subscales of CBI

Subscales	Group	Group	Mean Difference	Std. Error	Sig.
Respectful Deference	Patient	Nurse	-13.00902*	1.16197	<.01
	Patient	Nursing Student	-9.68762*	.89867	<.01
	Nurse	Nursing Student	3.32140*	1.09893	.008
Assurance Of Human Presence	Patient	Nurse	-12.47519*	1.61405	<.01
	Patient	Nursing Student	-9.95905*	1.24830	<.01
	Nurse	Nursing Student	2.51614	1.52649	.227
Positive Connectedness	Patient	Nurse	-8.84511*	.89285	<.01
	Patient	Nursing Student	-6.59143*	.69053	<.01
	Nurse	Nursing Student	2.25368*	.84441	.022
Professional Knowledge and Skill	Patient	Nurse	-5.08722*	.49928	<.01
	Patient	Nursing Student	-3.87810*	.38615	<.01
	Nurse	Nursing Student	1.20912*	.47220	.029
Attentive to Other's Experience	Patient	Nurse	-3.23258*	.78514	<.01
	Patient	Nursing Student	-3.51714*	.60722	<.01
	Nurse	Nursing Student	-.28456	.74254	.922

*. The mean difference is significant at the 0.05 level.

The findings of pairwise in Table 4.11 among group means according to subscales reveal two clusters of subscale as following:

1) Respect Deference, Positive Connectedness, Professional Knowledge and Skill Subscales distinguish the groups' means on perception of nurse caring behaviors into 3 groups exclusively.

Patient < Nursing Students < Nurses

2) Assurance of Human Presence and Attentive to Other's Subscales distinguish group mean on the perception of nurse caring behaviors into 2 inclusively.

Patient < Nursing Student, Nurse

Comparison of the Total CBI Score to the groups (Patients, Nurses and Nursing Students) Demographic Data

Patients

The result of the analysis of variance on the comparison of the patients' demographic data (age, marital status, educational level, number of admissions during the last 5 years, number of days in the hospitals during the current admission) on perception of nurse caring behaviors to the total CBI score were showed (See Appendix K). The table demonstrates significant difference between the patients' marital status and number of days of patients during the current admission on how they perceived nurse caring behaviors. The results leading to compute pairwise among group mean of the numbers of days range of patients during the current admission by Tukey-method and the result illustrate a distinguished on the group mean. The mean differences on the perception of nurse caring behaviors were grouped into three (3-10days, 11-20 days, 21-30 days). The mean of 3 to 10 days range in the hospitals during the current admission of the patients were lower than 11 to 20 days and 21 to 30 days. This the researcher assumed that the longer days the patients stay in the hospitals, the higher they perceived the nurse caring behaviors (See appendix K.1)

Nurses

The result of the analysis of variance on the comparison of the nurses' demographic data (number of years experienced in medical-surgical, age, marital status) on perception of nurse caring behaviors to the total CBI scores were showed (See appendix L). The table demonstrates significant difference between the nurses' number of years experienced in medical-surgical unit and nurses' age on how they perceived nurse caring behaviors. The results leading to compute pairwise among group mean of number of years the nurses experienced in medical-surgical by Tukey-method and the result illustrate a distinguished on the group mean. The mean differences on the perception of nurse caring behaviors were grouped into three (1-10 years, 11-20 years, 21-30 years). The mean of 1 to 10 years range of the nurses experienced in the medical-surgical were lower than 11 to 20 years and 21 to 30 years. This the researcher assumed that the longer year nurses have experienced in the medical-surgical, the higher they perceived the nurse caring behaviors (See appendix L.1)

Nursing Student

The result of the analysis of variance on the comparison of the nursing students' demographic data (gender, age, grade point average) on perception of nurse caring behaviors to the total CBI scores were showed. However, the table shows no significant difference between the nursing students' demographic data on how they perceived nurse caring behaviors (See Appendix M)

Summary

The descriptive statistic characteristics of the participants investigated in the current study have been explained. The common top rankings of nurse caring behavior as perceived by the patients, nurses and nursing students were knowing how to give shots, IVs, etc., treating patient information confidentially and calling the patient by his/her preferred name.

There were statistically significant different among the patients' perception on how they perceived nurse caring behaviors compared to the nurses' perception and nursing students' perception. The means of the patients on how they perceived the nurse caring behavior were lower than the means of the nurse and nursing students in every subscale of the CBI-42 items. Although there were no significant differences between the nurses' perception and the nursing students' on how they perceived nurses caring behaviors. However, the means score of nursing students were slightly lower than means of nurses in every subscales of except the last subscales (Attentive to Other's experience).

The different in the comparison between patients' perception, nurses' perception and the nursing students' perception of nurse caring behavior was measured using the total score of the CBI, the subscales totals on the CBI. The one-way ANOVA was utilized for statistics and demonstrated significance different on all the five subscales. Turkey HSD post-hoc test was run to compare the differences in the groups (patients, nurses and nursing students) in each subscale of CBI. The research hypothesis was accepted as the ANOVA showed differences among the patients to the nurses and nursing students. Although nurses and nursing students

showed no significant difference only the mean score of the nurse were slightly higher than the nursing students.

In addition, one-way ANOVA was used to compare the demographic characteristics of the patients, nurses and nursing students with the total CBI score and there were significant difference among the patients' number of day of the days in the hospital during the current admission and the nurses showed significant difference in the numbers of years experienced in medical-surgical. However, there was no significant difference in the nursing students' demographic data. The pairwise Tukey-method was run to compare those differences among the demographic data of the patients and nurses. The results of the Tukey pairwise showed that the longer days the patient stays in the hospital, the higher they perceived the nurse caring behaviors. For the nurses, the longer they have experienced in the medical-surgical, the higher they perceived nurses caring behavior.

CHAPTER V

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

This chapter provides the discussion of the study findings. It includes conclusion, discussion of the characteristics of the participants' perception, limitation, implications for nursing, and recommendation for future research.

Summary

The purpose of this descriptive comparative study was to explore the nurse caring behaviors at the medical-surgical unit, Cambodia by comparing the perceptions among the patients, nurses and nursing students by using the international well known instruments Caring Behavior Inventory by Wolf (1994). The theoretical framework used in this study was by Jean Watson's Theory of Human Caring (Watson, 1979). A sample of 312 participants was recruited. The patients and the nurses were recruited from the Khmer-Soviet Friendship hospital and the Preah Kossamak Hospital and as for the nursing students were from the Technical School for Medical Care, University of Health Science. Data collection was carried out from June to July 2013.

The instruments used in this study included the demographic characteristics questionnaire and the caring behavior inventory questionnaire. The patients responded to a set of 6 questions for the demographic characteristics part and 42 questions for the nurse caring behavior in an assessment structured. The nurses responded to a set of 4 questions for the demographic characteristics part and 42 questions for the nurse caring behavior in an assessment structured. The nursing students responded to a set of 3 questions for the demographic characteristics part and 42 questions for the nurse

caring behavior in an assessment structured. The validity and reliability of the instruments were examined.

According to the study findings, the patients ranged in age from 18 to 60 years old, with the mean age of 39.75 years old (SD =39.75). The patients were predominantly male (60%), married (46%), and had six to ninth grade secondary education or less or never been to school at all. In addition, nearly all the patients were admittedly from 1 to 5days (93%) during their admission in the last 5 years and more than three quarters of the patients (78%) had 1 to 10 numbers of days in the hospital during their last admission. As for the nurses, were marginally more female (58%), married (63%), and were in nursing 10 years or less (79%). Nurses' ages ranged from age 23 to age 59 with a mean of 32.14 years old (SD = 8.83). Finally, the last populations of the study were the nursing students which were primarily female (64%), ages ranged from age 20 to age 23 with a mean of 23.07 years old (SD = 1.49) and with a grade point average of 3.51 to 4.00.

The investigation illustrates significant differences in the perception of the nurse caring behavior between the patients to the nurses and nursing students. The subscale total means of the CBI were significantly different between the patients to the nurses and nursing students in the five subscales: respectful deference to other, assurance of human presence, positive connectedness, professional knowledge and skill and attentiveness to other's experience. Although there were no significant differences between the nurses' perception and the nursing students' on how they perceived nurses caring behaviors. However, the means score of nursing students were slightly lower than means of nurses in every subscales of except the last subscales (Attentive to Other's experience).

In addition, one-way ANOVA was used to compare the demographic characteristics of the patients, nurses and nursing students with the total CBI score and there were significant difference among the patients' number of day of the days in the hospital during the current admission and the nurses showed significant difference in the numbers of years experienced in medical-surgical. However, there was no significant difference in the nursing students' demographic data. The pairwise Tukey-method was run to compare those differences among the demographic data of the patients and nurses. The results of the Tukey pairwise showed that the longer days the patient stays in the hospital, the higher they perceived the nurse caring behaviors. For the nurses, the longer they have experienced in the medical-surgical, the higher they perceived nurses caring behavior.

