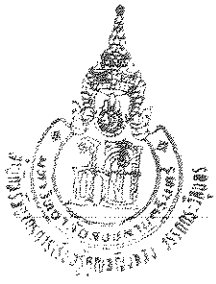

Factors Relating to Nurses' Caring Behaviors for Dying Patients in Southern Thailand

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ABSTRACT

The purposes of this descriptive research were to describe the level of nurses' caring behaviors for dying patients in southern Thailand and to examine the relationship between nurses' personal factors and environmental factor and nurses' caring behaviors for dying patients in southern Thailand. Proportionate stratified random sampling was used to select 360 registered nurses who had been working in general hospitals, regional hospitals, and university hospital in southern Thailand for at least one year. Instruments used in the study included the Demographic Data Questionnaire (DDQ), the Nurse's Caring Behaviors for Dying Patients Questionnaire (NCBDPQ), the Nurse's Self-Awareness Questionnaire (NSAQ), and the Shortened Form of Corley's Moral Distress Scale. These three questionnaires were content validated by three experts. The reliability of these three questionnaires were tested with 30 nurses yielding Cronbach's alpha coefficients of .97, .93 and .84, respectively.

The level of nurses' caring behaviors for dying patients was analyzed by using frequency, percentage, mean and standard deviation. Both parametric and nonparametric statistics were used to analyze the relationships between nurses' caring

behaviors for dying patients and related factors. The level of nurses' caring behaviors for dying patients was high (M = 2.12, SD = 0.43). The five dimensions of the nurses' caring behaviors including compassion, confidence, conscience, commitment and comportment were also at a high level (M = 2.29, SD = 0.50; M = 2.08, SD = 0.59; M = 2.39, SD = 0.47; M = 2.18, SD = 0.52, respectively). However, only the competence dimension was at a moderate level (M = 1.82, SD = 0.51). The examination of the relationship between personal factors and caring behaviors reveals a significant correlation between caring behaviors and age (r_s = .12, p < .05), professional experience (r_s = .12, p < .01), training experience (t = 1.44, p < .05), self-awareness (r = .37, p = .00) and moral distress (r = .16, p = .001), respectively.

The relationship between personal factors and caring behaviors gives new information that might influence strategies and approaches taken with the aim of improving end of life care. Further research is also recommended.

Keywords: caring behaviors, factors, dying patients, nurses, southern Thailand

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Chuleeporn Prompahakul

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CHAPTER 1

INTRODUCTION

This chapter presents the background of the study and significance of the problem, the objectives of the study and research questions. It also describes the conceptual framework of the study, hypotheses, definition of terms, and the significance of the study.

Background and Significance of the Problem

Advance in medical technology has contributed to increasing the life span of people. The statistics show that the average lifespan of the world population has increased. In the United States, the life expectancy was estimated to increase from 77.4 years in 2005 to 78.3 years in 2010 and 79.5 in 2020 (Heron, Hoyert, Murphy, Kochanek, & Tejada-Vera, 2009). The life expectancy statistics in Asian countries are similarly increasing like western countries (Economic and Social Commission for Asia and the Pacific, 2008). The same is also true for Thailand, in that the population's life expectancy has risen to 67.9 years in men and 75.0 years in women (World Health Organization [WHO], 2007). The changing in population aging results in an increasing elderly population which leads to an increasing number of chronically ill patients (Naughton, Bennett, & Feely, 2006). The numbers of terminally ill patients or dying patients are assumed to be higher. Due to the increasing number of terminally ill patients, the demand of care at the end-of-life (EOL) is also increasing.

According to the WHO (2010), the palliative and end of life care is aimed to improve the quality of life of patients and to reduce the problems faced by

their families which are associated with life-threatening illnesses, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. In addition, palliative care applies a team approach to meet the needs of patients and their families. Nurses therefore, play a significant role in caring for dying patients and their families in order to improve quality of life.

In Thailand, palliative and end of life care (EOLC) services have developed rapidly over the past 20 years (Nilmanat & Phungrassami, 2006). According to the Thailand National Hospital Accreditation Authority, the provision of palliative care and EOLC has been announced to be a quality indicator for hospital care (Institute of Hospital Quality Improvement and Accreditation [IHQIA], 2003). However, a multitude of research studies have found that the current nursing standards related to caring for dying patients and their families and the quality of EOLC do not meet the desired expectation of both dying patients and their families (Chopchai, 2000; Maneerak, 2001; Saechit, 2004). These findings can reflect the inadequate caring behaviors of the nurses in providing care for dying patients.

According to Roach (2002), caring is the human mode of being. Nursing is a caring professional. Caring is what distinguishes nursing from other professions. Caring is the locus of all attributes used to describe nursing. People choose nursing as a career because they really want to care for patients. Nurses are professionalized in the capacity to care by a curriculum based on holistic, integral humanism and a caring environment. For dying patients, the nurse is a professional caregiver who provides directed care. Nurses have to use caring to help dying patients

and their families to pass all suffering encountered throughout the dying process and achieve a peaceful death (Henderson et al., 2007; Luck, Jackson, & Usher, 2008).

There are several factors related to nurses' caring behaviors for dying patients. It was found that a nurse's age (Amonprompukdee, 2004; Lange, Thom, & Kline, 2008), professional experience (Apaiwong, 2000; Brunton & Beaman, 2000; Lange et al., 2008; Mateprasart, 1991; Noh, Arthur, & Sohng, 2002; Suwanmalee, 1996; Wattanachot, 1997), training experience on end of life care (Tsai et al., 2005; Wong, Lee, & Mok, 2001), and experience of caring for dying patients (Pokpalagon, 2005; Pratumwan & Unipun, 1995) were found to be a nurse's personal factors related to caring behaviors for dying patients.

In addition, a nurse's self-awareness also is a significant personal factor related to caring behaviors of nurses for dying patients. Self-awareness reflects an understanding and acceptance of one's own self which allows nurses to acknowledge a client's differences and uniqueness (Townsend, 2003). A number of studies showed that a nurse's self-awareness had a positive relationship with their caring behaviors for dying patients (Daodee, 1994; Intong, Sumalia, Sintara, & Tontheerapat, 2005). In addition, Antai-Otong (2007) stated that poor self-awareness can make nurses avoid patients and separate herself or himself from an end-of-life situation.

Moral distress is another factor that was found to be associated with caring behaviors among nurses. While caring for dying patients a nurse may confront various constraint situations which leads to moral distress (Corley, Elswick, Gorman, & Clor, 2001; Elpern, Covert, & Kleinpell, 2005; Oberle & Hughes, 2001; Schwarz, 2003; Ulrich, Soeken, & Miller, 2003). Moral distress causes low caring behaviors

because it creates an increasing sense of powerlessness that limits the nurse's capacity for self-efficacy and decreases the capacity for caring which is reflected by low caring competence (Kelly, 1998; Nathaniel, 2002; Tiedje, 2000; Wilkinson, 1988). In addition, moral distress is associated with ineffective communication, fragmented care and lack of advocacy, which in turn is associated with inadequate or inappropriate conscience behavior (Bowers, Esmond, & Jacobson, 2000; Wilkinson).

Not only a nurse's personal factors, but also their working unit was found to be an important environmental factor which is related to the caring behaviors of nurses for dying patients. Various studies found that the differences in terms of environment, ratio of nurse to patients, job description and the severity of the condition of patients between an intensive care unit and a general unit can be barriers in caring for dying patients (Amonprompukdee, 2004; Beckstrand, Callister, & Kirchhoff, 2006; Simpson, 1997).

There are many studies that have been conducted to explore the caring behaviors of nurses (Amonprompukdee, 2004; Brunton & Beaman, 2000; Daodee, 1994; Madiyono, 2004; Pokpalagon, 2005; Tanking, 2010). However, these studies used various caring concepts to explore the issue. A few studies had been conducted to explore the caring behaviors of nurses for dying patients, (Amormprompukdee; Daodee; Pokpalagon). However most of these studies mainly focused on nurses' caring practices for dying patients which is not reflected in the caring attributes of nurses which is the core of the nursing profession. In addition, most of the studies which were conducted in Thailand included only settings in Bangkok (Amormprompukdee; Daodee; Pokpalagon). Therefore, the researcher opts to study this interesting issue.

The purposes of this study were to describe the level of nurses' caring behaviors for dying patients and to examine the relationship between nurses' personal factors including age, professional experience, training experience, experience of caring for dying patients, self-awareness, and moral distress and environmental factor with nurses' caring behaviors for dying patients. The findings from this study could serve as a valuable database to be implemented in the nursing practice, education, and research in order to enhance nurses' self-awareness, reduce moral distress in working, and improve nurses' caring behaviors for dying patients.

Objectives of the Study

The objectives of this study were formulated as follows:

1. To describe the level of caring behaviors for dying patients of nurses in southern Thailand
2. To examine the relationship between nurses' personal factors (age, professional experience, training experience, experience of caring for dying patients, self-awareness, and moral distress) and caring behaviors for dying patients of nurses in southern Thailand
3. To examine the relationship between environmental factor and caring behaviors for dying patients of nurses in southern Thailand

Research Questions

The research questions were stated as follows:

1. What is the level of caring behaviors for dying patients of nurses in southern Thailand?

2. What is the relationship between nurses' personal factors and caring behaviors for dying patients of nurses in southern Thailand?
3. What is the relationship between environmental factor and caring behaviors for dying patients of nurses in southern Thailand?

Conceptual Framework of the Study

The conceptual framework of the study was derived from the conceptualization of Roach's six Cs of caring and related literature in the concerned field. According to Roach (2002), caring is professionalized in nursing and is the specific characteristic of the nurse. Caring is integrated into every aspect of nursing. A person with a caring behavior has a quality of investment and engagement when one interacts with another person. During the interaction, "one expresses oneself fully and through which one touches the other person most intimately and authentically, and thus it mean to be a human" (p. 38). Roach describes attributes of human behavior that expresses caring in six components which starts with the letter "C." These six Cs serve as a helpful basis for identification of caring behaviors. These include Compassion, Competence, Confidence, Conscience, Commitment, and Comportment. The meaning of each component was defined by Roach (p. 43) as follows:

1. Compassion is a way of living born out of an awareness of one's relationship to all living creatures. It engenders a response of participation in the experience of another, it also engenders sensitivity to the pain and brokenness of the other and a quality of presence that allows one to share and make room for the other.

2. Competence is the state of having the knowledge, judgment, skills, energy, experience, and motivation required to respond adequately to the demands of the professional responsibilities and appropriate to the demand of human care.

3. Confidence is the quality that fosters trusting relationships between the nurse with the patients.

4. Conscience is the morally sensitive self attuned to value. Professional caring is reflected in a mature conscience and is understood to subsume the moral-ethical imperatives and norms of professional life.

5. Commitment is a complex affective response characterized by a convergence between one's desires and one's obligations, and by a deliberate choice to act in accordance with them.

6. Comportment is the appropriateness of dress and language of the nurse while caring for patients.

There are several factors related to a nurse's caring behaviors for dying patients. These can be divided into 2 major factors, including a nurse's personal factors and environmental factors as detailed below.

1. Nurse's personal factors are the factors that come from the nurse's own self including age, professional experience, training experience, experience of caring for dying patients, self-awareness, and moral distress.

Age: Age is an indicator of maturity and capability in managing the environment, mentality, perception, including the ability to understand and make a decision in performing behaviors. These abilities will gradually increase with advancing age (Erikson, 1993). Some studies have shown that senior nurses have

higher levels of caring behaviors for dying patients than younger nurses (Amonprompukdee, 2004; Lange et al., 2008).

Professional experience: Professional experience is very important for every profession especially in nursing. According to Orem (1995), the professional experience is a factor that is related to the expert level for nursing practice. Several studies found that professional experience have a positive relationship with nurses' caring behaviors (Apaiwong, 2000; Brunton & Beaman, 2000; Lange et al., 2008; Mateprasart, 1991; Noh et al., 2002; Suwanmalee, 1996; Wattanachot, 1997).

Training experience: Training is an important method that can improve the skills of caring for EOL patients and their families (Chaipet, 2008). A substantial number of studies reported that special training and coursework about death and dying improved caring behaviors toward terminally ill patients and families (Tsai et al., 2005; Wong et al, 2001).

Experience of caring for dying patients: Experience in caring for dying patients would provide nurses to gain a deep understanding in the needs of patients, the emotional change of patients, and the physio-psychological change of patients. Hence, nurses having more experience would know how to respond with a higher level of caring abilities for EOL patients (Pokpalagon, 2005). The studies found a positive relationship between experience of caring for dying patients and their caring behaviors (Pokpalagon; Pratumwan & Unipun, 1995).

Nurse's self-awareness: Self-awareness is the process of understanding one's own beliefs, thoughts, motivations, feelings, behaviors and recognizing how they affect others (Boyd, 2005). Self-awareness is especially

important in caring for patients who are seriously ill or who are in an end-of-life condition. Developing self-awareness help nurses to take control and cope when confronted with difficult situations while taking care of patients (Smith, 2007). The understanding and acceptance of one's own self helped nurses care for the patients as individuals (Townsend, 2003). Studies found that a nurse's self-awareness correlated positively with their caring behaviors (Daodee, 1994; Intong et al., 2005)

Moral distress: Moral distress is the painful feelings that arise when a nurse knows morally the correct thing to do but cannot act because of constraints or hierarchies (Corley et al., 2001). Moral distress causes negative effects on caring for dying patients which is reflected in nurses' caring behaviors. Moral distress was found to have a negative effect on the caring behaviors of nurses in caring for dying patients. Moral distress results in ineffective communication, fragmented care, and lack of advocacy which is very important in caring for dying patients (Corley, 2002; Nathaniel, 2002).