Discussion

This study revealed few similarities and more differences among the patients', nurses' and nursing students' perceptions regarding nurse caring behaviors.

First of all the top patients' perception of nurse caring behaviors were ranked from the highest to the lowest were knowing how to give shots, IVs, etc, treating patient information confidentially, including the patient in planning his or her care, returning to the patient voluntarily, appreciating the patient as a human being, relieving the patient's symptoms, being patient or tireless with the patient, calling the patient by his/her preferred name, managing equipment skillfully, using a soft, gentle voice with the patient. Such findings show few similarities with the previous studies which showed the top ranking of the patients where knowing how to give shots, IVs,

as the patient's top perception of nurse caring behaviors (Scharf and Caley's, 1992; Baldursdottir and Jonsdottir, 2002).

As for the top nurses' perception of nurses caring behaviors were also ranked from highest to lowest were calling the patient by his/her preferred name, showing respect for the patient, knowing how to give shots, IVs, etc, being hopeful for the patient, treating the patient information confidentially, giving the patient's treatments and medication on time, giving instructions to the patient, giving the patient information so that he or she can make a decision, including the patient in planning his or her care, appreciating the patient as a human being. These findings of the nurses are consistent with the study by Andrews et. al. (1996) where nurses completed the top three highest ranked caring behaviors reported were 'shows respect for the patient', 'allows patient to express feelings' and treats patient information confidentially.

On the other hand, the top nursing student' perception of nurses caring behaviors as ranked from highest to lowest were treating patient information confidentially, helping to reduce the patient's pain, putting the patient first, knowing how to give shots, IVs, etc, showing respect for the patient, being honest with the patient, calling the patient by his/her preferred name, supporting the patient, encouraging the patient to call if there are problems, using a soft, gentle voice with the patient. These findings are in congruence with previous study on nursing students by Watson et al. (1999a, b, 2001) which reported that as the nursing education program proceeded, the psychosocial aspect seemed to be more apparent as nursing caring behaviors.

However, the patients, nurses and nursing students agreed on 3 out of the 10 top nurse caring behaviors. The top following three items were ranked among the 10 tens by the group include: “knowing how to give shots, IVs, etc., treating the patient information confidentially and calling the patient by his/preferred name. It showed that among the group, they perceived only one item of the nurses’ behaviors in professional knowledge and skill (subscale) as the highest. Nevertheless, the findings differ from a number of studies which showed that the patients and nurses did not concur the same nurses caring behavior (Windmark-Petersson et.al, 2000; Paspastavrou, 2011).

Despite that, just 3 out of the top 10 nurse caring behaviors are still low in comparison among the group. It showed that their perceptions are slightly alike only but the differences are more. Thus, this study studied further by analyzing the score of the CBI among the groups (patients, nurses and nursing students) that they have rated by comparing the mean, standard deviation, ANOVA and Turkey HSD post-hoc test to see if the total score of the CBI and by subscales are different or not.

The result of the analysis of variance on total CBI-42 items scores. The result shows that there is a difference in the perception of the patients, nurses and nursing students ($p<.01$) regarding the nurse caring behaviors. The pairwise among group means according to total score CBI items also showed a distinguished on the group mean. The mean of the patients perceived on nurses caring behaviors were lower than means of nurses and nursing students on the total CBI score. Thus, the score of the five subscales of the CBI among the groups were also computed and the finding showed means of patients perceived on nursing caring behaviors are lower than means of nurses and nursing students in every subscale. The results leading to compute pairwise among group mean by Tukey-method and the result reported that Respect

Deference, Positive Connectedness, Professional Knowledge and Skill Subscales distinguish the groups' means on perception of nurse caring behaviors into 3 groups exclusively which the patients perception is lower than the nursing students and the nursing students is lower than the nurses. Assurance of Human Presence and Attentive to Other's Subscales distinguish group mean on the perception of nurse caring behaviors into 2 inclusively which the patient is lower than the nursing students and nurses. In conclusion, the results illustrated that the nurses' perception are different from the nurses and nursing students. This is congruence to many studies such as the study by Papastavrou (2011) which indicates that nursing staff may not accurately assess patients' perceptions of caring and that patient care is not congruent to the patients' preferences, expectations, or individual needs Significant differences were found between patients and nurses in their perception of nurses' caring behaviors in many reviewed studies. Another study by Amendolair (2007) also indicate that nurses may not accurately assess patient perceptions of caring and that patient care is not congruent to the patient perception. Studies by (Von-Essen, 2003) have also generally demonstrated significant differences in patient's and nurse's perceptions of nurse caring behaviors.

On the other hand, the nursing students' score is only slightly lower than the nurses in the total scores. This can conclude that the nurses and nursing students perceived the same nurses' caring behaviors. This is congruence to the study by Mangold's study (1991), where both the nurses and nursing students agreed on the top nurse caring behaviors.

In conclusion, patient's perceptions of nurses caring behaviors are lower among the groups can due to many reasons and it has been reflected in many studies.

Nurses are experiencing difficulties demanding them to balance activities of caring with the task determined by the working environment. The increased number of patients' admission, shortage of nurses, inadequate numbers of beds in the medical and surgical units, and early discharge have lead to nurse having doubts in their capacity to show caring behaviors for the patients. The risk in neglecting some patients occurs due to the increase workload of the nurses leading to prioritizing the more seriously ill patient (Baldursdottir & Jonsdottir, 200 (Baldursdottir et. al., 2002).

Limitation

On the overall, the present study involved some limitations. First of all, study sample of the nurses was the whole nurses at the medical-surgical unit of the two hospitals but only 84% response rate due to their busy schedule and less cooperation as they have never been studies in Cambodia involving nurse caring behavior. The study cannot be generalized on other settings as it's only conducted at the two main government hospitals and in the medical-surgical which have same standard and similar practice in the settings. Last, an uncontrolled distraction due to the overload patients in the settings.

Implications for nursing

The implications of this study focus on the implications for nursing practice, nursing education, and nursing research as follows:

Implications for nursing practice

The current study sheds light on the knowledge regarding the nurse caring behaviors. Based on the findings, the nurses and nurse administrators in Cambodia

can use it to change in many ways in their practice. It is crucial for the nurses and nursing students to know how the patient perceives the nurse caring behaviors in Cambodia. The nurses and nursing administrators can work together in changing and adjusting to the patient's perception the planning of care and nursing practice decisions.

Nurses at the Medical-Surgical unit in Cambodia also need to continually use the expression of caring behaviors every time they care for the patients and also how patient perceived as the top nurse caring behaviors which are not only psychological aspects but the top is instrumental and technical skills.

There should also be an ongoing training and education for the nurses who are still in their diploma to be able to adopt and adjust to the new curriculum and new knowledge in modern/current nursing.

In the contribution to transpersonal caring relation, nurses need to acquire identification, correct detect, and associate with the spirit within another by being honest and being in the center of caring times such as "actions, words, behaviors, cognition, body language, feelings, intuition, thought, senses, the energy field" etc. Movements, gestures, touch; sound, facial expression, procedures, information, verbal communication and scientific, technical, pleasing appearance, and the communication with nursing human acts or deliberate caring-healing modalities are all of the nurse's ability to have the connection with individuals within the transpersonal spirit- to spirit level (Watson, 1988). However, the above caring behaviors as mentioned by Watson (1988) must still be developed to reflect their caring behaviors in order to express their professional identity.

Implications for nursing education

This study can enlighten the nurse educators in Cambodia to generate new perspective and new options in teaching and learning about being aware of the nurse caring behaviors and the different perspective and views among the patients, nurses and nursing students.

Nursing students should apply nurse caring behaviors into the nursing process before rendering care to the patients.

Nursing students should also have the opportunity to investigate and do more research regarding the differences views and perception and how to be a good caring nurse in the future.

Implication for nursing research

The current study is the first study in Cambodia in regards to the nurse caring behaviors. The findings of this study will serve as a reference and first step for newer researcher in explore and study more about the nurse caring behaviors in different settings or different population. Since this study was conducted in Phnom Penh the capital city of Cambodia so further investigations should be carry out in other regions in Cambodia. Different kinds of instruments in the assessment and exploration of the nurse caring behaviors should be use for further investigations or compare. In this investigation, the CBI was used to measure nurse caring behavior and could be use as a factor in further studies.

Recommendations

Based on the findings of the present study, the following recommendations for future research can be made as follows:

From this Study:

- A consideration in implementing the evaluation should be done with the nursing staff and nursing students caring behaviors to ensure changes and improvements. There should also be an ongoing or continues training for the diploma nurses to able to update knowledge in the modern nursing.

- Nurse must be aware of how the patients perceived nurse caring behaviors in order to avoid conflict and showing caring behaviors at all time.

-Studies relating to caring behaviors shouldn't be failed to consider and provide more attention to.

-Education of nurses should promote caring behaviors and the ethic of caring behaviors must be taught and practiced by nurses, nurse educators and nursing students because the quality of care and life are created by the care providers.

Further Research

-Studies should be conducted to replicate the present study in diverse settings and within one sample group of population or a qualitative research to get deeper results.

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APPENDICES

APPENDIX A

APPROVAL OF DISSERTATION PROPOSAL

Announcement

Faculty of Nursing, Chulalongkorn University

Proposal Approved in the academic year 2012

ID	5477208836
Name	Miss Quynh anh Doan
Academic Program	Master of Nursing Science Program in Nursing Science
Chairperson	Assoc. Prof. Dr. Sureeporn Thanasilp
Advisor	Asst. Prof. Dr. Sunida Preechawong
External Examiner	Dr. Choosak Khampalikit
Title of Thesis	FACTORS RELATED TO DIETARY BEHAVIORS OF VIETNAMESE PATIENTS WITH RECURRENT KIDNEY STONE POST-OPERATION

ID	5477170536
Name	Miss Naryna Yel
Academic Program	Master of Nursing Science Program in Nursing Science
Chairperson	Assoc. Prof. Dr. Waraporn Chaiyawat
Major-advisor	Assoc. Prof. Dr. Sureeporn Thanasilp
Co-advisor	Asst. Prof. Dr. Branom Rodcumdee
External Examiner	Dr. Choosak Khampalikit
Title of Thesis	NURSES' CARING BEHAVIOR IN THE MEDICAL-SURGICAL UNIT, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES AND NURSING STUDENTS

Approval by Faculty Board No. 7/2013, April 23, 2013

Announce date April 25, 2013

(Pol.Capt. Yupin Aungsuroch, Ph.D.)

Associate Professor and Dean, Faculty of Nursing

APPENDIX B

INSTRUMENTS (ENGLISH AND CAMBODIAN)

APPENDIX B 1

Demographic Data Questionnaire for Patients

Direction for Patients:

Please complete the following information. Kindly circle and write in your answer:

1. Sex: a. female b. male

2. Age: _____

3. Marital Status:

    a. Single
    b. Married
    c. Divorced
    d. Widowed
    e. Separated

4. Educational Level:

    1. 1-6 grade
    2. 6-9 grade
    3. 9-12 grade
    4. 1-2 years university
    5. 3-4 years university
    6. Other_____

5. Number of admissions to hospital in the last 5 years
    _____

6. Number of days in hospital during the last admission
    _____

Tinñn½yRbCasaRsþ
sMrab;GñkCMgW
esckþIENnaM

bMeBjnUvBt’manxageRkam
edayKUrrgVg;CuMvij rWsresrnUvcMelIy³

1> ePT³ k>RsI x>Rbus
2> Gayu³ _____
3> sßanPaBénGaBah_BiBah_
   k> enAlIv
   x> erobkar
   K> ElglHKña
   X> emm:ay rW eBaHma:y
   g> minrs;enACamYyKña
4> kMriténkarsikSa
   k> fñak;TI 1-6
   x> fñak;TI 6-9
   K> fñak;TI 9-12
   X> qñaMTI 1-2 énsklviTénsklviTüal½y
   g> qñaMTI 3-4 énsklviTénsklviTüal½y
   c> epSg² _____
5> cMnYn
   Edl)ansMrakgBüa)alkñúgmnÞIreBTü
   kñúgkMLúgeBl5qñaMknøgmkenH.

_____

6> cMnYnéf¶ énkarcUlsMrakBüa)alkñúgmnÞIreBTü cugeRkaybMput.

_____

Demographic Data Questionnaire for Nurses

Direction for Nurses:

Please complete the following information. Kindly circle or write in your answer:

1. Sex: a. female b. male
2. Age: _____
3. Marital Status:
   a. Single
   b. Married
   c. Divorced
   d. Widowed
   e. Separated
4. Number of years in nursing
   _____

Tinñn½yRbCasaRsþ sMrab;Kilanubdæak esckþIENnaM

bMeBjnUvBt'manxageRkam edayKUrrgVg;CuMvij rWsresrnUvcMelIy³

1> ePT³ k>RsI x>Rbus
2> Gayu³_____
3> sßanPaBénGaBah_BiBah_

k> enAlIv
x>erobkar
K> ElglHKña
X> emm:ay rW eBaHma:y
g>Edlminrs;enACamYyKña
4> cMnYnqñaMEdl)ancUleFVIkarCaKilanubdæa
k _____

Demographic Data Questionnaire for Nursing Students

Direction for Nursing Students:

Please complete the following information. Kindly circle or write in your answer:

1. Sex: a. female b. male
2. Age: _____
3. GPA: _____

Tinñn½yRbCasaRsþ sMrab;nisSitKilanubdæak

esckþIENnaM

bMeBjnUvBt'manxageRkam edayKUrrgVg;CuMvij nigsresrnUvcMelIy³

1>ePT³ k>RsI x>Rbus
2>Gayu³
3>BinÞúsrubRbcaMqñaM (GPA): _____

APPENDIX B 2

CARING BEHAVIORS INVENTORY

Directions for Patients:

Please read the list of items that describe nurse caring behaviors. For each item, please circle the answer that stands for the extent that a nurse or nurses caring made visible and felt during your last hospitalization.

Remember, *you* are the patient

	never	**almost never**	occa-sionally	usually	almost always	always
1. Attentively listening to the patient.						
2. Giving instructions to the patient.						
3. Treating the patient as individual						
4. Spending time with the patient						
5. Touching the patient to communicate caring						
6. Being hopeful for the patient						
7. Giving the patient information so that he or she can make a decision						
8. Showing respect for the patient						
9. Supporting the patient						
10. Calling the patient by his/her preferred name						
11. Being honest with the patient						
12. Trusting the patient						
13. Being empathetic or identifying with the patient						
14. Helping the patient grow						
15. Making the patient physically or emotionally comfortable						
16. Being sensitive to the patient						
17. Being patient or tireless with the patient						
18. Helping the patient						
19. Knowing how to give shots, IVs, etc.						

20. Being confident with the patient						
21. Using a soft, gentle voice with the patient						
22. Demonstrating professional knowledge and skill						
23. Watching over patient						
24. Managing equipment skillfully						
25. Being cheerful with the patient						
26. Allowing the patient to express feelings about his or her disease and treatment						
27. Including the patient in planning his or her care						
28. Treating patient information confidentially						
29. Providing a reassuring presence						
30. Returning to the patient voluntarily						
31. Talking with the patient						
32. Encouraging the patient to call if there are problems						
33. Meeting the patient's stated and unstated needs						
34. Responding quickly to the patient's call						
35. Appreciating the patient as a human being						
36. Helping to reduce the patient's pain						
37. Showing concern for the patient						
38. Giving the patient's treatments and medication on time						
39. Paying special attention to the patient during first times, as hospitalization, treatments						
40. Relieving the patient's symptoms						
41. Putting the patient first						
42. Giving good physical care						

APPENDIX B 3

CARING BEHAVIORS INVENTORY

Directions for Nurses and Nursing Students:

Please read the list of items that describe nurse caring behaviors. For each item, please circle the answer that you have say or done to make the patients felt cared for.

	never	**almost never**	occa-sionally	usually	almost always	always
1. Attentively listening to the patient.						
2. Giving instructions to the patient.						
3. Treating the patient as individual						
4. Spending time with the patient						
5. Touching the patient to communicate caring						
6. Being hopeful for the patient						
7. Giving the patient information so that he or she can make a decision						
8. Showing respect for the patient						
9. Supporting the patient						
10. Calling the patient by his/her preferred name						
11. Being honest with the patient						
12. Trusting the patient						
13. Being empathetic or identifying with the patient						
14. Helping the patient grow						
15. Making the patient physically or emotionally comfortable						
16. Being sensitive to the patient						
17. Being patient or tireless with the patient						
18. Helping the patient						
19. Knowing how to give shots, IVs, etc.						
20. Being confident with the patient						
21. Using a soft, gentle voice with the patient						

22. Demonstrating professional knowledge and skill						
23. Watching over patient						
24. Managing equipment skillfully						
25. Being cheerful with the patient						
26. Allowing the patient to express feelings about his or her disease and treatment						
27. Including the patient in planning his or her care						
28. Treating patient information confidentially						
29. Providing a reassuring presence						
30. Returning to the patient voluntarily						
31. Talking with the patient						
32. Encouraging the patient to call if there are problems						
33. Meeting the patient's stated and unstated needs						
34. Responding quickly to the patient's call						
35. Appreciating the patient as a human being						
36. Helping to reduce the patient's pain						
37. Showing concern for the patient						
38. Giving the patient's treatments and medication on time						
39. Paying special attention to the patient during first times, as hospitalization, treatments						
40. Relieving the patient's symptoms						
41. Putting the patient first						
42. Giving good physical care						

]bkrN¾sMrab;vas;
“\riyabTénkarEfrkSanigykcitþTukdak;”

esckþIENnaM

sUmemtþGannUvtaragrayxageRkam

Edlerobrab;GMBI \riyabTénkarEfrkSanigykcitþTukdak;rbs;Kilan ubdæak.