The environmental factor is the unit that the nurse is working in. There are some differences between an intensive care unit and a general unit that can be a barrier for nurses to provide good care for EOL patients. Both of these units are different in terms of the environment setting, the goal of care, and the ratio of nurses to patients which can affect the caring behaviors of the nurse (Beckstrand et al., 2006; Amonprompukdee, 2004; Simpson, 1997).

The conceptual framework of this study is summarized in the following Figure 1.

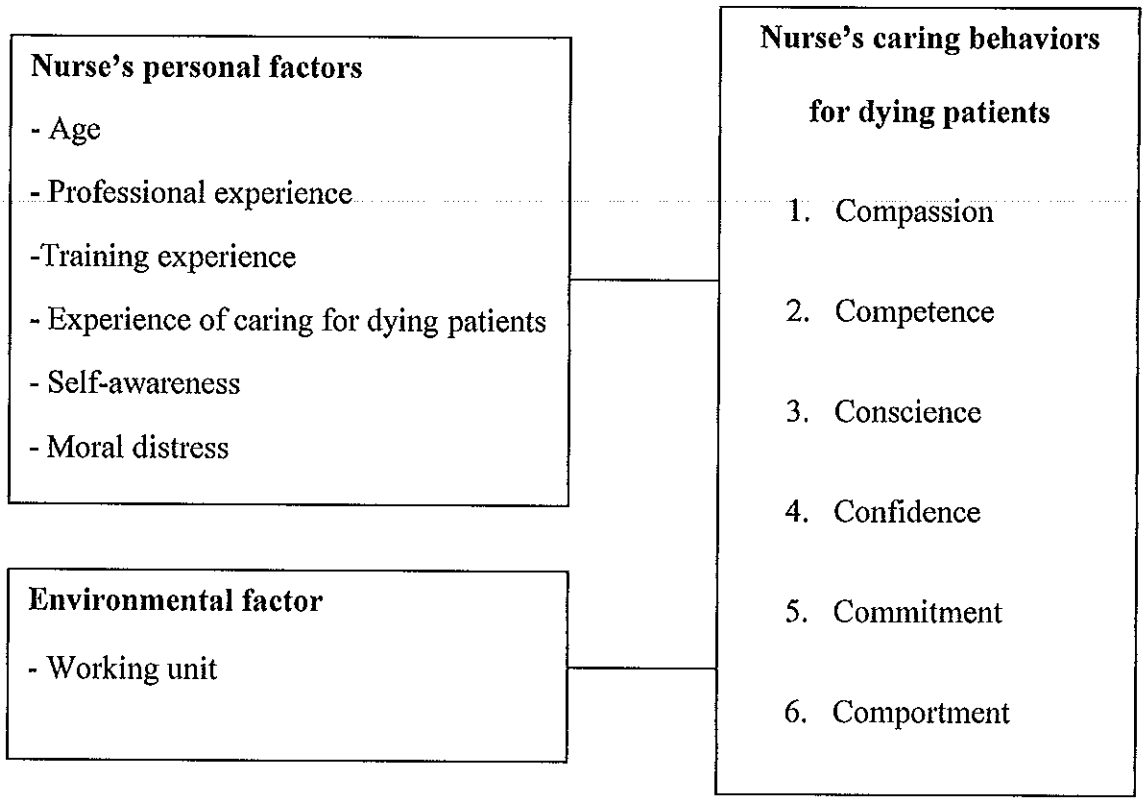

Figure 1 Conceptual framework of the study

Hypotheses of the Study

The hypotheses of this study are working hypotheses that are stated as follows:

1. There is a positive relationship between age, professional experience, training experience, experience of caring for dying patients, and self-awareness with caring behaviors for dying patients of nurses in southern Thailand
2. There is a negative relationship between moral distress and caring behaviors for dying patients of nurses in southern Thailand
3. There is a relationship between the working unit and caring behaviors for dying patients of nurses in southern Thailand

Definition of Terms

Caring behavior for dying patients refers to the perception of the nurse on the frequency of actions or performances she or he exhibits while providing care for dying patients. These behaviors encompass the following six attributes which are compassion, competence, conscience, confidence, commitment, and comportment. In this study, nurses' caring behaviors for dying patients were measured by the Nurse's Caring Behaviors for Dying Patients Questionnaire which was developed by the researcher based on Roach's six Cs caring attributes.

Nurse's personal factors refers to nurse's age in year, professional experience, training experience, experience of caring for dying patients, self-awareness, and moral distress.

Age refers to the number of a nurse's age in years.

Professional experience refers to the number of years working as a registered nurse since finishing a bachelor degree until now.

Training experience refers to the experiences of nurses in attending a seminar, conference, or workshop related to end of life care.

Experience of caring for dying patients refers to the number of dying patients nurses have been taking care of within the past year.

Nurse's self-awareness refers to the perception of nurses on knowing and understanding oneself in terms of what they are "thinking", "feeling", and "doing" in providing care for dying patients. The perceived self-awareness was measured by the Nurse's Self-awareness Questionnaire which was developed by Daodee (1994). The self-awareness questionnaire consists of 20 items relating to two

aspects of self awareness, private and public self awareness. Higher scores indicate a higher level of self-awareness.

Moral distress refers to the perception of nurses on the intensity of painful feelings from situational constrains while caring for dying patients. Moral distress was measured by the Shortened Form of Corley's Moral Distress Scale which was modified by Hamric (2007) based on Coley's Moral Distress Scale and translated into Thai by the researcher. The Shortened Form of Corley's Moral Distress Scale consists of 21 items. The higher scores indicate higher levels of moral distress.

The environmental factor refers to the unit or place in which the nurse is working and it is categorized into intensive care unit and general unit.

Significance of the Study

The results of this study would be useful for appropriate planning to improve nursing services for dying patients and their families, develop nursing curriculums, teaching, and learning processes in the EOLC area. It can provide information for nursing administrators to develop hospital policies in providing effective EOLC to patients and their families. Moreover, the results of this research serve as a preliminary step for further study in the area of EOLC.

CHAPTER 2

LITERATURE REVIEW

The literature review is an important part of research study. For this study, a number of related articles and studies on the following topics were reviewed:

1. Concept of End of Life Care for Dying Patients
   - 1.1 Definition of palliative care and end of life care
   - 1.2 Impacts of terminal illness on dying patients and families
   - 1.3 Needs of dying patients and families
2. Caring Behaviors for Dying Patients and Families
   - 2.1 Concept of caring
   - 2.2 Roach's Six Cs of caring concept
   - 2.3 Caring behaviors for dying patients based on six Cs and related literature
3. Nurse's Caring Behaviors Measurement Tools
4. Factors Related to Nurse's Caring Behaviors for Dying Patients and their Families

Concept of End of Life Care for Dying Patients

Dying is a critical phase in the life of patients and their families. Nurses play a vital role in ensuring good quality of care for dying patients. The concept of end of life care for dying patients is very important. It can guide the nurses to provide good care for dying patients. The concept of end of life care for dying patients includes a definition of palliative care and end of life care, the impacts of terminal illness on dying patients and their families and the needs of dying patients and their families.

Definition of palliative care and end of life care

Palliative care is often used interchangeably with end of life care. These two concepts share the principle of care. The World Health Organization (2010) defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief from suffering by means of early identification and impeccable assessment and treatment of pain and other problems like physical, psychosocial and spiritual. In addition, palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients to live as actively as possible until death. It also offers a support system to help the families to cope during the patients' illness and in their own bereavement and uses team approaches to address the needs of patients and their families, including bereavement counseling, if indicated. It will also enhance quality of life, and may also positively influence the

course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and also includes those investigations needed to better understand and manage distressing clinical complications (WHO, 2010). Palliative care can be offered to the patient at any point in their medical treatment regimes, even while receiving aggressive treatments for disease (Geoghan, 2008).

On the other hand, end of life care is under the umbrella of palliative care. The end of life care is used in a short period of life (Kuebler, Lynn, & Von Rothen, 2005). The term 'end of life' usually applies to the last year of life (Bennett, Davies, & Higginson, 2010). End of life care refers to care provided for patients in terminal stage or with an advanced chronic illness for which there is no medical treatments to cure the illness and is reasonably expected to result in the death of the patients (AGS, 2007; Kuebler, Berry, & Heidrich, 2002). As it is difficult to define the period of end-of-life care, several tools recently were developed to predict a patient's prognosis such as Karnofsky Performance Status (KPS), the Eastern Cooperative Oncology Group (ECOG), and Palliative Performance Scale (PPS). Both KPS and ECOG are used to predict the prognosis in malignant diseases while the PPS is used for nonmalignant diseases. The score of each measurement is interpreted as KPS or PPS score of 50 from 100 or less, or an ECOG score of 2 from 4 or higher, and it predicts that a patient may have a prognosis of six months or less. The patients in this group are patients who are in need of EOLC (Kinzbrunner, Weinreb, & Policzer, 2002).

Although end of life care is scholarly defined as care given to patients during the last year of life, health care providers practically perceive the meaning of

EOL or terminally ill patients as the same as the word dying. Physicians usually diagnose patients in a terminal stage when the disease cannot be cured or the patient does not response to the full treatment, losing function of organs for sustaining life; or brain dead based on the criteria of the Medical Council of Thailand (Sittipan, 2005). This definition is similar with the definition given by the nurses in clinical practice. In the study by Chaipetch (2008) on ICU nurses' experiences in caring for dying patients which found that ICU nurses described the meaning of dying patients in two ways; as the patients who had a little chance to survive and not likely to be rescued and the patient who had deteriorating signs and symptoms. These findings were consistent with the study of the perception of nurses in general units. Nurses in general units categorized the end of life patients into three groups; tend to die patients, life-threatening patients, and hopeless and incurable patients (Labhantakul, 2000). They perceived that the patient who was diagnosed as brain dead, or who does not respond to high doses of fully medical treatment, or who has multiple organ failure, and who will die shortly. In addition, the nurses in a general unit perceived that the patient in a critical period also is dying because the conditions of the patient cannot be predicted; there is fifty percent chance that the patient may die or survive (Labhantakul).

The definition of a dying patient used in this study is based on the theory and the real practice in the Thai context, which refers to the hospitalized persons who are diagnosed with an advance disease or terminally ill or there are no curative treatments. The patients have serious illnesses, multiple organ failure and a severe risk of dying at any time during the admission in the hospital. The time left of life is no more than one month.

Impacts of terminal illness on dying patients and families

Being sick with a terminal illness affects not only the patients but also their families. The impacts of terminal illness on dying patients and their families can be categorized into 3 inter-related parts (1) physical aspect, (2) psychosocial and emotional aspect, and (3) spiritual aspect.

1. Physical aspect

During the dying trajectory, the patient suffers from several distressful symptoms. The SUPPORT study documented that during a dying patient's last 3 days of life, 80% of dying hospitalized patients suffered severe fatigue, 50% severe dyspnea, and 40% severe pain (Lynn et al., 1997). The most common symptoms reported by families in the last week of life were fatigue, dyspnea, and dry mouth, while the most distressing were fatigue, dyspnea, and pain (Solano, Gomes, & Higginson, 2006). In the long-term care setting, dyspnea, pain, and noisy breathing predominated in the last 2 days of life, while in hospitalized patients, the most distressing symptoms in the last 24 hours were known to be pain, excess respiratory secretions, and agitation (Georges, Onwuteaka-Philipsen, van der Heide, van der Wal, & van der Maas, 2005). Anorexia, constipation, nausea/vomiting, incontinence, pressure sores, and insomnia have also been identified as particularly distressing in dying patients (Doorenbos, Given, Given, & Verbitsky, 2006; Georges et al.; Solano et al.).

On the other hand, the family caregivers' physical status can be impacted on while they are involved in caring for EOL patients. At the end stage of life, the family has to take care of the patient all the time which can lead to inadequate time to sleep and rest. These directly lead to the decline of a family caregiver's

physical health status (Seachit, 2004; Sakul, 2001). Various studies found that caregivers reported that they suffered from headaches, low back pain, muscle strain, loss of appetite, and weight loss (Maneerojjana, 2001; Nilmanat, 2004; Jennifer, Kathleen, Dorothy, & Kathleen, 2010).

2. *Psychosocial and emotional aspect*

It was evident that depression, grief, anxiety, fear, uncertainty, and worry about dying are commonly reported by patients with terminal illness (Hsu, Lu, Tsou, & Lin, 2003). In addition, studies in cancer and non-cancer dying patients reported that the 50% of dying patients experience anxiety (Solano & Higginson, 2006). A common cause of anxiety in the hospice/palliative care population is mainly uncontrolled pain and dyspnea (Plonk & Arnold, 2005). In addition, inability to speak or communicate with others leads to anxiety in the dying patients due to the fact they cannot express their feelings or needs (Verhaeghe, Defloor, Zuuren, Duijnstee, & Grypdonck, 2005). In addition, it has been estimated that 25% to 75% of terminally ill patients suffered from depression (Hallenbeck, 2003). Fear of death also was noted as an important cause of anxiety and depression in dying patients (Fine, 2001; Smith, Gomm, & Dickens, 2003). For older adults, unsatisfaction or unhappiness with personal and professional achievements can mitigate or exacerbate emotional distress; and worries about a spouse are often prominent among dying patients (Block, 2006; Institute for Clinical Systems Improvement, 2009). In the critical period, there are many treatments and much equipment that are provided to the patient, so that the patient always remains separated from their family. The restricted time to visit the patient also is a factor that causes separation between the patient and their family.

In addition, various studies found that during the palliative period, families reported that they had high levels of anxiety and depression (Grunfeld et al., 2004; Rhee et al., 2008). This is because they cannot help the patient to get relief from pain, the fear of loss of their beloved one, and the frustration about the adverse effects of treatment (Grunfeld et al.; Rhee et al.)

Also, terminally life-threatening illness can have a major impact on family economic circumstances. Researchers have demonstrated that serious illness often results in a decline in the economic well-being of a family (Rossi et al., 2007; Woolhandler & Himmelstein, 2004). In the SUPPORT study, Covinsky and colleague (1994) found that 20% of family members having seriously ill adult patients had to make a major life change (including quitting work) to provide care for their loved one, and that 31% of families lost all or most of their savings in the process of caring for their ill relative.

3. Spiritual aspect

During the critical period of the dying patient's life, there are many treatments provided to the patient which may cause separation from their families. The unfamiliar environment and isolation may increase loneliness and fear in the dying patient (Rokach, Matalon, Safarov, & Bercovitch, 2007; Rokach & Rokach, 2005; Verhaeghe et al., 2005). In addition, the social loneliness was also considered as a factor that contributes to feelings of powerlessness and helplessness (Sand, Strang, & Milberg, 2008). A recent study showed that powerlessness and helplessness are issues of clinical significance to the dying patient and their families (Miberg et al., 2004).

In addition, dying patients may suffer religious and spiritual pain. The religious pain is a condition in which a patient is feeling guilty over the violation of moral codes and values of his or her religious tradition. Patients in religious pain believe that God is keenly disappointed in their past or present behaviors, actions, or thoughts. Reviewing past behaviors or actions that are against the dying patient's religious practice leads them to experience religious pain (Satterly, 2001). The inability to perform religious practice also causes religious distress for dying patients (Anandarajah & Hight, 2001; Kuuppelomaki, 2001; Nelson, Rosenfeld, Breitbart, & Galietta, 2002). On the other hand, spiritual pain is the emotional or physical distress because of the loss of self which includes physical self, identity, and relationship (Schoepfer, 2007; Carnevale, 2009).Some dying patients are faced with spiritual pain because they cannot do or say their last wish to their loved one due to isolation from their families and they are worried about the person left after their death (Pichaikul, 2000; Verhaeghe et al., 2005). Also, physical symptoms distress, a feeling of alienation, a sense of worthlessness, a sense of burden on others and the desire for a hastened death are the causes of spiritual suffering (Nilmanat et al., 2010).

In addition, not being able to predict the amount of time left for the patient's life causes uncertainty and hopelessness in the family (Nakjarean, 2001; Watee, 2001; Stajduhar & Davies, 1998). Moreover, the family also has a conflict of feelings between being tired of caring for the dying family member and the duty of children to take care of their parents which lead to spiritual suffering (Maneerojjana, 2001). All the impacts of terminal illness could result in the alteration of the quality of life of dying patients and their family. These impacts also reflect the needs for care from health professionals.

Needs of dying patients and their families

Due to the impacts from a terminal illness during the dying process, the patient and their family need some help from the health care profession. The needs of the dying patient and their family can be classified into fours aspects as follows:

1. *Information needs*

Optimal communication has been identified by the patients and families as one of the most important aspects of medical care at the end of life (Parker et al., 2007). Patients and caregivers have indicated a need for clear information at all stages of the disease process about the illness itself, prognosis and symptom management, and information that will aid decision making about clinical treatment options (Clayton, Butow, & Tattersall, 2005; Hagerty, Butow, Ellis, Dimitry, & Tattersall, 2005; Parker et al.). Also, survival information was shown to be important information which is to be given in a way that allows the patient to prepare for death, finalize affairs, and say good-bye to loved ones (Clayton, Butow, Arnold, & Tattersall, 2005; Hagerty et al.). According to a systematic review of prognostic end-of-life communication with adults in the advanced stages of a life-limiting illness, it was reviewed that caregivers possibly need more detailed information about the dying process more than the patient needed. This information enables the caregivers to prepare mentally and feel confident that they can provide both physical care and emotional support required by their loved one (Parker et al.).

In addition, systematic reviews also reviewed that many of the issues raised have direct clinical implication for health professions. Both patients and caregivers wanted a trusted health professional who provided information in small chunks, without jargon. They preferred a health professional who showed empathy,

care, compassion, and honesty, as long as the honesty was balanced with sensitivity and hope (Hagerty et al., 2005; Parker et al., 2007). They also preferred a health professional who encouraged questions and checked patient and caregiver understanding. These reviews also recommended that health professionals should clarify patient and caregiver information needs individually and tailor the information accordingly, recognizing that each person's needs are likely to vary at different time points through the course of an illness. In addition, information may need to be repeated on different occasions to meet patients' and caregivers' needs (Hagerty et al.; Parker et al).

2. *Physical needs*

The dying patient always suffers from unbearable symptoms. So, their physical needs are aimed at alleviating distressful symptoms (Poor & Poirrier, 2001; Truog et al., 2001). The most important need is the need for adequate symptom management especially in pain and dyspnea (Pichaikul, 2000; Rokach & Roakch, 2005). In addition, the dying patient needs comfort care such as hygiene care for mouth, body, skin, and hair; respiration care; turning position; nutrition; defecation and urination; and a safe environment (Wataneeyawech, Eamjoy, & Tungamnuay, 1998).

In addition, when the patient is in the critical period, the family should focus on the physical needs of the patient. The families need the best medication, treatment and care from physicians and nurses for the patient because they hope that it may prevent the patient from dying (Aramrom, Nilmanat, & Chailanga, 2009; Jitjalearnkul, 2004). Furthermore, after the families are in a stage of crisis for some time, they will pay attention to their physiological needs. They will

express their physical needs such as wanting a waiting room with a telephone, comfortable furniture, blankets and a place to lie down, a cafeteria, and a toilet and a bathroom near the unit (Aramrom et al.; Pichaikul, 2000; Verhaeghe et al., 2005). Beside these comfortable items, the families also need someone to help take care of them.

3. Psychological needs

Patients needs for a supportive network including support from families, friends, care professionals, and someone to talk to (McIllmurray et al., 2001). In addition, when death approaches, families also want to be with the patient until the last moments of the patient's life. They hope that they can give the best to the patient or ask the patient about his or her last wishes (Aramrom et al., 2007). Being with the patient in the final time of life is part of Thai culture and belief. Thai people believe that, if the patient is with loved ones in the final moments of life, the patient will have a peaceful death (Sirilai, 2001).

Moreover, the dying patient and their families are in need of emotional support. They want to express their negative feelings, talk about possible death, be alone, and be encouraged to cry. Feelings accepted and respected by the nurses is also important for the patient and their family members (Verhaeghe et al., 2005). In some cases, the need for hope and reassurance seem to be greatest. The need for hope among the families to survive in sudden, unexpected and serious changes in the condition of trauma-coma patients appears to be greater than the case of chronically evolving illnesses (Mendonca & Warren, 1998).

4. Spiritual needs

Several studies explored the spiritual needs of dying patients. The findings from Taylor and Mamier's (2005) research indicate that about half of the patients suffering from cancer and their family caregivers needed spiritual support. Qualitative studies explored end of life patients' and families' spiritual needs, it was reviewed that needs related to religion were frequently the first spiritual needs participants identified. The spiritual need most often mentioned was the need to pray (Büssing & Koenig, 2010; Hermann, 2001). Also, the needs to read the Bible, to use scripture, to read inspirational material, to use inspirational material, to go to church and to sing/listen to music were identified by the patients as their preferred religious needs (Herman; Hermann, 2007).

In addition, the need for companionship was indicated by the patients as a spiritual need. In the final stage of life, not only did the dying patients want to be with family, children and friends but these people also wanted to be with the patients (Herman, 2001; Shih et al., 2009). The need to finish business, the need to have a positive outlook, and the need to experience nature were also expressed by the patient in their last hour of life (Herman). Moreover, caregivers reported that they need some help from nurses to facilitate the dying patients to go back home because they believe that if the patient died at home, the patient will have a peaceful death because he/she died among family members and in a familiar environment (Nilmanat, 2002; Saisook, 2001).

The impacts of terminal illness affect the quality of life of patients and their families. Thus, there is a need for care which is generated during this period. Nurses take full responsibility to respond to such needs thoroughly.

Caring Behaviors for Dying Patients and Families

Caring is the main focus of the nursing professional. Florence Nightingale, the mother of the nursing profession, stated that the most important work in nursing is caring and nurses have to take care of the patient based on the reason of the environment around the patient (Nightingale, 1980). This section explores in detail the concept of caring, Roach's Six Cs of caring concept, and caring behaviors for dying patient based on six Cs and related literature.

Concept of caring

Caring reflects the relationship of person with another person, animal, or thing with kindness, attention, and responsibility (Apiruknapanond, 1999). Several nursing theorists have developed a caring theory. For Leininger (1981), the caring concept is focused on the difference of cultural context. She defined caring as a feeling of dedication to another person to the extent that it motivates and energizes action to influence life constructively and positively by increasing intimacy and mutual self-actualization. On the other hand, Watson (1999) has focused the caring concept on the philosophic (existential phenomenological) and spiritual basis of caring and sees caring as the ethical and moral idea of nursing. Watson stated that caring is the moral ideal of nursing, in which nurses become responsive to another person as a unique individual, perceive the patient's feelings, and act for protection, enhancement, and preservation of the patient's dignity. Roach (2002) also defined caring as a human mode of being caring. Within nursing the notion of caring is representative of distinctive caring attributes and embodies certain features pertinent to the profession of nursing.

In conclusion, caring is a central concept in nursing. In this study, the researcher used Roach's six C's of caring attributes to describe the nurse's caring behaviors for dying patients because each attribute of a caring nurse can serve all dimensions of the patient's and family's needs at the end of life.

Roach's Six Cs of caring concept

Roach (2002) stated that caring is the human mode of being. Caring is fundamental for human growth and healing. Caring is professionalized in nursing. Caring is the locus of all attributes used to describe nursing. Roach described six attributes of caring in the letter C. The Six Cs, Compassion, Competence, Confidence, Conscience, Commitment, and Comportment are the attributes that reflect the nurse's caring behaviors. At this level, the specific manifestations of caring, as represented by behaviors such as spending time with patients, checking factual information, identifying and using relevant knowledge, performing technical procedures, showing respect, maintaining trusting relationships, keeping commitment and comportment in dress and language were generalized into Six Cs as follows:

1. *Compassion*

Compassion was defined as "a way of living born out of an awareness of one's relationship to all living creatures. It engenders a response of participation in the experience of others, feeling the pain and brokenness of the others and a quality of presence that allows sharing and making room for the other" (Roach, 2002, p.50).

Roach (p.45) expressed the compassionate caring behavior as recognizing the needs of the patients and family. In addition, the caring nurse can

express compassionate by recognizing the loss of patients and family at the end of life. Allowing the patient and family to express fear also reflects a caring behavior. Moreover, compassionate care can be expressed by feeling the pain of the patients and their families.

2. *Competence*

Competence is an important caring behavior that nurses have to provide for the effective care of the dying patient. Competence was defined by Roach (2002, p.54) as "the state of having the knowledge, judgment, skills, energy, experience, and motivation required to respond adequately to the demands of the professional responsibilities and appropriately to the demand of human care".

Roach (p. 46) explained that nurses can express competence by being able to assess, plan, implement, and evaluate a plan of care to meet the needs of patient and family. In addition, the nurse should be able to treat and manage symptoms at the end of life which also reflects the caring competence. Moreover, nurses should guide the patients and their family by using communication skills which reflect high caring competence.

3. *Confidence*

Caring confidence is "the quality that fosters trusting relationships without dependency, communicating truth without violence and creating a relationship of respect without paternalism or without engendering a response born out of fear or powerlessness" (Roach, 2002, p. 56).

According to Roach (p. 46), nurses can express confidence by showing the patients that the nurse can help them to be comfortable. For example, giving good information and advice to patients and their families in such a way that

creates a sense of trust in the nurse. In addition, the nurse's showing ability based on knowledge, skills, and experiences also is another way to create trust. Moreover, creating awareness in the patient that you are there for her and her family and you will bring the family together reflects the confidence of the nurse in caring for the dying patient.

4. *Conscience*

Conscience is the morally sensitive self attuned to value. Professional caring is reflected in a mature conscience and is understood to subsume the moral-ethical imperatives and norms of professional life (Roach, 2002, p.58).

According to Roach (p. 47), the nurse can express conscience by doing things that is right in a particular situation and advocate for the patient. In addition, being sensitive in an informal sense of right-wrong, which is important to realize that the patient has a right to know about their own condition is an expression of a caring conscience. Moreover, respecting, providing care based on the patient's rights and making a decision based on ethical principles are also important for the nurse's caring conscience.

5. *Commitment*

Roach (2002, p.62) defined commitment as "a complex affective response characterized by a convergence between one's desires and one's obligations, and by a deliberate choice to act in accordance with them".

Commitment can be expressed by sticking with patients throughout a crisis. In addition, nurses can express commitment by realizing the ongoing relationship with patient's family and informing them that the nurse is committed to their needs until the patient dies. Nurses should stay for the duration and

be available when needed. The nurse can let the patient and family know about their commitment to them. Moreover, the convergence between what nurses want to do and what nurses ought to do also reflects the nurse's commitment (Roach, p.48).