sMrab;elxerognimYy² sUmKUr (√) nUvcMelIyEdlqøúHbBa©aMg eGayGñkeXIjnUv\riyabTrbs;Kilanubdæak cMeBaHkarEf rkSanigykcitþTukdak;eTAelIGñkCMgW kñúgkMLúgeBlsMrakBüa)al.

sUmcaMfa*Gñk* CaGñkCMgW ebIGñkCaKilanubdæaksUmCMnYsGñkC MgWeTACa *Gñk* CaKilanubdæak.

	min Edl esa H	**esÞ IrE t min Edl**	**eday eBl ¼eB lxøH**	**tam Fmµ ta**	**esÞ IrE t Ca nic ©**	**C an ic ©**
1> sþab;GñkCMgWedayyk citþTukdak;						

2> bgðat;Bnül;nigENnaMe pSg²eTAelIGñkCMgW						
3> rab;GanGñkCMgWdUc buKÁlepSg²						
4> cMNayeBlevlaCamYyG ñkCMgW						
5> kan; Bal;GñkCMgWedIm,Ibgð ajnUvkarykcitþTukdak; kñúgkMLúgeBlsnÞna						
6> bgðajnUvPaBmansgÇw mdl;GñkCMgW						
7> cg¥úlbgðajnUvsßanPaB viC¢manepSg² rbs;GñkCMgWeTA dl;GñkCMgW ehIynigsßanPaBCMgWrbs ;Kat;						
8> pþl;nUvkareKarBdl;Gñ kCMgW						
9> KaMRTGñkCMgW						
10> ehAGñkCMgWedayeQµa HRtWmRtUv						
11> pþl;nUvPaBesµaHRtg;cMeB						

aHGñkCMgW						
12> TukcitþeTAelIGñkCMgW						
13> sÁal;rWecHyl;citþGñkCMgW						
14> CYyGñkCMgWeGaylUtlas;suxPaB						
15> pþl;nUvPaBsuxRsYlTaMgpøÚvkaynigpøÚvcitþdl;GñkCMgW						
16> yl;eyaKBIGarmµN¾kñúgkarEfTaMGñkCMgW						
17> ecHGt;Fµt;rWminbgðajPaBGs;kMlaMgdl;GñkCMgW						
18> pþl;CMnYydl;GñkCMgW						
19> ecHcak;fñaMnigcak;sarU:m .l.						
20> pþl;PaBeCOCak;ral;kargarcMeBaHGñkCMgW						
21> eRbIsMelgsuPaBrabsaeTAelIGñkCMgW						
22> bgðajnUvcMenHdwgvi						

C¢aCIv³nigCMnaj						
23> yamemIlGñkCMgW						
24> kan;kab;]bkrN½sMPar³eB Tüeday CMnajbiunRbsb;						
25> bgðajPaBrIkraydl;GñkCM gW						
26> GnuBaØat[GñkCMgWbe Ba©jrWsMEdgGarmµN½ rbs;xøÚn cMeBaHCMgWnigkarBüa)al						
27> bBa©ÚlGñkCMgWral; EpnkarN½énkarEfrkSarb s;Kat;						
28> rkSaral;Bt’manrbs;GñkC MgWCakarsMgat;						
29> bgðajnUvvtþmankk;ekþA dl;GñkCMgW						
30> RtLb;eTAemIlGñkCMg WedayesckþIsµR½Kcitþ						
31> niyayCamYyGñkCMgW						

32> elIkTwkcitþGñkCMgW[ehAebImanbBaðaGVImYy						
33> bMeBjnUvtMrUvkarrbs;GñkCMgWTaMgtMrUvkarR)ab;nig minR)ab;						
34> eqøIytbrh½seTAnwgkarehArbs;GñkCMgW						
35> elIktMekIgGñkCMgWdUcmnusSelak						
36> CYykat;bnßyPaBQIcab;rbs;GñkCMgW						
37> bgðajPaBxVl;xVaydl;GñkCMgW						
38> pþl;karBüa)alnigfñaMdl;GñkCMgWTan;eBl						
39> pþl;nUvkaykcitþTukdak;karsMrakeBTüCaBiesscMeBaHGñkCMgWEdlkMBugTTYlkarBüa)alCael						

IkdMbUg						
40> eFVI[eraKsBaØaGñkCMg WmanPaBFUrRsal						
41> pþl;PaBsMxan;dl;GñkCM gWmuneK						
42> pþl;karEfrkSaragkaydl;Gñ kCMgW[)anl¥						

APPENDIX C

PERMISSION DOCUMENT

FOR USING THE INSTRUMENTS

Request Letter for Permission to Use Caring Behavior Inventory

01-20-13

Zane Robinson Wolf, Ph.D., R.n., FAAN
Dean School of Nursing
1900 West Olney Ave
Philadelphia, PA 19141

Dr. Wolf
I am working on my thesis for my Masters of Science in Nursing through Chulalongkorn University, Bangkok, Thailand and would like to use your CBI tool as published in Assessing Measuring in Nursing and Health Science (Watson 2002) and also translate it into Cambodian (Khmer) Language as Cambodia is where I will conduct the research and collect the data.

REQUEST FOR RELEASE FOR THE CARING BEHAVIOR INVENTORY (CBI)
(Wolf, 1986, Wolf et al., 1994)

Name: Naryna Yel

Degree: BSN from Adventist University of the Philippines 2010
Silang Cavite, Philippines

Pursuing MSN Adult Nursing
Chulalongkorn University
Bangkok, Thailand

My address: 254 Phayathai Road
Pathumwan, Bangkok Thailand, 10330
Email: narynayelstar@yahoo.com

Phone: Mobile: (66) 835546783

Brief Description of my research project:

1. To explore the nurse caring behavior in the Medical-Surgical unit, Cambodia as perceived by the patients.

2. To explore the nurse caring behavior in the Medical-Surgical unit, Cambodia as perceived by the nurses.
3. To explore the nurse caring behavior in the Medical-Surgical unit, Cambodia as perceived by the nursing students.
4. To compare the nurse caring behavior among the perception of patients, nurses and nursing students.

Research Problem

Significant differences were found between patients and nurses in their perception of nurses' caring behaviors in many reviewed studies. There is also no literature or research regarding nurse caring behaviors in the perception of patients, nurses and nursing students in Cambodia thus makes planning for the development of health care systems as well as nursing systems difficult.

How many subjects will complete the CBI?

Approximately 300 subjects

This is for a research project involving my thesis. My major advisor is:

Sureeporn Thanasilp, RN, D.N.S
Associate Dean, Faculty of Nursing
Chulalongkorn University
Boromrajachonnani Srisattapat buliding, Fl. 11
Rama 1 Rd., Wang Mai, Patumwan,
Bangkok 10330, Thailand
Email: s_thanasilp@hotmail.com

I agree to share the results of my study with Zane Robinson Wolf. She will add the results to the database. I will also give her descriptive information about the subjects who completed the CBI.

Naryna Yel

From: naryna yel [narynayelstar@yahoo.com]
Sent: Tuesday, January 22, 2013 8:03 AM
To: Zane Wolf
Subject: Permission to use Caring Behavior Inventory tool

Dear Dr. Wolf,

I am working on my thesis for my Master of Science in Nursing through Chulalongkorn University,
Bangkok Thailand and would like to use your CBI tool as published in Assessing Measuring in Nursing and Health
Science (Watson, 2002).

Please see attachment letter

Naryna Yel

From: Zane Wolf <wolf@lasalle.edu>
To: naryna yel <narynayelstar@yahoo.com>
Sent: Wednesday, January 23, 2013 2:29 AM
Subject: RE: Permission to use Caring Behavior Inventory tool

Thank you.

Zane Robinson Wolf, PhD, RN, FAAN
Dean Emerita and Professor
School of Nursing and Health Sciences
La Salle University
Editor, International Journal for Human Caring
St. Benilde Tower 3330
1900 West Olney Avenue
Philadelphia, PA 19141
215 991 2273
215 991 2941 (Fax)
wolf@lasalle.edu

From: naryna yel [narynayelstar@yahoo.com]
Sent: Wednesday, January 23, 2013 8:42 AM
To: Zane Wolf
Subject: Re: Permission to use Caring Behavior Inventory tool

Dear Dr. Wolf,

Thank you so much for your permission to use your tool.

Sincerely Yours,
Naryna Yel

From: Zane Wolf <wolf@lasalle.edu>
Subject: RE: Permission to use Caring Behavior Inventory tool
To: "naryna yel" <narynayelstar@yahoo.com>
Date: Wednesday, January 23, 2013, 7:30 AM

I wish you the best, Naryna.