6. Comportment

Comportment was defined by Roach (2002, p.64) as "the appropriateness of dress and language of nurses while caring for the patients. Because dress and language are symbols of communication and can be harmony or disharmony while caring for the patients. When nurses visit a special person, their mode of dress and choice of language are usually in accordance with regard, esteem and respect of the patient concerned. Without necessarily reflecting on the matter, nurses usually dress and use language consistent with their attitude toward the person or the occasion.

Comportment can be expressed by showing respect to the patients and their family by using appropriate language. In addition, nurses can express comportment by showing the patients and their family, proper dress, manners, and actions. Nurses should show their own manner as a professional nurse. Moreover, nurses can express comportment by showing the patients and their family that nurses care about how they come together to comfort the patient. Furthermore, presenting one's own self as someone who demands respect also reflects the nurse's comportment (Roach, p.48).

Caring behaviors for dying patients based on six Cs and related literature

1. Compassion

Numerous studies expressed how nurses behave as compassionate beings. London and Lundstedt (2007) studied families' satisfaction on nurses' caring behaviors for EOL patients. The results found that the families appreciate compassionate behaviors of nurses. They expressed the nurse's compassionate behaviors as a hug from a nurse giving them comfort and feeling less anxiety, the nurse's sincere concern about the needs of both patient and families all the time even during night shift, the nurse taking care of them like they are the nurse's family member. Similarly, nurses in studies of the development of nurses' caring behavior scale in both a Thai and Taiwan context also identified treating patients like relatives as in one item of nurse's caring behavior which reflects love and care (Lee-Hsieh, Kuo, Tseng, & Turton, 2005; Udomluck, Tonmukayakul, Tiansawad, & Srisuphan, 2010). Another study by Marco, Buderer, and Thum (2005) also found that at the end of life the families were satisfied in nurses' caring behavior in responding to patient needs.

Chaipet (2008) found that ICU nurses express that they cared for dying patients and families with heart, with love, and empathy. Nurses also care for the patient's family members as their own families. In addition, Peter (2006) found that to provide compassionate care at the end of life, the nurse has to recognize patients and families' needs. Moreover, Von Dietze and Orb (2000) states that touching is an action that reflects the understanding of the nurse in the patient's feelings. Wilkin (2003) and Brilowski and Wendler (2005) identified the same

components of caring as comfort and presence. Nurses can provide comfort by touching and actively listening to the patient.

2. Competence

A study of Chaipet (2008) found that ICU nurses consider specific knowledge in caring for dying patient such as assessing pain in the unconscious patient, caring for the patients who have a different culture, psychological care, and spiritual care. The nurses in this study improved their knowledge by self study from related books or research studies. They always improved their skills by following senior nurses. In addition, the American Association of Colleges of Nursing (1997) identified competencies as necessary for the nurse to provide high quality care to patients and families during the transition at the end of life which is the same as Mullen and Thomas (2009). These competencies are communication skills, collaboration skills, assessment and care planning, symptom management, advance care planning, and applied knowledge gained from palliative care research to end-of-life education and care. This is the same as results from Marco et al. (2005) and Roger, Karlsen, and Addington-Hall (2003) studies which found that end of life families viewed competent nurses as those who have effective communication. Moreover, cultural competencies are also important in caring for the dying patient such as language, religion, beliefs, values, and the perception of illness (Giger, Davidhizar, & Fordham, 2006; Nyatanga, 2002). Furthermore, technology is involved in EOLC, therefore technological competency is needed for the caring nurse (Locsin, 2005). However, high tech' skills and 'high touch' skills should go together (Arthur, Pang, & Wong, 2001).

3. Confidence

ICU nurses in a study of Chaipet (2008) explain that they make the patients and families confident in them by being with them during the dying period. Numerous studies also stated that being with critically ill patients is especially important (Brilowski et al., 2005; Wilkin, 2003). Nurses identified a caring nurse as one who spends time with patients when they are afraid, worried, or lack confidence (Forest, 2004; Udomluck et al., 2010). In addition, introducing yourself to the patient is an important way to create a trusting relationship with the patient and family (Daodee, 1994)

4. Conscience

In caring for the dying patient nurses can act in the advocacy role by asking for things that the patient should receive based on the patient's rights (Poor & Poirrer, 2001; Thacker, 2008). According to Arthur et al (2001) identified advocacy caring as one attribute of a caring nurse which consists of speaking on behalf of the patient in relation to their care, speaking up for the patient when it is perceived something harmful will be done to the patient, preventing problems from occurring, knowing what to do, and being able to document care. In addition, the nurse should provide equal care for each person based on standard care and individual needs and give information when the patient is ready to know (Roach, 2002, p. 47). Moreover, a caring nurse should make decisions based on ethical decision making including nonmalificence, beneficence, confidentiality, autonomy, justice, and truth telling (Poor & Poirrer).

5. Commitment

Numerous studies found that nurses can behave as committed to care for the patient by keeping promises to the patient (Daodee, 1994; Lee-Hsieh et al., 2005). In addition, responding quickly to the patient's calling or asking is also showing a commitment to care (Brunton & Beaman, 2000).

6. Comportment

Appropriate dress and language of the nurse is the symbol of a caring nurse. These include verbal, nonverbal language, and the expression of feelings (Daodee, 1994). Lee-Hsieh et al. (2005) developed an instrument to measure a nurse's caring behavior. The patients in this study identified the comportment of a caring nurse as a nurse who is patient and avoids being impatient or cross in tone or appearance. Moreover, the nurse can behave respectful to the patient by calling the patient by his/her prefered name and appropriate pronoun (Brunton & Beaman, 2000). According to Thailand Nursing Council, a professional nurse is a nurse who follows the standard of care, shows respect to patients, health care providers, and the nursing profession.

Nurse's Caring Behaviors Measurement Tools

There are several measurement tools used to explore a nurse's caring behavior. It was found that mostly, these tools were developed by researchers based on the conceptual framework of their studies. Some studies applied the original instrument that was developed by nursing scholars or previous studies to be appropriated with the samples of the study. These tools are categorized into two

groups, which are measurement tools for general nurse's caring behavior and measurement tools for specific nurse's caring behavior in end of life care.

1. Measurement tools for general nurse's caring behaviors

1.1 Caring Assessment Instrument (CARE-Q)

The original sixty-item version of the CARE-Q was developed to identify nurses' caring behaviors by Larson in 1981 (as cited in Watson, 2002). The CARE-Q items were developed from the ground up with special concern about the caring needs and perceptions of cancer patients. The view of nurse caring used in the instrument development was intended to create a subjective sense of feeling cared for in the patient. Feeling cared for is a sensation of well-being and safety resulting from enacted behaviors of another. The specific concern of the instrument is to measure, by ranked importance, the differences and similarities of perceptions that nurses and patients have of identified nurse's caring behaviors.

Delphi survey of practicing nurses on caring behaviors and a study of patients' behaviors were used in developing this instrument which resulted in the identification of 69 nurse caring behaviors, and later it was reduced to fifty items with six dimensions as a final version. The CARE-Q uses Q methodology as a means of scoring. Therefore, the subjects were forced to sort cards, each containing a statement item, into categories that range from most important to less important. This instrument was used to measure the nurse's caring behavior that was perceived by both patients and nurses in various studies especially in the oncology field. The reliability from these studies ranked from .64 to .94 (Gooding, Sloan, & Gagon, 1993; Komorita, Doehring, & Hirchert, 1991; Scharf & Caley, 1993).

The CARE-Q seems to be good for measuring a nurse's caring behavior. Nevertheless, it also has limitations such as the difficulties in selecting one item over another as the most important, some participants did not sort the cards according to direction, and the Q-methodology used in this instrument might cause misinterpretation in the analyzing process (Watson).

1.2 Care Satisfaction Questionnaire (CARE SAT)

Larson and Ferketich in 1993 incorporated the 50 items of the CARE-Q into a VAS and renamed it as the Care Satisfaction Questionnaire (CARE/SAT) (Larson & Ferketich, 1993 as cited in Beck, 1999. Twenty-one additional items were added to the questionnaire to assess overall satisfaction with nurse's caring behaviors in each of the six sub-scales. The participants were asked to place an `X' on the 100-centimetre line next to the item statement to indicate the degree to which they agreed or disagreed based on their experiencing that specific nursing action while they were hospitalized. Cronbach's alpha for the total CARE/SAT was .94.

However, the limited use of this instrument has occurred to date. Some of the difficulties are related to negatively worded statements mixed with those positively worded. Mixing between positively and negatively worded statements may lead to wrong analysis and an unreliablity of the total scores which might occur due to not reading carefully (Andrew, Daniels, & Hall, 1996).

1.3 Caring Behavior of Nurse Scale (CBNS)

The Caring Behaviors of Nurses Scale (CBNS) was developed by Hinds in 1988 as a 22-item visual analog scale (Watson, 2002). The conceptual frame work that guided the scale development was derived from the existential theory

of humanistic nursing. Hinds stated that the caring behaviors used in CBNS are the composite of purposeful nursing acts and attitudes which seek to alleviate undue discomforts and meet anticipated needs of patients, convey concern for the well-being of patients, and communicate professional competence to patients (Hinds, 1988 as cited in Beck, 1999). This instrument was designed to detect nursing caring actions. Each item has a possible response ranging from 0 to 100 points. Scoring is interpreted as the higher the score the higher the patient's perception of being cared for by the nurses. Cronbach's alpha was .86.

1.4 Caring Behavior Assessment Tool (CBA)

The Caring Behaviors Assessment Tool (CBA) was developed by Cronin and Harrison in 1998 based on the conceptual definition of caring of Watson's (1985) theory of human care (as cited in Watson, 2002). Caring is the process by which the nurse becomes responsive to another person as a unique individual, perceives the other's feelings, and sets that person apart from the ordinary (Cronin & Harrison, 1998 as cited in Watson). The CBA consists of 61 nursing caring behaviors grouped into seven sub-scales including humanism, helping, expression of positive and negative, teaching, supportive, human need and existential. The items are rated on a 5-point Likert scale, to reflect the degree to which each nursing behavior reflects caring. There are various uses of this instrument to examine a nurse's caring behavior which found the reliability ranked from .66 to .93 (Watson).

1.5 Caring Behavior Inventory (CBI)

The Caring Behaviors Inventory (CBI) was developed by Wolf in 1994 which was the second empirical measurement tool of caring to be reported in nursing literature. The conceptual theoretical basis was derived from

caring literature in general and Watson's (1988) Transpersonal Caring Theory (as cited in Watson, 2002). Nurse caring was defined as interactive and intersubjective process that occurs during moments of shared vulnerability between nurse and patient, and that is both self-and other-directed (Watson, 1988 as cited in Watson). The CBI is a four-point Likert scale which consists of 42 items. The reliability of this instrument ranked from .96 to .98 (Watson).

1.6 Caring Dimensions Inventory (CDI)

The Caring Dimensions Inventory (CDI) was developed by Watson and Lea in 1997 based on Leninger's caring theory and literature. The CDI is a five-point Likert scale which consists of 25 items. The Cronbach's alpha coefficient for internal consistency reliability was reported to be .91. However, no other studies were located which used the CDI (Watson, 2002).

1.7 Holistic Caring Inventory (HCI)

The Holistic Caring Inventory (HCI) was developed by Latham in 1996 as part of her doctoral studies. The conceptual theoretical basis of the instrument is Howard's holistic dimension of the Humanistic Caring Model. Based on the Humanistic Caring Model, caring is considered in context of perceptive influences (patients' need for cognitive and behavioral control and level of self-esteem) and the outcomes of these encounters (appraisals, coping strategies, psychological distress, and coping effectiveness) (Latham, 1996 as cited in Watson, 2002).

The HCI has a total of 39 items, comprising 4 subscales, i.e., Physical, Interpretive, Spiritual, and Sensitive. The instrument was constructed as a four-point summated Likert scale. The reliability of all four caring subscales were .89. However, no other studies were located which used the CHI (Watson).

1.8 The Caring Ability Inventory (CAI)

The Caring Ability Inventory was developed by Nkongho in 1992 measures a person's ability to care when involved in a relationship with others (Watson, 2002). The conceptual basis for the instrument was derived from the caring ability based on Mayeroff's (1997) definition of caring as helping another grow and actualize himself. Caring is a process, a way of relating to someone that involves development (Mayeroff, 1997 as cited in Beck, 1999). The CAI has a total of 80 items with a seven-point Likert scale. A Cronbach's alpha was reported at 0.79. However, no other studies were located which used the CAI (Watson).

1.9 Caring Attribute Scale (CAS)

Nyberg's Caring Attributes Scale (CAS) was developed by Nyberg in 1990 based on the conceptual definition of Mayeroff, Noddings, and Watson's caring definitions. The CAS is a Likert scale composed of four sub-scales: an ideal scale, an actual scale, a supervisor caring scale, and a 5-year scale. These sub-scales only differ in their instructions. The participants complete each sub-scale based on attributes they perceive to be ideal, those attributes actually used in practice, perceptions of caring behavior of supervisors, and where caring will be in 5 years. Each sub-scale consists of the same 20 behaviors which participants rate on their degree of agreement or disagreement on a scale of 1-5, with one being the most often used behavior in practice. Cronbach's alpha coefficients for the four subscales ranged from 0.87-0.98 with a sample of graduate nursing students (Watson, 2002).

1.10 Thai Nurses' Caring Behavior Scale (TNCBS)

The TNCBS was developed by Udomluck and colleagues in 2010 based on the caring definition and dimension from an integrated review of

relevant literature, focus group discussions with 30 patients, and individual interviews with 7 patients. Six dimensions with 87 items from these processes were found to be included in the Thai nurses' caring behaviors. These items were assessed by three nursing experts who had backgrounds in qualitative research, caring content and instrument development. As a result of the experts' assessments, 30 of the original 87 items, with five items in each of the six domains, were retained for the first version of the TNCBS. The first version of the TNCBS was designed using a 4-point Likert-like format ranging from 4 (always practice) to 1 (hardly or did not practice).

The first version of the TNCBS was reviewed for content validity by five experts. Revisions were made in the instrument based upon the experts' feedback. The second version consisted of an acceptable 63-item.The second version was examined for internal consistency, stability and face validity to assess accuracy, clarity, appropriateness in terms of readability and length of time for responding to the scale. Cronbach's alpha coefficient was used to determine the scale's internal consistency and found to be 0.98 for the overall scale.

2. Measurement tools for specific nurse's caring behaviors in end of life care

The Caring Behaviors for Dying Patients of Thai Nurses (CDP) Scale was developed by Daodee (1998). The conceptual framework used in development of the CDP is based on Watson's caring theory and Kubler-Ross's conception of human responses of dying patients. The CDP consisted of 65 items with a four-point Likert scale. This instrument was used in another two studies to

measure the caring behaviors of nurses in caring for dying patients. The reliability of the CDP ranged from .95 to .96 (Amonprompukdee, 2004; Daodee, 1998).

In conclusion, based on these eleven tools in measuring the caring behavior of nurses, nine tools were developed in western countries. Two tools including TNCBS and CPD were developed in Thailand. Almost all of the tools used to measure caring behaviors of the nurses in general situations, only the CPD was developed to measure the caring behaviors of the nurses in specific in end-of-life care

Different caring instruments are based on varying definitions of caring. The majority of these instruments conceptualize caring as nursing competencies and skills. Only one CBI was conceptualized as an interpersonal intervention. This views caring as an intimate exchange between the nurse and patient that can enhance the growth of both parties which falls into the confidence component based on Roach six caring attributes.

Although the ten instruments stated were developed to measure caring behaviors in general, they also can be applied to a specific situation, for example, the CPD which was developed from the general instrument of CBA to measure caring behaviors of nurses in EOLC context. However, the difference of the CPD and the NCBDPQ, which was used in this study, is that the NCBDPQ is used to measure the attributes of the nurses in caring for dying patients, not for measuring nursing activities.

Factors Related to Nurse's Caring Behaviors for Dying Patients and Families

Several factors that are related to nurse's caring behaviors for dying patients are categorized into two groups; personal factors and environment factor.

1. Nurse's personal factors

The demographic data of nurses that was considered as relating factors to caring behaviors for dying patients included age, professional experience, training experience, experience of caring for dying patients, educational level, self-awareness, and moral distress.

Age. Erikson (1993) stated that age is associated with development and maturity level, therefore an older person has a better pattern in the way of life than a younger person. The increasing age will increase the maturity level and responsibility of working. Numerous studies showed that age is associated with the caring behavior of nurses. However, the relationship between the age of a nurse and caring behaviors for dying patients remains inconclusive. Some studies have shown that senior nurses have higher levels of caring behaviors for dying patients than younger nurses (Amonprompukdee, 2004; Lange et al., 2008). However, there are several studies which found that there is no significant correlation between age and a nurse's caring behaviors for dying patients (Jaidee, 1997; Pokpalagon, 2005; Servaty, Krejci, & Hayslip, 1996; Wattanachote, 1997). Wattanachote (1997) studied the perception and caring behavior for the communication of truth telling about dying in 593 intensive care unit nurses in 16 government hospitals in the metropolitan city of Bangkok. It was found that nurses of different ages and experiences had no significant difference in the perception on communicating the truth and talking about dying.

Professional experience. Professional experience is very important for every profession especially in nursing. According to Orem (1995), professional experience is a factor that is related to an expert level of nursing practice. The expert nurse, who has worked for several years gains professional experience in taking good

care of the EOL patient more than the beginner nurse which can be reflected by their caring behaviors. There are several studies which found that years of professional experience have a positive relationship with the nurse's caring behavior (Apaiwong, 2000; Brunton & Beama, 2000; Lange et al., 2008; Mateprasart, 1991; Noh et al., 2002; Suwanmalee, 1996; Wattanachot, 1997). Nevertheless, some studies have shown that there were no significant difference between professional experience and caring behaviors (Limvipaveeanan, 1992; Mahanuparp, Leksawat, & Sukumwang, 1998).

Training experience. A substantial number of studies reported that special training and coursework about death and dying improved caring behaviors toward terminally ill patients and their families (Tsai et al., 2005; Wong et al., 2001). Similarly, ICU nurses perceived that training is an important method that can improve the skills of caring for EOL patients and their families (Chaipet 2008). It was found that lack of training courses is the main barrier for ICU staff nurses and health care providers to provide the optimal care for the end of life patients (Carlet et al., 2004; Chaipet 2008). On the other hand, a study of Pokpalagon (2005) found that there was no significant difference in the caring behaviors in end of life care of professional nurses by training experience (n=270, F= 1.112). However, this study was conducted only in a government hospital in Bangkok.

Experience of caring for dying patients. The direct experience about death and dying significantly correlated with nursing competency in taking care of the patient at the end of life (Pratumwan & Unipun, 1995). The study of Chaipet (2008) found that the increasing amount of a nurse's direct experience in taking care the EOL patient helped nurses learn and understand their role in taking care of the

EOL patients. In addition, a study of Pokpalagon (2005) found that there was a positive relationship between experience of caring for dying patients and the caring behaviors of the nurses. This study explained that the higher number of EOL patients under the care of the nurses would provide nurses to gain a deeper understanding in the needs of patients, the emotional change in patients, and the physio-psychological change of patients. Hence, nurses having more experience would know how to respond to their patients with a higher level of caring abilities for EOL patients.

Educational level. Learning is the way to gain more knowledge in each branch of interest. The higher educational level of a person provides more systematical thinking, competency, and skills in searching for new knowledge when compared to a person with a lower educational level. Wattanachote (1997) found that there were significant differences among educational levels, perception, and communication for truth telling about dying ($p<0.05$). The nurses who have an education higher than bachelor degree level had better communication for truth telling about dying more when compared to nurses who possessed only a bachelor degree.

Religion background. For Thai nurses, religion seemed to be the most influencing factor on caring behaviors. In Thailand, Buddhism is the main religion. Islam is the second most practiced religion for Thai people (Thailand Health Profile, 2001-2004).The main teaching of Buddhism is the integrating of compassionate (karuna) and conscience care (do no evil, to cultivate good, and to purify the mind) (Payutto, 2001).There is some evidence that Buddhism influences nurses' caring behaviors in Thailand, especially with regard to moral competence (Jormsri, Kunaviktikil, Katefian, & Chaowalit, 2005), cultural care (Lundberg, 2000), and the meaning of death (Wisesrith, Nuntaboot, Sangchart, & Tuennadee, 2003). All

of these results support the influences of Buddhism on the nurses', patients, relatives' caring behavior and relationships.

McGrath (1998) discussed Buddhist spirituality as a compassionate perspective on hospice care. She asserted that the practical, everyday metaphysics of Buddhist philosophy, which are based on notion of compassion and wisdom, a willingness to serve, a tolerance or a duty to do no harm, and the significance of death, shares the commonality with a hospice discourse. In addition, Phosrithong (1993) also found that nurses who scored high regarding the Dhamma had more positive caring behaviors than those nurses who scored low in this section. Moreover, Hirst (2003) explored the notion of mindfulness from a number of perspectives and concluded that the Buddhist understanding of mindfulness provides an excellent strategy for preparing to be active in a caring relationship.

Nurse's self-awareness. Self-awareness is commonly used in psychiatric nursing to enhance the interpersonal relationship between the nurse and patient through the communication process. Nowadays this concept is applied in a variety of nursing contexts (Eckroth-Bucher, 2010).

The original statement of the self-awareness theory was developed by Duval and Wicklund in 1972. They described a simple system of self-awareness which consisted of self, standards, and attentional focus. The theory assumed that the orientation of conscious attention was the essence of self-evaluation. Self was defined very broadly as the person's knowledge of the person. Focusing attention on the self brought about an objective self-awareness, which initiated an automatic comparison of the self against standards. A standard was defined as a mental presentation of correct behavior, attitude, and trait. If a discrepancy was found between self and

standards, a negative effect was said to arise. This aversive state then motivated the restoration of consistency. Two behavioral routes were proposed. People could either actively change their actions, attitudes, or traits to be more congruent with the representation of the standard.

In 1975, Fenigstein, Scheier, and Buss proposed useful classic distinction of self-awareness. In their concept the two terms of self-consciousness and self-awareness were used interchangeable. However, a recent study identifies the difference between these two terms. Consciousness was described as the level of self-awareness. Morin (2006) categorized four levels of consciousness, beginning with unconsciousness which referred to not awake and having non self-awareness, followed by consciousness which means being awake but having non self-awareness. The third level of consciousness is being awake and aware in one's self and the last level of consciousness refers to the highest level of self-awareness which was called meta-self-awareness. Fenigstein et al. defined self-awareness as the capacity to become the object of one's own attention. It occurs when an organism focuses not on the external environment, but on the internal milieu; it becomes a reflective observer, processing self-information. Self-awareness consists of two dimensions, namely private self-awareness and public self-awareness. Private self-awareness refers to a tendency to focus on the internal aspects of the self such as thinking and feeling, whereas public self-awareness describes a tendency to focus on the external, observable aspects of self such as behavior, talking, and action (Fenigsteinet al.). Not only the theory but Fenigstein et al. also developed a Self-Consciousness Scale to measure differences in private and public self-consciousness.

In 1998, Burnard introduced a concrete concept of self-awareness. He defined self as thoughts, feelings, and behaviors/acting. Therefore, the straight definition of self-awareness is the awareness of one's own thoughts, feelings, and behaviors. He also extended that definition a little further which included the notion of being aware of the effect that one has on other people.

The theory also described the value of self-awareness. Rungapadiachy (1999) states that being self-aware should be compulsory for every nurse in the health profession. Several studies found that self-awareness in the nurse is very important for the nursing profession in providing care for the client (Cook, 1999; Jack & Miller, 2008; Jack & Smith, 2007; Rowe, 1999). Bernard (1992) suggests that developing self-awareness helps nurses to be less of a victim and enables nurses to take control and responsibility for a situation and it also helps nurses to cope when confronted with a difficult situation while taking care of their clients (Smith, 2007). In addition, self-awareness is an important key for improving nurse-client relationships via the communication/counseling technique (Rowe, 1999). The understanding and acceptance of own self will allow the nurse to acknowledge a client's differences and uniqueness which can help the nurse to express more compassionate care (Townsend, 2003). Daodee (1994) developed the measurement in Thai language based on the self-awareness concept of Burnard and the self consciousness scale of Fenigsteinet al. to measure Thai nurses' self-awareness and its relationship with caring behaviors in caring for the dying patient. The results from this study found that a nurse's self-awareness correlated positively with caring behaviors at a moderate level with a significance level of $p < 0.001$ ($r = 0.31$). This finding was consistent with a study of Intong et al. (2005) on nurses' awareness and behavior for caring for HIV/AIDS

patients who receive ARV in 136 registered nurses. The findings showed a significant positive correlation between nurse self-awareness and caring behaviors at a moderate level (r = .31, p = .025). Not only the quantitative studies but also the qualitative study found that to care for the dying patient the nurse also should have self-awareness (Chaipet, 2008). Another study of Kongsuwan & Locsin (2010) found that Thai ICU nurses caring for a person who had a peaceful death expressed that to help the dying patient face a peaceful death, the nurse's readiness of mind to care is very important. In this study, the participants explained the readiness of mind is focusing in their thoughts on wishing and good fortune for the dying persons.

Moral distress. Morality is commonly part of religious belief, a primary role of religion is to exert control over its followers by setting and promoting rules and customs for people to follow (Ratanakul, 2004). This human condition of moral distress certainly existed before Andrew Jameton put a name to it, and his description of moral distress is the first instance of this concept appearing in literature. Many researchers have tried to refine definitions or offer examples for clarification of the concept. However, nearly every subsequent source relies on Jameton's definition.

Jameton, in his 1984 nursing ethics textbook (as cited in Jameton, 1993) distinguished moral dilemma from moral distress. Moral dilemma arises when two or more principles or values conflict or more than one principle applies and there are good reasons to support mutually inconsistent courses of action. On the other hand, moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action. Coley et al. (2001) defined moral distress as the painful feelings that arise when the nurse knows the morally correct thing to do but cannot act because of constraints or hierarchies.

Various literature has found that moral distress is a major problem in the nursing profession especially in end-of-life care. Most of the studies found that the situations related to EOLC are the major situations that cause moral distress in nursing practice. For example, role conflict, differences between physicians and nurses, end of life decision making, critical care vs fertile care, and managing care directives are identified as sources of the nurse's moral distress in taking caring of dying patients (Corley et al., 2001; Elpern et al., 2005; Oberle & Hughes, 2001; Schwarz, 2003; Ulrich et al., 2003).

To measure moral distress, many measurements have been developed. However, the Moral Distress Scale (MDS) is the most well validated instrument and has more psychometric information than any other measures (Lerkiatbundit & Borry, 2009). The MDS was first developed by Coley with the original 32-item based on Jameton's concept of moral distress. The second revision of MDS consisting of 38 items was also developed by Coley et al. (2001) for use in critical care nurses. In 2007, Hamric and Blackhall developed 21 items of the Shortened Form of Corley's Moral Distress Scale which is specific in EOLC.