Zane Wolf

Zane Robinson Wolf, PhD, RN, FAAN
Dean Emerita and Professor
School of Nursing and Health Sciences
La Salle University
Editor, International Journal for Human Caring
St. Benilde Tower 3330
1900 West Olney Avenue
Philadelphia, PA 19141
215 991 2273
215 991 2941 (Fax)
wolf@lasalle.edu

APPENDIX D

CONTENT VALID INDEX

The Content Validity of the Caring Behavior Inventory (CBI)

The details of all of the experts; opinions are as following:

1= not relevant
2= somewhat relevant
3= quite relevant
5= relevant

Items	Consistency Level				Comment
	1	2	3	4	
1. Attentively listening to the patient. sþab;GñkCMgWedayykcitþTukdak;				4	
2. Giving instructions to the patient. bgðat;Bnül;nigENnaMepSg²eTAelIGñkCMgW				4	
3. Treating the patient as individual rab;GanGñkCMgWdUcbuKÁlepSg²				4	
4. Spending time with the patient cMNayeBlevlaCamYyGñkCMgW				4	
5. Touching the patient to communicate caring kan;Bal;GñkCMgWedIm,IbgðajnUvkarykcitþTukdak; kñúgkMLúgeBlsnÞna				4	
6. Being hopeful for the patient bgðajnUvPaBmansgÇwmdl;GñkCMgW				4	
7. Giving the patient information so that he or she can make a decision pþl;nUvBt’maneTAdl;GñkCMgWedwIm,I[BYkKat;eFVIkarsMercciþ				4	

8. Showing respect for the patient pþl;nUvkareKarBdl;GñkCMgW				4	
9. Supporting the patient KaMRTGñkCMgW				4	
10. Calling the patient by his/her preferred name ehAGñkCMgWedayeQµaHRtWmRtUv				4	
11. Being honest with the patient pþl;nUvPaBesµaHRtg;cMeBaHGñkCMgW				4	
12. Trusting the patient TukcitþeTAelIGñkCMgW				4	
13. Being empathetic or identifying with the patient sÁal;rWecHyl;citþGñkCMgW				4	
14. Helping the patient grow CYyGñkCMgWeGaylUtlas;suxPaB				4	
15. Making the patient physically or emotionally comfortable pþl;nUvPaBsuxRsYlTaMgpøÚvkaynigpøÚvcitþdl;GñkCMgW				4	
16. Being sensitive to the patient yl;eyaKBIGarmµN¾kñúgkarEfrkSaGñkCMgW				4	
17. Being patient or tireless with the patient ecHGt;Fµt;rWminbgðajPaBGs;kMlaMgdl;GñkCMgW				4	
18. Helping the patient				4	

pþl;CMnYydl;GñkCMgW					
19. Knowing how to give shots, IVs, etc. ecHcak;fñaMnigcak;sarU:m .l.				4	
20. Being confident with the patient pþl;PaBeCOCak;ral;kargarcMeBa HGñkCMgW				4	
21. Using a soft, gentle voice with the patient eRbIsMelgsuPaBrabsaeTAelIGñk CMgW				4	
22. Demonstrating professional knowledge and skill bgðajnUvcMenHdwgviC¢aCIv³nig CMnaj				4	
23. Watching over patient yamemIlGñkCMgW				4	
24. Managing equipment skillfully kan;kab;]bkrN½sMPar³eBTüeday CMnaj biunRbsb;				4	
25. Being cheerful with the patient bgðajPaBrIkraydl;GñkCMgW				4	
26. Allowing the patient to express feelings about his or her disease and treatment GnuBaØat[GñkCMgWbeBa©jrW sMEdgGarmµN½rbs;xøÚncMeBa HCMgWnigkar Büa)al				4	
27. Including the patient in planning his or her care bBa©ÚlGñkCMgWral;EpnkarN½én karEfrkSarbs;Kat;				4	
28. Treating patient information confidentially rkSaral;Bt’manrbs;GñkCMgWCa				4	

karsMgat;					
29. Providing a reassuring presence bgðajnUvvtþmankk;ekþAdl;GñkCMgW				4	
30. Returning to the patient voluntarily RtLb;eTAemIlGñkCMgWedayesckþIsµR½Kcitþ				4	
31. Talking with the patient niyayCamYyGñkCMgW				4	
32. Encouraging the patient to call if there are problems elIkTwkcitþGñkCMgW[ehAebImanbBaðaGVImYy				4	
33. Meeting the patient's stated and unstated needs bMeBjnUvtMrUvkarrbs;GñkCMgWTaMgtMrUvkarR)ab;nig minR)ab;				4	
34. Responding quickly to the patient's call eqøIytbrh½seTAnwgkarehArbs;GñkCMgW				4	
35. Appreciating the patient as a human being elIktMekIgGñkCMgWdUcmnuSelak				4	
36. Helping to reduce the patient's pain CYykat;bnßyPaBQIcab;rbs;GñkCMgW				4	
37. Showing concern for the patient bgðajPaBxVl;xVaydl;GñkCMgW				4	
38. Giving the patient's treatments and medication on time pþl;karBüa)alnigfñaMdl;GñkCMgWTan;eBl				4	

39. Paying special attention to the patient during first times, as hospitalization, treatments pþl;nUvkaykcitþTukdak;karsMrakeBTü CaBiesscMeBaHGñkCMgW EdlkMBugTTYlkarBüalCaelIkdMbUg				4	
40. Relieving the patient's symptoms eFVI[eraKsBaØaGñkCMgWmanPaBFUrRsal				4	
41. Putting the patient first pþl;PaBsMxan;dl;GñkCMgWmuneK				4	
42. Giving good physical care pþl;karEfrkSaragkaydl;GñkCMgW[)anl¥				4	

$$\text{CVI} = \frac{\text{number of items rated quite/very relevant or agreement by the raters(experts)}}{\text{number of the total items}}$$

$$= \frac{10}{10}$$

$$= 1$$

APPENDIX E

LIST OF THE EXPERTS

List of Expert for Content Validity of the CBI

1. Dr. Mom Kong, MD

   Executive Director of Cambodia Movement for Health

2. Dr. Daravuth Yel, MD, PGDHE, MS

   Technical Officer , Tobacco Free Initiative, Substance Abuse and Mental Health, World Health Organization

3. Dr Sao Sovanratnak, MD

   Cheif deputy,Department of Planning and Health Information (Cambodia) Ministry of Health

4. Ms. Yoeu Phallin

   Officer, World Health Organization

APPENDIX F

DOCUMRNTARY PROOF OF ETHICAL CLEARANCE

No. 004 / 2013

Faculty of Nursing, Chulalongkorn University
Borommaratchachonnani Srisataphat
Building, Rama1 Road, Pathumwan,
Bangkok 10330, Thailand
Tel. (662)-218-1131 Fax. (662)-218-1130

June 13 , 2013

The Ethical Review Committee for Research
National Ethic Committee for Health Research
#2 Kim Il Sung Blvd, Khan Toul Kork,
Phnom Penh, Cambodia.

Dear Sir/Madam

This is to inform you that Miss Naryna Yel is our student in a Master of Nursing Science Program, Faculty of Nursing, Chulalongkorn University. She has been approved for conducting the thesis "NURSES' CARING BEHAVIOR IN THE MEDICAL-SURGICAL UNIT, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES AND NURSING STUDENTS" under supervision of Associate Professor Sureeporn Thanasilp, D.N.S., A.P.N. and Assistant Professor Branom Rodkumdee, Ph.D., R.N. I am writing this letter to ask for your kind consideration to approve this proposal.

On behalf of the Faculty of Nursing, Chulalongkorn University, I would like to express my grateful for your valued support, and please give permission for Miss Naryna Yel to contact and give you detailed information.

Sincerely,

Waraporn Chaiyawat

(Waraporn Chaiyawat, D.N.S., APN)
Associate Professor and Deputy Dean

ក្រសួងសុខាភិបាល
MINISTRY OF HEALTH
គណៈកម្មាធិការជាតិក្រមសីលធម៌
សំរាប់ការស្រាវជ្រាវសុខាភិបាលដែលពាក់ព័ន្ធនឹងមនុស្ស
National Ethics Committee for Health Research

លេខ....០០៩)...NECHR

ព្រះរាជាណាចក្រកម្ពុជា
KINGDOM OF CAMBODIA
ជាតិ សាសនា ព្រះមហាក្សត្រ
NATION RELIGION KING

ភ្នំពេញ, ថ្ងៃទី.20...ខែ..06...ឆ្នាំ2013....

Ms. Naryna Yel

Project: Nurses caring behavior in the Medical-Surgical unit, Cambodia : the comparison among the perception of patients nurses and nursing students. Version N° 1 , dated 13th June 2013.

Reference: - Your letter on 13th June 2013
- Summary report of NECHR's secretaries on 14th June, 2013

Dear Ms. Naryna Yel,

I am pleased to inform you that your study protocol entitled "Nurses caring behavior in the Medical-Surgical unit, Cambodia : the comparison among the perception of patients nurses and nursing students. Version N° 1 , dated 13th June 2013" has been approved by National Ethic Committee for Health Research (NECHR). This approval is valid for twelve months after the approval date.

The Principal Investigator of the project shall submit following document to the committee's secretariat at the National Institute of Public Health at #2 Kim Il Sung Blvd, Khan Tuol Kok, Phnom Penh. (Tel: 855-23-880345, Fax: 855-23-881949):

- Annual progress report
- Final scientific report
- Patient/participant feedback (if any)
- Analyzing serious adverse events report (if applicable)

The Principal Investigator should be aware that there might be site monitoring visits at any time from NECHR team during the project implementation and should provide full cooperation to the team.

Regards,

Chairman

Prof. ENG HUOT

លេខ ២ មហាវិថី គីម អ៊ីលស៊ុង . ខណ្ឌទួលគោក , រាជធានីភ្នំពេញ , ទូរស័ព្ទ (៨៥៥-២៣) ៨៨០ ៣៤៥ , ទូរស័ព្ទដៃ (៨៥៥-១២) ២៨០ ៧៩០ , (៨៥៥-១២) ៨៤២ ៤៤២
2 Blvd KIM YL SUNG, Khan Toul Kork, Phnom Penh , Tel : (855-23) 880 345 , Mobile phone : (855-12) 280 790, (855-12) 842 442

APPENDIX G

DOCUMRNTARY PERMISSION FOR COLLECING DATA

Faculty of Nursing, Chulalongkorn University
Borommaratchachonnani Srisataphat
Building, Rama1 Road, Pathumwan,
Bangkok 10330, Thailand
Tel. (662)-218-1131 Fax. (662)-218-1130

No. 006 / 2013

June 28 , 2013

Director of Khmer-Soviet Friendship Hospital
Yothapol Khemarak Phoumin (St. 271),
12306 Phnom Penh, Cambodia.

Dear Sir/Madam

This is to inform you that Miss Naryna Yel, a student in our Master of Nursing Science Program, Faculty of Nursing, Chulalongkorn University, is currently conducting a thesis titled, "NURSES' CARING BEHAVIOR IN THE MEDICAL-SURGICAL UNIT, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES,AND NURSING STUDENTS" under the supervision of Assistant Professor Branom Rodkumdee, Ph.D., R.N. and Associate Professor Sureeporn Thanasilp, D.N.S., A.P.N.

I would like to ask for your kind permission for her to collect data, from 50 patients and 35 nurses in your hospital.

On behalf of the Faculty of Nursing, Chulalongkorn University, I would like to express my grateful for your valued support, and please give permission for Miss Naryna Yel to contact and give you detailed information.

Sincerely,

Waraporn Chaiyawat

(Waraporn Chaiyawat, DNS, APN)
Associate Professor and Deputy Dean

No. 006 / 2013

Faculty of Nursing, Chulalongkorn University
Borommaratchachonnani Srisataphat
Building, Rama1 Road, Pathumwan,
Bangkok 10330, Thailand
Tel. (662)-218-1131 Fax. (662)-218-1130

June , 2013

Director of Preah Kossamak Hospital
No. 28CEo, Yothapol Khemarak Phoumin (St. 271),
12157 Phnom Penh, Cambodia.

Dear Sir/Madam

This is to inform you that Miss Naryna Yel, a student in our Master of Nursing Science Program, Faculty of Nursing, Chulalongkorn University, is currently conducting a thesis titled, "NURSES' CARING BEHAVIOR IN THE MEDICAL-SURGICAL UNIT, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES,AND NURSING STUDENTS" under the supervision of Assistant Professor Branom Rodkumdee, Ph.D., R.N. and Associate Professor Sureeporn Thanasilp, D.N.S., A.P.N.

I would like to ask for your kind permission for her to try out the instrument, Caring Behavior Inventory, and to collect data in your hospital. Thirty patients and 30 nurses are required for the try out and data will be collected from 50 patients and 35 nurses.

On behalf of the Faculty of Nursing, Chulalongkorn University, I would like to express my grateful for your valued support, and please give permission for Miss Naryna Yel to contact and give you detailed information.

Sincerely,

Waraporn Chaiyawat

(Waraporn Chaiyawat, DNS, APN)
Associate Professor and Deputy Dean

Faculty of Nursing, Chulalongkorn University
Borommaratchachonnani Srisataphat
Building, Rama1 Road, Pathumwan,
Bangkok 10330, Thailand
Tel. (662)-218-1131 Fax. (662)-218-1130

No. 006 / 2013

June , 2013

Director of Technical School for Medical Care,
University of Health Science
Yothapol Khemarak Phoumin (St. 271),
near Khmer Russian Hospital,
12306 Phnom Penh, Cambodia.

Dear Sir/Madam

This is to inform you that Miss Naryna Yel, a student in our Master of Nursing Science Program, Faculty of Nursing, Chulalongkorn University, is currently conducting a thesis titled, "NURSES' CARING BEHAVIOR IN THE MEDICAL-SURGICAL UNIT, CAMBODIA: THE COMPARISON AMONG THE PERCEPTION OF PATIENTS, NURSES,AND NURSING STUDENTS" under the supervision of Assistant Professor Branom Rodkumdee, Ph.D., R.N. and Associate Professor Sureeporn Thanasilp, D.N.S., A.P.N.

I would like to ask for your kind permission for her to try out the instrument, Caring Behavior Inventory, and to collect data in your school. Thirty nursing students are required for the try out and data will be collected from 156 nursing students.

On behalf of the Faculty of Nursing, Chulalongkorn University, I would like to express my grateful for your valued support, and please give permission for Miss Naryna Yel to contact and give you detailed information.

Sincerely,

Waraporn Chaiyawat

(Waraporn Chaiyawat, DNS, APN)
Associate Professor and Deputy Dean

ភ្នំពេញ ២៧ ឧសភា ២០១៣

សូមគោរពជូន
លោកប្រធានមន្ទីរពេទ្យមិត្តភាពខ្មែរ-សូវៀត

លិខិតសុំការអនុញ្ញាតប្រមូលពត៌មានពីអ្នកជំងឺនិងគិលានុបដ្ឋាក

ខ្ញុំឈ្មោះ ឃុល ណារីណា ជាគ្រូបង្រៀនបរិញ្ញាបត្រគិលានុបដ្ឋាកនៃសាលាមហ្វេកទេសថែទាំវេជ្ជសាស្ត្រ សាកលវិទ្យាល័យវិទ្យាសាស្ត្រសុខាភិបាល។ សព្វថ្ងៃខ្ញុំកំពុងបញ្ចប់ការសិក្សាថ្នាក់អនុបណ្ឌិតគិលានុបដ្ឋាក នៅមហាវិទ្យាល័យឈូឡាឡុងកន (Chulalongkorn University) នៃទីក្រុងបាំងកក ប្រទេសថៃ។ ជាខណៈនេះខ្ញុំកំពុងធ្វើ សារណាចប់ដើម្បីបញ្ចប់ការសិក្សា ហើយសារណានេះមានចំនងជើងថា "ឥរិយាបទនៃការថែរក្សានិងយកចិត្តទុកដាក់របស់គិលានុបដ្ឋាកផ្នែក វេជ្ជសាស្ត្រនិងវះកាត់ នៅក្នុងប្រទេសកម្ពុជា៖ ការប្រៀបធៀបរវាង ការយល់ឃើញ របស់អ្នកជំងឺ, គិលានុបដ្ឋាក និង និស្សិតគិលានុបដ្ឋាក"។ ការសិក្សាស្រាវជ្រាវនេះ នឹងធ្វើឡើងនៅមន្ទីរពេទ្យចំនួន ពីរនៃ ប្រទេសកម្ពុជា និង នៅសាលាមហ្វេកទេសថែទាំវេជ្ជសាស្ត្រ។ ចំពោះការសិក្សានេះ ខ្ញុំនឹងចែកសំនួរឱ្យ អ្នកជំងឺ និងគិលានុបដ្ឋាកផ្នែក វេជ្ជសាស្ត្រនិងវះកាត់ និង និស្សិតគិលានុបដ្ឋាកឆ្នាំចុងក្រោយទាំងអស់ ដើម្បីនឹងស្រង់យកមតិយោបល់និងការយល់ឃើញនិងឥរិយាបទរបស់ពួកគាត់ ចំពោះឥរិយាបទនៃការថែរក្សានិងយកចិត្តទុកដាក់របស់គិលានុបដ្ឋាក។ ការសិក្សានេះនឹងជួយពង្រឹងស្ថានភាព របស់គិលានុបដ្ឋាក និងនិស្សិត គិលានុបដ្ឋាកអោយមាន ឥរិយាបទកាន់តែល្អក្នុងការថែរក្សា និងយកចិត្តទុកដាក់ទៅលើអ្នកជំងឺ។ មិនត្រឹមតែប៉ុណ្ណោះនឹងជួយឱ្យអ្នកជំងឺ មានសេចក្តីពេញចិត្តនិងអាច ជាសុខភាព កាន់តែប្រសើរ។

ដោយអាស្រ័យហេតុនេះ សូមលោកប្រធានមន្ទីរពេទ្យមិត្តភាពខ្មែរ-សូវៀតអនុញ្ញាតឱ្យខ្ញុំប្រមូលពត៌មានដោយក្តីគោរព ។