Lack of research study in this field describes the relationship between moral distress and caring behavior. However, some studies explain that moral distress has an impact on inadequate and inappropriate care of a patient, which can be reflected from caring behaviors (Lerkiatbundit & Borry, 2009). As such nurses may feel guilty and blame themselves for not living up to their professional ideals, and may develop an increasing sense of powerlessness that limits their capacity for self-efficacy (Kelly, 1998; Tiedje, 2000). Nurses may also experience a decreased capacity for caring (Nathaniel, 2002; Wilkinson, 1988) which reflects a low caring

competency. In addition, moral distress is associated with ineffective communication, fragmented care and lack of advocacy, which in turn is associated with inadequate or inappropriate conscience behavior (Bowers et al., 2000; Wilkinson). Moreover, the nurses who experienced repeated moral distress may lose the ability to provide quality patient care (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005a). Nurses may avoid the role of a primary nurse or by decreasing their interaction with patients and their families (Corley, 2002; Nathaniel) which reflects a decrease in conscience and commitment in caring. Religion has been found to be a strategy people use to cope with situations leading to moral distress. Religion helps persons overcome suffering by finding the meaning, purpose and hope in life (Baldacchino & Draper, 2001). Meltzer and Huckabay (2004) found that nurses who didn't consider religion to be important in their lives were significantly more emotionally exhausted than nurses who reported that religion was very important in their lives.

Opposite to these negative effects mentioned, moral distress also has a beneficial effect, in that it facilitated personal and professional growth and led to more skill in compassionate care. Benner (1991) suggested that being open to new experiences implies learning from failure which link to further experiences about emotional responses along with a resolve to avoid this painful lesson again.

2. *Environmental factor*

Working unit. The units in the hospital, can be separated into two types such as; a general unit and intensive care unit. There are some differences between these two units that can be a barrier for the nurse to provide good care for the end of life patient. In ICU, where a critically ill patient needs to be taken care of, the ratio of nurse to patients is 1:2 which increases the opportunity for ICU nurses to

provide care for the dying patient. Nurses cannot pay more attention to only one patient because of lack of time due to a heavy work load and a high patient to nurse (Beckstrand et al., 2006). Nurses expressed frustration in their practice about the lack of time for caring. They identified the lack of time to be a common barrier to providing good care for EOL patients in ICU results in decreasing quality of care (Beckstrand et al.).

Losawadkul and Poungchompoo (2004) studied families' needs of critically ill cardiovascular disease patients in the EOL and found that most family members wanted to be bedside with the patient until the last minute of life. But, the regulations of the intensive care unit limit the time and number of persons visiting the patient which seems to be a barrier. So, in this situation, it can reflect that nurses cannot provide holistic nursing care during the end of life care to the family members which is an important component of end of life care.

The environment is a barrier in providing quality EOLC. A study by Simpson (1997) about the experiences of nurses caring for hopelessly ill patients in an intensive care unit (ICU) found that the nurses reported that the environment in ICU is a barrier for nurses to provide holistic care to the patient and their family at the end of life. Because in ICU there is a lot of equipment for taking care of the patient such as a ventilator, drainage tubes, and intravenous lines and also the sound of ventilator machines or many equipment alarms that cause the family to feel fear and less comfortable to stay beside the patient. The environment in ICU causes the family to be separated from the patient.

According to the above mentioned reports, the results of these studies in the EOLC field are inconclusive. Some studies showed that a nurse's self-

awareness, technological factor, moral distress, and the personal factors are related factors in the caring behaviors of the nurse for a dying patient while some studies do not report such findings. Therefore, this study would like to examine the relationship between these personal factors and environmental factor with the nurse's caring behaviors for dying patients.

Summary

In conclusion, the dying patient is the hospitalized person who is diagnosed with an advance disease or the patient who is terminally ill or has no curative treatments and has less than one month left for his or her life. During the dying process, both dying patients and their families face various types of suffering. The patients suffer from pain, dyspnea, fatigue, nausea and vomiting, and delirium which are the physical impact from terminal illness. Inability to speak their wishes, isolation due to restricted visiting times, and economical problems contribute to anxiety, depression, and loneliness. The patients do not know when they will die which leads to uncertainty and helplessness. In addition, the inability to perform religious practices and find the meaning of life causes spiritual distress and religious pain. Moreover, families also experience various impacts including physical decline, headache, and weight loss; psychological; and spiritual distress.

Therefore, the patients and their families need some help from health care providers. Nurses play a vital role in taking care of the patients. They need to conduct symptom management especially pain management, information, psychological, and spiritual support. To serve the needs and relieve the suffering of the patients and their families, a nurse's caring behaviors play a direct role. Roach's

Six Cs caring concept is the six attributes of a nurse which can reflect the nurse's caring behaviors for dying patients. To care for dying patients, nurses need to possess compassion, competence, confidence, conscience, commitment and comportment behavior. However, there are various factors relating to a nurse's caring behavior for dying patients such as personal factors including age, professional experience, training experience, experience of caring for dying patients, educational level, religion background, self-awareness, and moral distress; and the environmental factor which is the type of working unit.

CHAPTER 3

RESEARCH METHODOLOGY

This chapter describes all the elements of research methodology including research design, setting, sample size estimation, instruments, ethical consideration, data collection procedure, and data analysis of the research study.

Research Design

The descriptive correlation design was used to examine the relationship between nurses' personal factors including age, professional experience, training experience, experience of caring for dying patients, self-awareness, and moral distress; and working unit with nurses' caring behaviors for dying patients.

Population and Settings

The target population in this study was registered nurses, who took care of hospitalized patients in intensive care units, general medical wards, and general surgical wards in general hospitals, regional hospitals and university hospital in southern Thailand. The total populations were 2,174 registered nurses.

In southern Thailand, the hospitals are classified into three levels based on the number of beds i.e., community hospitals which had less than 120 beds, general hospitals which consisted of 120-500 beds, and regional hospitals having more than 500 beds. General hospitals were secondary care level and regional hospitals were at tertiary care level. Not only were general and regional hospitals included in this study but also university hospital which was built as teaching and

learning places for health science students. Therefore, these three settings have a responsibility in providing advanced care for patients including terminally ill patients. From personal interviews with nurse administrators, it was found that in some hospitals the units were separated only ICU, surgical ward, medical ward, orthopedic ward, pediatric ward, and obstetric ward. The top three units that have the highest incidence of death were ICU, surgical ward, and medical ward.

Therefore, in this study the data were collected from nurses who worked in ICU, a general medical ward, and a general surgical ward of general hospitals, regional hospitals, and university hospital. In southern Thailand, there are fifteen general hospitals, five regional hospitals and one university hospital.

Sample and Sample Size

Sample

The following inclusion criteria were used to recruit subjects in this study (1) Licensed as registered nurse (RN), (2) worked in ICU, a general medical ward, or a surgical ward for at least one year, and (3) willing to participate in this study.

Sample size

The estimated number of subjects was determined by power analysis. In quantitative correlation studies, power analysis is useful to ascertain the significance of the study findings (Polit & Beck, 2008). The necessary sample size was estimated at a level of significance (α) of .05, which is the accepted minimum level of significance. The power of .80 is a conventional standard for the power of the test. Since the caring construct of this study was operationalized differently from the

previous study and had various variables, the researcher used a small effect size of 0.20 to ensure that the small variation of the phenomenon under this investigation could be observed. Using these parameters, the estimated sample size was 197 (Polit & Beck, 2008, p. 601).

However, previous studies found that only 20 percent of the respondents choose to answer the questionnaire by postal mail (Schleyer & Forrest, 2000; Zhang, 2000). Therefore, it can be assumed that approximately an 80% response rate was anticipated. To overcome the anticipated low response rate, the researcher added an extra 80% of samples to the estimated sample size and which yields a total number of 360 registered nurses to be the actual sample size for this study.

Sampling Technique

In this study, the stratified proportionate random sampling was used in order to recruit a representative sample. Before randomly sampling, the researcher determined the number of registered nurses working in ICUs, medical wards, and surgical wards in general hospitals, regional hospitals, and university hospital in southern Thailand during the data collection period.

Then, the researcher separated the strata level of each hospital into general hospital and regional/university hospital. After that the researcher randomly selected 50% of the hospitals in each stratum. In this stage, the hospital names were announced. For the next step, the researcher identified the strata level of each selected hospitals into ICUs and general units and then calculated the number of nurses in each unit based on the following formula.

$$\frac{n \times n1}{N}$$

n = Number of samples in this study (n = 360)

n1 = Number of samples in each strata

N total = Total population of randomly selected hospitals (N = 1,438)

Example: Chumphon Khet Udomsakdi Hospital

- Number of samples in ICU = (360 × 43)/1,438 = 11
- Number of samples in general unit = (360 × 42)/1,438 = 11

Table 1

Number of Registered Nurses in Selected Hospitals in Southern Thailand

Hospital	ICU	Number of samples in ICU	General unit	Number of samples in general unit	Total
General hospitals					
1. Chumphon Khet Udomsakdi Hospital	43	11	42	11	22
2. Ranong Hospital	17	4	56	14	18
3. Phang-nga Hospital	17	4	45	11	15
4. Vachira Phuket Hospital	34	9	66	17	26
5. Krabi Hospital	16	4	44	11	15
6. Phatthalung Hospital	19	5	101	25	30
7. Naradhiwasrajanagarindra Hospital	30	8	135	33	41
8. Songkla Hospital	20	5	103	26	31

Table 1 (continued)

Hospital	ICU	Number of samples in ICU	General unit	Number of samples in general unit	Total
Regional/university Hospitals					
1. Maharaj Nakhon Si Thammarat Hospital	51	13	230	57	70
2. Trang Hospital	30	8	54	14	22
3. Songklanagarind Hospital	136	33	149	37	70
Total	413	104	1025	256	360

The sampling technique is shown in Figure 2.

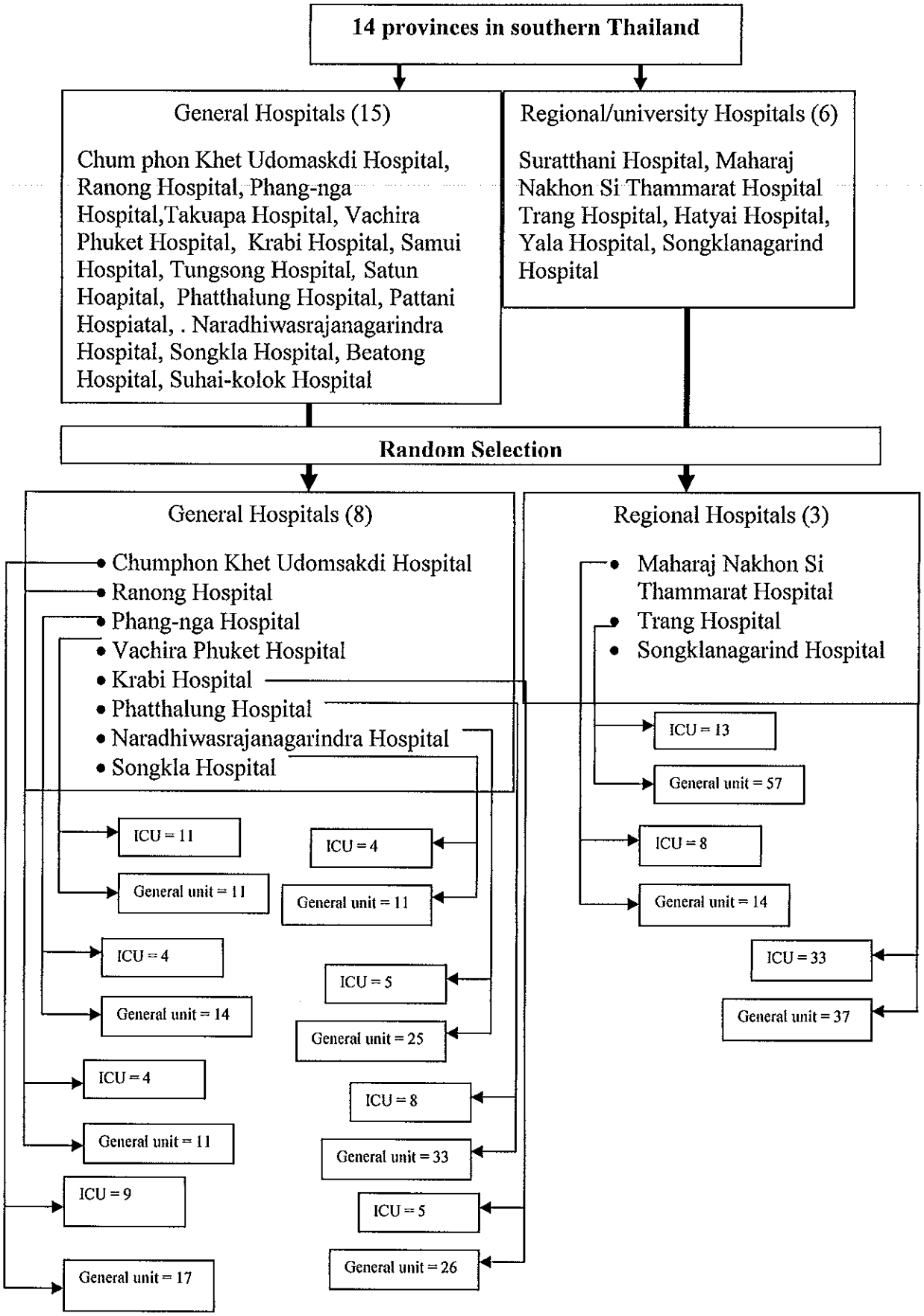

Figure 2 Sampling technique

Instrumentation

The questionnaires used in this study consisted of four parts: Demographic Data Questionnaire (DDQ), Nurse's Caring Behavior for Dying Patient Questionnaire (NCBDPQ), Nurse's Self-Awareness Questionnaire (NSAQ), and Shortened Form of Corley's Moral Distress Scale.