ភ្នំពេញ ថ្ងៃទី ២៧ ខែ ឧសភា ឆ្នាំ ២០១៣
ហត្ថលេខាសាមីខ្លួន

ឃុល ណារីណា

ភ្នំពេញ ០៥ មិថុនា ២០១៣

សូមគោរពជូន
លោកប្រធានមន្ទីរពេទ្យព្រះកុសមៈ

លិខិតសុំការអនុញ្ញាតប្រមូលពត៌មានពីអ្នកជំងឺនិងគិលានុបដ្ឋាក

នាងខ្ញុំឈ្មោះ យ៉ិល ណារីណា ជាគ្រូបង្រៀនបរិញ្ញាបត្រគិលានុបដ្ឋាកនៃសាលាបច្ចេកទេសថែទាំវេជ្ជសាស្ត្រ សាកលវិទ្យាល័យវិទ្យាសាស្ត្រសុខាភិបាល។ សព្វថ្ងៃនាងខ្ញុំកំពុងបញ្ចប់ការសិក្សាថ្នាក់អនុបណ្ឌិតគិលានុបដ្ឋាក នៅមហាវិទ្យាល័យចុឡាឡុងកន (Chulalongkorn University) នៃទីក្រុងបាំងកក ប្រទេសថៃ។ នាពេលៈនេះនាងខ្ញុំកំពុងធ្វើ សារណាដើម្បីបញ្ចប់ការសិក្សា ហើយសារណានេះមានចំណងជើងថា "ឥរិយាបទនៃការថែរក្សានិងយកចិត្តទុកដាក់របស់គិលានុបដ្ឋាកផ្នែក វេជ្ជសាស្ត្រនិងវះកាត់ នៅក្នុងប្រទេសកម្ពុជា÷ ការប្រៀបធៀបរវាងការយល់ឃើញ របស់អ្នកជំងឺ, គិលានុបដ្ឋាក និង និស្សិតគិលានុបដ្ឋាក"។ ការសិក្សាស្រាវជ្រាវនេះ នឹងធ្វើឡើងនៅឯមន្ទីរពេទ្យចំនួន ពីរនៃប្រទេសកម្ពុជា និង នៅសាលាបច្ចេកទេសថែទាំវេជ្ជសាស្ត្រ។ ចំពោះការសិក្សានេះ នាងខ្ញុំនឹងចែកសំនួរឱ្យ អ្នកជំងឺ និងគិលានុបដ្ឋាកផ្នែកវេជ្ជសាស្ត្រនិងវះកាត់ និង និស្សិតគិលានុបដ្ឋាកឆ្នាំទីបួនទាំងអស់ ដើម្បីនឹងស្រង់យកមតិយោបល់និងការយល់ឃើញនិងយល់ដឹងរបស់ពួកគាត់ចំពោះឥរិយាបទនៃការថែរក្សានិងយកចិត្តទុកដាក់របស់គិលានុបដ្ឋាក ។ ការសិក្សានេះនឹងជួយពង្រឹងស្មារតី របស់គិលានុបដ្ឋាក និងនិស្សិតគិលានុបដ្ឋាកអោយមាន ឥរិយាបទកាន់តែល្អក្នុងការថែរក្សា និងយកចិត្តទុកដាក់ទៅលើអ្នកជំងឺ។ មិនត្រឹមតែប៉ុណ្ណោះនឹងជួយឱ្យអ្នកជំងឺមានសេចក្តីពេញចិត្តនិងមាន ជាសុខភាព កាន់តែប្រសើរ ។

ដោយអាស្រ័យហេតុនេះ សូមលោកប្រធានមន្ទីរពេទ្យព្រះកុសមៈ មេត្តាអនុញ្ញាតឱ្យនាងខ្ញុំប្រមូលពត៌មានដោយក្តីអនុគ្រោះ ។

ភ្នំពេញ ថ្ងៃទី ០៥ មិថុនា ឆ្នាំ ២០១៣
ហត្ថលេខានាមខ្លួន

យ៉ិល ណារីណា

វេជ្ជ.ស្រី គីមប៊ុណ្ណារិទ្ធ

05.6.2013

ភ្នំពេញ ២២ ឧសភា ២០១៣

សូមគោរពជូន
លោកវេជ្ជបណ្ឌិត អៀមសុផល
លោកនាយកសាលាបច្ចេកទេសថៃថាំវេជ្ជសាស្ត្រ

លិខិតសុំការអនុញ្ញាតប្រមូលពត៌មានពីនិស្សិតគិលានុបដ្ឋាកផ្នែកទី៤

នាងខ្ញុំឈ្មោះ ឃុិល ណារីណា សព្វថ្ងៃកំពុងបញ្ចប់ការសិក្សាថ្នាក់អនុបណ្ឌិត នៅមហាវិទ្យាល័យឆ្លងឡាឡុងកន (Chulalongkorn University) នៃទីក្រុងបាំងកក ប្រទេសថៃ។ នាពេលៈនេះនាងខ្ញុំកំពុងធ្វើ សារណាដើម្បីបញ្ចប់ការសិក្សា។ សារណានេះមានចំនងជើងថា "សិរីយាបទនៃការថែរក្សាដឹងយកចិត្តទុកដាក់របស់គិលានុបដ្ឋាកផ្នែក វេជ្ជសាស្ត្រធិងវះកាត់ នៅក្នុងប្រទេសកម្ពុជា៖ ការប្រៀបធៀបរវាងការ ឈឺឈាប់ល្អ របស់អ្នកជំងឺ, គិលានុបដ្ឋាក និង និស្សិតគិលានុបដ្ឋាក" ។ ការសិក្សាស្រាវជ្រាវនេះ នឹងធ្វើឡើងនៅឯមន្ទីរពេទ្យចំនួន ពីរនៃ ប្រទេសកម្ពុជា និង នៅសាលាបច្ចេកទេសថៃថាំវេជ្ជសាស្ត្រ។ ចំពោះការសិក្សានេះ នាងខ្ញុំនឹងចែកសំនួរឱ្យ និស្សិតគិលានុបដ្ឋាកឆ្នាំទីបួនទាំងអស់ ដើម្បីនឹងស្រង់យកមតិយោបល់ និងការយល់ឃើញរបស់ពួកគេ ចំពោះសិរីយាបទនៃការថែរក្សាដឹងយកចិត្តទុកដាក់របស់ពួកគេជាគិលានុបដ្ឋាក នៅពេលចុះកម្មសិក្សាតាមមន្ទីរពេទ្យ នាងផ្តែកវេជ្ជសាស្ត្រធិងវះកាត់។
ការសិក្សាទេះនឹងជួយពង្រឹងស្មារតី របស់និស្សិតគិលានុបដ្ឋាកអោយមាន សិរីយាបទកាន់តែល្អក្នុងការថែរក្សា និងយកចិត្តទុកដាក់ទៅលើអ្នកជំងឺ និងនៅពេលពួកគេក្លាយជាគិលានុបដ្ឋាកអាប់។ នាពេលខាងមុខ។ មិនត្រឹមតែប៉ុណ្ណោះនឹងជួយឱ្យអ្នកជំងឺ មានសេចក្តីពេញចិត្តនឹងមាន ជាសុខភាព កាន់តែប្រសើរ។

ដោយអាស្រ័យហេតុនេះ សូមលោកនាយកមេត្តាអនុញ្ញាត ឱ្យនាងខ្ញុំប្រមូលពត៌មានដោយក្តីអនុគ្រោះ ។

ភ្នំពេញ ថ្ងៃទី ២២ ខែ ឧសភា ឆ្នាំ ២០១៣
ហត្ថលេខាសាមីខ្លួន

ឃុិល ណារីណា

APPENDIX H

INFORMED CONSENT

Informed Consent Form

Address …….
Date ……..

Code number of participants …….

I who have signed here below agree to participate in this research project.

Title "Nurses' caring behaviors in the Medical-Surgical unit Cambodia: the comparison among the perception of patients, nurses and nursing students"

Principle researcher's name Naryna Yel
Contact address Nº 27, St. 1019Z, Sk. Phnom Penh Thmey, Kh. Sen-Sok, Phnom Penh
Telephone (home) (855) 12880461 **Cell phone** (855) 92732669
Email: narynayelstar@yahoo.com

I have read or been informed about rationale and objectives of the project, my care/work at the hospital will not be affected by the participation in this study. The researcher has explained to me and I **clearly understand with satisfaction.**

I willingly **agree** to participate in this project and consent the researcher to response to questionnaires about Nurses' caring behaviors in the Medical-Surgical unit, Cambodia: the comparison of among the perception of patients, nurses and nursing students. *The questionnaires have 42 items.*

I have the **right** to withdraw from this research project at any time as I wish with no need to **give any reason**. This withdrawal **will not have any negative impact upon me**.

Researcher has guaranteed that all the answers will be **kept confidential**. Results of the study will be reported as total picture.

If I am not treated as indicated in the information sheet, I can report to the National Ethics Committee for Health Research in Cambodia. Address: #2, Kim I1 Sung Blvd, Khan Toul Kok, Phnom Penh, Cambodia Tel: 855-12-842-442, sarayvannat@gmail.com

I also have received a copy of information sheet and informed consent form.

Sign …….
(……...……)
Researcher

Sign ……..
(……...…….)
Participant

Sign ……
(……..)
Witness

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APPENDIX I

PARTICIPANT INFORMATION SHEET

Form of
Patient/Participant Information Sheet

Title of research project Nurses' caring behaviors in the Medical-Surgical unit Cambodia: the comparison of the actual and expected behaviors in the perception of the nurses, student nurses and patients.

Principle researcher's name Naryna Yel **Position** Master student in nursing, Faculty of Nursing, Chulalongkorn University, Thailand.
Office address Technical School for Medical Care, University of Health Science, Phnom Penh, Cambodia
Home address Nº 27, St. 1019Z, Sk. Phnom Penh Thmey, Kh. Sen-Sok, Phnom Penh
Telephone (office) **Telephone (home)** 855-12880461
Cell phone 66-835546783 **Email:** narynayelstar@yahoo.com

I am Naryna Yel, a master degree nursing student in my final semester at Chulalongkorn University, Bangkok, Thailand. I am currently, working on my thesis to fulfilled the requirement for my graduation. I am interested in studying about the nurses' caring behaviors and comparing between the perception of the patients, nurses and nursing students at the medical-surgical unit, Cambodia.

The details of this study are as follow:

1. The objective of this study is to compare the actual and expected nurses' caring behaviors in the Medical-Surgical unit, Cambodia as perceived by the patients, nurses and nursing students.
2. This study will provide database about the similarities or differences between the groups. It is crucial to help nurse and health care providers to understand the nurses' caring behaviors from both the nurse providers self and patients perception. The findings will provide a scientifically-based guideline and influence the health care providers, nurse leaders and managers with respect to patient care planning and nursing practice decisions. Promoting good relationships between nurse and patient which will benefit both the health care provider and the patient. The nurse can render high quality of care with caring behaviors and satisfy the patient as what they expected.
3. Participants in this study are the patients that is conscious, coherent and above the age of 18 and under the age of 65 and is getting care in this medical-surgical unit under the Khmer-Soviet and Calmette hospitals; the nurses who work in the medical-surgical unit these two hospitals and the fourth year nursing students who have been trained at this unit in these two hospitals.

When the permission is granted from the hospital and nursing school, the researcher will ask the permission from the patients. They will sign the consent form before participating in answering the questionnaire.

The participants will receive the information from the researcher about the objective of the study and the process of the data collection. The participants care at the hospital will not be affected by the participation of the study.

Each questionnaire does not know who completed it. Please read the brief instructions at the first page of the questionnaire. After obtaining complete questionnaire, each participant will be put in an envelope and seal. There is no correct or incorrect answer; they are just the perception of the participants. The

questionnaires have 42 items that include (1) Respectful deference to other (courteous regard for the other)= 12 items, (2) Assurance of human presence (investment in the other's need and security)= 12 items, (3) Positive connectedness (optimistic and constant readiness of the part of the nurse to help the other)= 9 items, (4) Professional knowledge and skill (proficient, informed and skillful nurse)= 5 items, and (5) Attentiveness to other's experience (appreciation or and engrossment in the other's perspective and experience)= 4 items. Participants will take 20-30 minutes to complete a packet of the questionnaires.

4. Participants to the study are voluntary and they have the right to withdraw from the study at any time and no reason is needed. There will be no negative impact upon the participant.

5. If you have any question or would like to obtain more information, the participants can contact the researcher Naryna Yel, phone number 855-12299712.

6. Your information will be kept confidential. Results of the study will be reported as a total picture. Your name will not be addressed in the data; a code number is used to ensure confidentiality.

7. If researcher does not perform upon participants as indicated in the information, the participants can report the incident to the National Ethics Committee for Health Research in Cambodia. Address: #2, Kim I1 Sung Blvd, Khan Toul Kok, Phnom Penh, Cambodia Tel: 855-12-842-442, sarayvannat@gmail.com

APPENDIX J

ANOVA OF THE GROUPS'SCORES ON THE CBI SUBSCALES

Table J. ANOVA of the groups' scores on the CBI subscales

SUBSCALE		df	F	P
Respect Subscale	Between Groups	2	83.06	<.01
	Within Groups	309		
	Total	311		
Assurance Subscale	Between Groups	2	42.42	<.01
	Within Groups	309		
	Total	311		
Positive Subscale	Between Groups	2	65.08	<.01
	Within Groups	309		
	Total	311		
Profession Subscale	Between Groups	2	70.35	<.01
	Within Groups	309		
	Total	311		
Attentive Subscale	Between Groups	2	18.16	<.01
	Within Groups	309		
	Total	311		

APPENDIX K

ANOVA COMPARISON OF THE TOTAL CBI SCORE TO PATIENTS (N=105) DEMOGRAPHIC DATA AND TUKEY PAIRWISE

Table K. ANOVA comparison of the Total CBI Score to Patients (n=105) Demographic data

Demographic Data	Group	Sum of Squares	df	Mean Square	F	Sig.
Gender	Between Groups	10.283	1	.251	1.059	.412
	Within Groups	14.917	103	.237		
	Total	25.200	104			
Age	Between Groups	57.003	3	1.390	1.038	.440
	Within Groups	84.387	101	1.339		
	Total	141.390	104			
Marital Status	Between Groups	47.596	2	1.161	1.581	.050
	Within Groups	46.252	102	.734		
	Total	93.848	104			
Educational level	Between Groups	169.443	5	4.133	1.195	.259
	Within Groups	217.947	99	3.459		
	Total	387.390	104			
Number of admissions during the last 5 years	Between Groups	9.222	1	.225	.899	.638
	Within Groups	15.768	103	.250		
	Total	24.990	104			
Number of days in the hospital during the current admission	Between Groups	21.452	2	.523	1.754	.022
	Within Groups	18.795	102	.298		
	Total	40.248	104			

Table K.1. Tukey Post-hoc test among the Number of days in the hospital during the current admission

Number of days range in the hospitals during the current admission		Mean Difference	Std. Error	Sig.
3-10	11-20	-9.85192*	.73328	<.01
3-10	21-30	-22.89160*	.89043	<.01
11-20	21-30	-13.03968*	1.08339	<.01

APPENDIX L

ANOVA COMPARISON OF THE TOTAL CBI SCORE TO NURSES (N=57)

DEMOGRAPHIC DATA AND TUKEY PAIRWISE

Table L. ANOVA comparison of the Total CBI Score to Nurses (n=57) Demographic data

Demographic Data	Group	Sum of Squares	df	Mean Square	F	Sig.
Number of years experienced in Medical-surgical	Between Groups	2468.557	2	77.142	2.740	.006
	Within Groups	675.583	54	28.149		
	Total	3144.140	56			
Age	Between Groups	33.868	3	1.058	2.088	.033
	Within Groups	12.167	53	.507		
	Total	46.035	56			
Marital Status	Between Groups	7.263	1	.227	.908	.606
	Within Groups	6.000	55	.250		
	Total	13.263	56			

Table L.1. Tukey Post-hoc test among the Number of years experienced in Medical-Surgical

Number of years experienced in Medical-Surgical		Mean Difference	Std. Error	Sig.
1-10 years	11-20 years	-13.60317*	.86838	<.01
1-10 years	21 to 30 years	-20.08889*	1.00753	<.01
11-20 years	21 to 30 years	-6.48571*	1.25147	<.01

APPENDIX M

ANOVA COMPARISON OF THE TOTAL CBI SCORE TO NURSING STUDENTS (N=150) DEMOGRAPHIC DATA

Table M. ANOVA comparison of the Total CBI Score to Nursing Students (n=150) Demographic data

CBI Total		Sum of Squares	df	Mean Square	F	Sig.
Gender	Between Groups	19.010	1	.257	1.239	.178
	Within Groups	15.550	148	.207		
	Total	34.560	149			
Age	Between Groups	16.323	1	.221	1.014	.476
	Within Groups	16.317	148	.218		
	Total	32.640	149			
Grade Point Average	Between Groups	75.417	4	1.019	1.060	.400
	Within Groups	72.083	145	.961		
	Total	147.500	149			

BIOGRAPHY

Name	Mrs Naryna Yel
Date of birth	February 07, 1988
Place of birth	Phnom Penh, Cambodia
Institutions attended	Adventist University of the Philippines, Philippines; 2006-2010, Bachelor of Science in Nursing Chulalongkorn University, Thailand; 2011-2013, Master of Nursing Science (Adult Nursing)
Position & Experience	2010-2011, Staff nurse at emergency and medical unit, International SOS Medical Clinic, Phnom Penh, Cambodia 2010-2011, Lecturer and Clinical Instructor, Technical School for Medical Care, University of Health Science, Phnom Penh, Cambodia