Part 1: Demographic Data Questionnaire (DDQ)

The DDQ was developed by the researcher. It consisted of 13 items, including age, gender, religion, religious practice, educational level, professional experience, the name of hospital, working unit, experience of caring for dying patients, training experience about end-of-life care, self study related to end-of-life-care, perceived knowledge related to end of life care, and responsibility about end of life care program.

Part 2: Nurse's Caring Behaviors for Dying Patients Questionnaire (NCBDPQ)

The NCBDPQ was developed for this study based on Roach's six Cs caring concept and related literature. It was a 40-item, self-report instrument which measures the perception of the nurse on the frequency of actions or performances she or he performs while providing care for the dying patients. The scale was designed to measure six dimensions of nurse's caring behaviors for dying patients which consisted of Compassion (items 1 to 7), Competence (items 8 to 17), Confidence (items 18 to 22), Conscience (items 23 to 28), Commitment (items 29 to 35), and Comportment (items 36 to 40). Participants were asked to rate their level of these actions on a 4-point scale ranging from 0 (never) to 3 (regularly). The total score was

transformed by summing each item score divided by number of total items (40 items). Similarly, the subscale scores were transformed by summing the items of each subscale divided by its number of total items. The scoring criteria and score interpretation are as follows:

Scoring Criteria

Never (0)	refers to	the participant never performed that behavior for the dying patients at all
Sometimes (1)	refers to	the participant performed that behavior for the dying patients occasionally
Often (2)	refers to	the participant performed that behavior for the dying patients frequently
Regularly (3)	refers to	the participant performed that behavior for the dying patients regularly

Score interpretation

The transformed total score and subscale score were interpreted as follows:

Score	Level of nurse's caring behaviors for dying patients
0.00 - 1.00	Low level
1.01 - 2.00	Moderate level
2.01 - 3.00	High level

Part 3: Nurse's Self-Awareness Questionnaire (NSAQ)

The NSAQ was developed by Daodee in Thai language (1994) based on Duval and Beck's (1972) and Fenigstin et al.'s (1975) self consciousness scale. It

was a 20-item self report instrument which measures the perception of nurses on knowing and understanding oneself when providing care for dying patients. The scale was designed to measure two dimensions of a nurse's self-awareness which were private self-awareness and public self-awareness, each consisting of 10 items. Two dimensions of a nurse's self-awareness were measured: private self-awareness (item 1-10) and public self-awareness (item 11-20). These two dimensions consisted of sixteen positive statements (items 1-3, 5-8, and 10-18) and four negative statements (items 4, 9, 19-20). Participants were asked to rate their level of self awareness on a 4-point scale ranging from 1 (disagree) to 4 (strongly agree). The score of a nurse's self-awareness ranged from 0-80. The NSAQ has shown adequate validity and reliability and has been used to explore a nurse's self-awareness in caring for dying patients (Daodee). The internal consistency reliability was .80. The score of negative statements were reversed to be 4 (disagree) to 1 (strongly agree). The total score was transformed by summing each item score divided by the number of total items (20 items). Similarly, the subscale scores were transformed by summing the items of each subscale divided by the number of total items. The scoring criteria and score interpretation are as follows:

Scoring Criteria

Disagree (1)	refers to	the participant does not agree with the statement at all
Slightly agree (2)	refers to	the participant neither disagrees nor agrees with the statement

Mostly agree (3)	refers to	the participant agrees with the statement
Strongly agree (4)	refers to	the participant agrees with the statement to a considerable extent

Score interpretation

The transformed total score and subscale score were interpreted as follows:

Score	Level of self-awareness
1.00 - 2.00	Low level
2.01 – 3.00	Moderate level
3.01 – 4.00	High level

Part 4: Shortened Form of Corley's Moral Distress Scale

The 21-item Shortened Form of Corley's Moral Distress Scale was used to measure moral distress that nurses experienced in each clinical situation while caring for dying patients (Hamric & Blackhall, 2007). Participants were asked to rate their level of perception in moral distress using a 5-point scale ranging from 0 (none) to 4 (great). The Shortened Form of Corley's Moral Distress Scale has shown adequate validity and reliability. The reliability of the Shortened Form of Corley's Moral Distress Scale was .85 when applied to a study of nurse-physician perspectives on the care of dying patients in intensive care units. The total score was transformed by summing each item score divided by number of total items (21 items). The scoring criteria and score interpretation are as follows:

Scoring Criteria

None (0)	refers to	there is no moral distress in the situation
A little (1)	refers to	the level of moral distress in situation is more than 0%
Moderate (2)	refers to	the level of moral distress in situation is more than 25%
Much (3)	refers to	the level of moral distress in situation is more than 50%
Great (4)	refers to	the level of moral distress in situation is more than 75%

Score interpretation

The transformed total score was interpreted as follows:

Score	Level of moral distress
0.00 – 1.33	Low level
1.34 – 2.66	Moderate level
2.67- 4.00	High level

Regarding the copyright issue, the permission for using the Nurse's Self-Awareness Questionnaire and translation to English language was granted and approved by the Dean of Graduate School, Mahidol University and for using the Shortened Form of Corley's Moral Distress Scale and translation to Thai language was also granted and approved by Dr. Hamric (Appendix G).

Validity and Reliability of the Instruments

Content validity

The content of each item of the Nurse's Caring Behaviors for Dying Patient Questionnaire was tested for the clarity, validity, and appropriateness of the language used by three experts which included one nurse and two nursing lecturers (Appendix F).

Reliability

The NCBDPQ Nurse's Caring Behaviors for Dying Patients Questionnaire, the NSAQ and the Shortened Form of Corley's Moral Distress Scale were tested for internal consistency by using Cronbach's alpha coefficients yielding the value of .97, .93, and .94, respectively. Moreover, six sub-dimensions of the Nurse's Caring Behaviors Questionnaire namely, compassion, competence, confidence, conscience, commitment, and comportment were also tested for internal consistency by using Cronbach's alpha coefficients yielding the value of .89, .92, .92, .89, .88, and .82, respectively. The reliability test was performed with 30 registered nurses who had similar criteria to the study subjects. The Cronbach's alpha coefficient of the instruments were in the acceptable range > .70 for a newly developed instrument and > .80 for the old instrument (Burns & Grove, 2007).

Translation of the Instruments

The original instrument of the Shortened Form of Corley's Moral Distress Scale was developed in the English language. Then, it was validated by three experts from the Faculty of Nursing, Prince of Songkla University, Thailand. In order to ensure equivalence of the version of these instruments in the Thai language, the

researcher applied the back translation technique. The preferred back-translation approach requires at least two independent translators (Hilton & Skrutkowski, 2002). In this approach, the first translator worked independently to produce a translated version. A second translator translated the translated version back to the original language. The third translator is then consulted to identify discrepancies, and adjustments are made for inconsistencies.

The Nurse's Caring Behaviors Questionnaire and the Nurse's Self Awareness Questionnaire, which were developed in the Thai language, also used the back translation process to produce the English version in order to publish them in this thesis.

Data Collection Procedure

Data collection procedures consist of two phases: the preparation phase and the collection phase.

Preparation phase

1. Permission for the study and ethical approval were obtained from the Faculty of Nursing, Prince of Songkla University, Hatyai, Thailand.

2. Permission was obtained from the directors of the selected hospitals.

3. After getting permission, the researcher contacted the head of the nursing department of each selected hospital to help in distributing and sending the questionnaire back to the researcher.

Collection phase

1. The nurses who met the inclusion criteria were identified.

2. The set of instruments used for collection were sent to each hospital by postal mail, except for Trang hospital, Songkla Hospital, and Vachira Phuket Hospital where the researcher distributed the questionnaires to the head nurses of each ward.

3. The subjects who agreed to participate in this study completed the questionnaires and sent them back to the nursing department within one week. After that, all of the questionnaires were sent to the researcher by postal mail. For those three hospitals mentioned above, the researcher collected the questionnaires back from the head nurses of each ward after one week.

Ethical Consideration

This study was conducted with the intention of protecting the human rights of all subjects. Prior to data collection, consent was obtained in order to assure the protection of human rights was ensured. The research proposal and instruments were approved by the Institutional Review Board, Faculty of Nursing, Prince of Songkla University (PSU), Thailand, and permission for data collection from the Directors of the selected hospitals was also obtained.

A covering letter giving assurances together with a demographic data form, and patient advocacy questionnaire, stating the purposes, procedures, and expected outcomes of the study were distributed to each subject. Subjects were asked for their willingness to participate, with the option to participate and/or withdraw from the study at any time without prejudice to them. In addition, the privacy of the subjects through anonymity was maintained. Each set of questionnaires were coded and the subject's name did not appear on it. Moreover, the security of the data during

the study was maintained. Only the researcher and her advisor were able to have access to the data.

Data Analysis

Computer software was used for the processing. The statistically significant level was set at .05. The analysis procedures were as follows:

1. Demographic data were analyzed by using frequency, percentage, mean, standard deviation, minimum, and maximum score.

2. Nurses' caring behaviors, nurses' self awareness, and moral distress were analyzed by descriptive statistics: mean, and standard deviation.

3. To examine factors relating to nurses' caring behaviors for dying patients, the following analyses and relevant statistic were performed.

3.1 Bivariate analysis. For factors that were measured at interval scale level, the relationship between this variable (self-awareness and moral distress) and caring behaviors was examined using Pearson product-moment correlation coefficients (r). If the assumptions of parametric statistics (normal distribution, homoscedasticity and linearity) were violated, the Spearman rank-order correlation coefficient (rho, r_S) was used.

3.2 Test of difference in analysis (T-test and ANOVA)

3.2.1 For two level factors, the independent t-test was used if the assumptions were met. The variable that did not meet the assumptions (categorical independent variable, normal distribution of independent variable, and homogeneity of variance between sample groups) was analyzed using the Man Whitney U test.

3.2.2 For three or more level factors (experience of caring for dying patients), One-way Analysis of Variance (ANOVA) was used. The comparable non-parametric test, Kruskal Wallis H Test was substituted if the assumptions of ANOVA were violated

CHAPTER 4

RESULTS AND DISCUSSION

This chapter presents the results of this study and discusses the findings of each research question. The results and discussion of the study are presented as follows:

1. Nurses' characteristics

2. Nurses' caring behaviors for dying patients in southern Thailand

3. The relationship between nurses' personal relating factors and nurses' caring behaviors for dying patients.

4. The relationship between environmental relating factor and nurses' caring behaviors for dying patients.

Results

Nurses' Characteristics

Table 2 presents an overview of the demographic characteristics of the nurses. Initially, three hundred and sixty questionnaires were distributed. Three hundred and fifty three returned questionnaires were used for the data analysis (98.06 % response rate). The samples consisted of 353 registered nurses.

The age of the participants ranged from 23 to 58 years with an average age of 34.36 (SD = 7.30). Females represented 98% of the study sample. About eighty-six percent were Buddhist. Three-fourths of respondents identified themselves as being moderately strict in religious practice. The majority were Bachelor-degree nurses (92.4%). The general working unit (69.1%) was noted to be the most frequent

specialty, while the rest of the sample (30.9%) represented Intensive Care Unit as their working unit.

The professional experience ranged from 1 to 35 years with a mean of 9.76 (SD = 6.54). Approximately, fifty-four percent of the respondents had experience in caring for more than fifteen cases of dying patients within the last year. About forty percent were trained by attending work shops or conferences relating to end of life care.

More than half of the respondents had self-directed learning related to EOLC (58.07%). Around three-fourths of them perceived their knowledge in caring for dying patients at a moderate level (77.1%), followed by a mild level of perceived knowledge (n = 48, 13.6%). Obviously, 66.6% of the respondents had a responsibility about the end of life program in their unit (Table 2).

Obviously, the respondents perceived the level of their self-awareness at a high level with the mean score of 3.14 (SD = 0.39). In contrast, moral distress was at a moderate level with the mean score of 2.16 (SD = 0.66) (Table 3).

Table 2

Frequency and Percentage of Nurses' Demographic Characteristics (N = 353)

Characteristics	n	%
Age (years)		
(M = 34.36, SD = 7.30, Min = 23, Max = 58)		
20-30	111	31.5
31-40	166	47.0
> 40	76	21.5
Gender		
Female	346	98.0
Male	7	2.0
Religion		
Buddhist	302	85.6
Islamic	43	12.2
Christian	8	2.2
Educational level		
Bachelor degree	326	92.4
Master degree	27	7.6
Perception about their religious practice		
Very strict	12	3.4
Moderate strict	266	75.4
Not strict	75	21.2
Working Unit		
General Unit	244	69.1
ICU	109	30.9

Table 2 (Continued)

Characteristics	n	%
Professional experience (years)		
(M = 9.76, SD = 6.54, Min = 1, Max = 35)		
1-5	115	32.6
6-10	113	32.0
11-15	61	17.3
>15	64	18.1
Experience of caring for dying patients		
1-5	47	13.3
6-10	67	19.0
11-15	47	13.3
>15	192	54.4
Training experience in caring for the dying patient		
Yes	143	40.5
No	210	59.5
Self study		
Yes	205	58.07
No	148	41.93
Perceived knowledge about care for dying patients		
High	33	9.3
Moderate	272	77.1
Mild	48	13.6
Responsibility about end of life program		
Yes	235	66.6
No	118	33.4

Table 3

Mean, Standard Deviation, and the Level of Nurses' Self-Awareness and Nurses' Moral Distress (N = 353)

Personal perceptions	M	SD	Level
Self-awareness	3.14	0.39	High
- Private self-awareness	3.13	0.41	High
- Public self-awareness	3.14	0.44	High
Moral distress	2.16	0.66	Moderate

Nurses' Caring Behaviors for Dying Patients

Descriptive analyses were computed in the NCBDPQ and its subscales. The NCBDPQ was designed to measure a nurse's perception on the frequency of actions or performances she performed while providing care for dying patients (Table 4). On average, most participants reported a high level of caring behaviors for dying patients (M = 2.12, SD = 0.43). Interestingly, the highest caring behaviors of the southern Thai nurse were conscience (M = 2.39, SD = 0.47), followed by compassion (M = 2.29, SD = 0.50), and next was commitment (M = 2.18, SD = 0.52). Comportment was found to be the fourth highest caring behavior (M = 2.11, SD = 0.52) and the fifth was confidence (M = 2.08, SD = 0.59). Surprisingly, competence was found to be the lowest caring behavior at a moderate level (M = 1.82, SD = 0.51), as presented in table 4.

Table 4

Mean, Standard Deviation, and the Level of Nurses' Caring Behaviors for Dying Patients and Subscale of the Nurses' Caring Behaviors for Dying Patients (N = 353)

Nurses' Caring Behaviors	M	SD	Level
Conscience	2.39	0.47	High
Compassion	2.29	0.50	High
Commitment	2.18	0.52	High
Comportment	2.11	0.52	High
Confidence	2.08	0.59	High
Competence	1.82	0.51	Moderate
Total	2.12	0.43	High

Five Items with Highest Mean Score and Five Items with Lowest Mean Score of the Nurses' Caring Behaviors for Dying Patients

Additional item analysis was made to rank each stated behavior using the item mean scores (Table 12, Appendix H). The majority of items which nurses reported with the highest scores of nurses' caring behaviors for dying patients fell in the conscience dimension in the following order (Table 5): (1) I intend to take care of the dying patient with all my best practices even though they are in the final time of their life (M = 2.56, SD = 0.55), (2) I give honor and pay respect to the dying patient as a human even though they are in an unconscious state (M = 2.55, SD = 0.55), (3) I provide equal care for every dying patient and their families (M = 2.53, SD = 0.57), (4) I am willing to listen to the dying patients and their families (M = 2.52, SD =

0.60), and (5) I respect the dying patient's decision or family's decision if the patient is not able to make a decision (M = 2.50, SD = 0.61).

Surprisingly, the five items which nurses reported as the lowest scores of nurses' caring behaviors for dying patients fell in the competence dimension in the following order (Table 6): (1) I apply clinical practice guidelines and research outputs for caring for dying patients and their families (M = 1.29, SD = 0.82), (2) I study to keep up to date with knowledge related to caring for dying patients and their families (M = 1.53, SD = 0.73), (3) I practice some skills of caring for dying patients and their families in order to respond to all needs (M = 1.57, SD = 0.74), (4) I have competence in using medical equipment and technologies in caring for dying patients (M = 1.67, SD = 0.87), and (5) I collaborate and work with other health care providers in caring for dying patients and their families holistically (M = 1.70, SD = 0.81).

Table 5

Five Items with Highest Mean Score of the Nurses' Caring Behaviors for Dying Patients (N = 353)

Items	Questions	Dimension	M	SD
1	I intend to take care of the dying patient with all my best practices even though they are in the final time of their life	Commitment	2.56	0.55

Table 5 (Continued)

Items	Questions	Dimension	M	SD
2	I give honor and pay respect to the dying patient as a human even though they are in an unconscious state	Conscience	2.55	0.55
3	I provide equal care for every dying patient and their families	Conscience	2.53	0.57
4	I am willing to listen to the dying patients and their families	Compassion	2.52	0.60
5	I respect the dying patient's decision or family's decision if the patient is not able to make a decision	Conscience	2.50	0.61

Table 6

Fives Items with Lowest Mean Score of the Nurses' Caring Behaviors for Dying Patients (N = 353)

Items	Questions	Dimension	M	SD
1	I apply clinical practice guidelines and research outputs in caring for dying patients and their families	Competence	1.29	0.82

Table 6 (Continued)

Items	Questions	Dimension	M	SD
2	I study to keep up to date with knowledge related to caring for dying patients and their families	Competence	1.53	0.73
3	I practice some skills of caring for dying patients and their families in order to respond to all needs	Competence	1.57	0.74
4	I have competence in using medical equipment and technologies in caring for dying patients	Competence	1.67	0.87
5	I collaborate and work with other health care providers in caring for dying patients and their families holistically	Competence	1.70	0.81

The Relationship between Nurses' Personal Relating Factors and Nurses' Caring Behaviors for Dying Patients

The Spearman rank-order correlation coefficient was used to examine the relationship between age and professional experience with caring behaviors and Pearson product-moment correlation coefficients was used to examine the relationship between self-awareness and moral distress with caring behaviors. The results found that age, professional experience, and moral distress had a low positive correlation with the total caring behaviors (r_s = .12, p <.05, r_s = .12, p < .05, and r = .16, p <.01,

respectively). There was a moderate positive relationship between nurses' self-awareness and nurses' caring behaviors ($r = .37$, $p < .001$) (Table 7). In other words, older nurses, longer professional experience, higher moral distress, and higher self-awareness, resulted in a higher level of nurses' caring behaviors for dying patients.

Table 7

Correlation Coefficients between Nurses' Caring Behaviors for Dying Patients and Age, Professional Experience, Nurses' Self-awareness, and Moral Distress (N = 353)

Related factors	Nurses' caring behaviors for dying patients	
		p-value
1. Age	.12*	.015
2. Professional experience	.12*	.01
3. Nurses' self-awareness	.37**	.000
4. Moral distress	.16**	.001

* Spearman rank-order correlation coefficient (rho, r_s)

** Pearson product-moment correlation coefficients (r)

Independent Sample Test was used to compare mean differences of caring behaviors between the trained nurses and untrained nurses. The findings of this study revealed that there was a significant mean difference in caring behaviors of nurses who were trained and were not trained ($t = 1.44$, $p < .05$) (Table 8). It indicates that the trained nurses had are better caring behaviors than untrained nurses.

Table 8

The Comparison of Nurses' Caring Behaviors for Dying Patients Based on Training Experience, Using Independent Sample Test (N = 353)

Variable	Training experience				*t*	*p*-value
	Yes		No			
	M	SD	M	SD		
Nurses' caring behaviors for dying patients	2.16	0.44	2.09	0.42	1.44	.04*

Note. Degree of freedom = 351

* $p < .05$

One-way Analysis of Variance was used to compare mean difference of caring behaviors among the experience of caring for dying patients groups, the results showed that the nurses' caring behaviors for dying patients were not significantly different among the groups ($F = 1.32, p > .05$) (Table 10).

Table 9

Mean and Standard Deviation of Nurses' Caring Behaviors for Dying Patients Based on Experience of Caring for Dying Patients (N = 353)

Experience of care for dying patients	Nurses' caring behaviors for dying patients	
	M	SD
1-5 cases	2.09	0.43
6-10 cases	2.09	0.42
10-15 cases	2.03	0.42
>15 cases	2.16	0.44

Table 10

The Comparison of Nurses' Caring Behaviors for Dying Patients Based on Experience of Caring for Dying Patients, Using One-way Analysis of Variance (N = 353)

Source of variance	SS	df	MS	*F*	*p*-value
Between groups	0.73	3	0.24	1.32	.26^{NS}
Within groups	64.48	349	0.19		

^{NS} $p > .05$

The Relationship between Environmental Relating Factors and Nurses' Caring Behaviors for Dying Patients

Furthermore, the Independent Sample Test was used to compare the mean difference of caring behaviors and working units. The findings of this study showed that there were not significant mean differences of caring behaviors of nurses who are working in general ward and ICU ($t = -0.71, p > .05$) (Table 11).

Table 11

The Comparison of Nurses' Caring Behaviors for Dying Patients Subscale Based on Working Unit, Using Independent Sample Test (N = 321)

Variable	Working units				*t*	*p*-value
	General ward		ICU			
	M	SD	M	SD		
Nurses' caring behaviors for dying patients	2.11	0.43	2.14	0.44	-0.71	.469^{NS}

^{NS} $p > .05$

Discussion

This study aimed to describe the level of caring behaviors of nurses for dying patients in southern Thailand and to examine the relationship between nurses' personal factors and an environmental factor and nurses' caring behaviors for dying patients in southern Thailand. The subjects were 353 registered nurses who were working in southern Thailand. 98.06 percent response rate of the subjects was found in this study. The findings of this study are discussed based on the main three parts including: (1) Nurses' caring behaviors for dying patients, (2) the relationship between nurses' caring behaviors for dying patients and nurse's personal factors (3) and the relationship between nurses' caring behaviors for dying patients and environmental factor.

Nurses' Caring Behaviors for Dying Patients

Not surprisingly, the total scale of nurses' caring behaviors for dying patients was at a high level. One explanation of a high level of caring behaviors is that the nurse has been professionalized in a caring environment. According to Roach (2002) nursing is a career in that the aim is to help people and to care for people. A nurse is refined to be a caring nurse from the day she or he enters into the nursing profession. Caring is integrated into the nursing profession through a curriculum based on a holistic, integral humanism, moralism, and caring environment.

Interestingly, the highest caring behavior of the southern Thai nurse was conscience. Conscience, understood as the morally sensitive self attuned value, is integral to personhood (Roach, 2002; p.58). Moral norms, standards, principles and values, grounded in religious faith. Nursing professionals have borrowed Buddhist

health related principles and applied them to the concept of caring (Watson, 2005). In Buddhism, the most fundamental Buddhist ethical precept is nonviolence or not to harm any living creature. In addition, three fundamental principles namely: not to do any evil, to cultivate good, and to purify the mind are the main teachings of Buddha (Payutto, 2001). As well as the demographic finding of this study which found approximately ninety six percent of the respondents were Buddhist and most of them identified themselves as moderately strict in religious practice. It could be said that the caring behaviors of Thai nurses has been constructed by their cultural background. As result of this, caring behaviors among Thai nurses was at high level.

Caring behaviors on the compassion dimension in this study is at a high level. Compassion is a way of entering into the experience of the patients, of sharing in difficulty, pain and suffering, of being moved and changed (Roach, 2002; p.25). As presented in this study, the caring nurses reported that they are willing to listen to the dying patients and their families as the fourth highest item. Listening to the patients is the way that helps a nurse enters the experience of the patient. This finding also supported other studies which found that providing available time and listening to the patients' expression is the way to express compassionate care (Brilowski & Wendler 2005; Wilkin, 2003).

The commitment to care consists of two key elements of one's desire and one's obligation (Roach, 2002; p58). In this sense, caring nurses must commit to themselves to meet the dying patients and families' needs. The nurses in this study reported that they intended to take care of the dying patient with all their best even though the patients are in the final time of their life. The nurses did not give up and tried to overcome the barrier in providing care for their patients. They keep promises

and respond to the patients' needs as soon as possible. Keep promises and respond to the patients' needs demonstrate that nurses gave the dying patients and families ongoing opportunities to realize that help is always available for them. Caring behaviors on the comportment dimension was found to be the fourth highest caring behavior. The caring nurses in this study also showed their caring presence with appropriate dress, language, and the expression of feeling. According to Roach, it is paramount that the professional looks and sounds like what nurses profess to be and provide the patient with respect first, disease second (p.48).

Confidence is a critical attribute of professional caring. Confidence is a basic responsibility that enables the development of a trusting relationship with the dying patients and families (Roach, 2002; p. 57). In this study caring nurses used their self to foster trusting relationships, beginning by introducing them self to the dying patient and families, providing care with quality, being informative and a good counselor and are with them any time they need help. These behaviors brought about the ability to have faith in the nurses who interact with dying patients and their families. This study's findings are consistent with other studies which found that being with the patients during their worrying time can increase better relationships between nurses and patients (Brilowski & Wendler, 2005; Wilkin, 2003).

Surprisingly, competence was found to be the lowest caring behavior at a moderate level for southern Thai nurses. A competent nurse is a nurse who has knowledge, judgment, skills, energy, experience, and motivation required to respond adequately to the demands of the professional nurse's responsibilities (Roach, 2002; p. 54). The findings of this study indicated that nurses had moderate levels of competence in caring for dying patients. One explanation is that in nursing, nurses

have specific knowledge, skills, judgment and experience which might depend on various factors such as education and training (Roach). Based on the demographic findings of this study, most of the respondents had an educational level of bachelor degree (91.6%). According to the survey on the undergraduate curriculum, it was found that the end of life content is limited at this level (Wright, Hamzah, Phungrassami, & Bausa-Claudio, 2008). Therefore, the nurses in this study lacked of knowledge related to end of life care. The same as the demographic findings which found that the nurses perceived their knowledge related to end of life care at a moderate level. This finding also supported other research in that it found a positive relationship between educational level and knowledge related to end of life care (Manosilapakorn, 2003).

In addition, training was found to be the specific way in order to enhance skills and practice (Roach). According to the demographic findings of this study, nearly sixty percent of the respondents were not trained by attending a conference or work shop. Moreover, the respondents in this study also indicated that they were lacking in applying the clinical practice guidelines and research outputs in caring for dying patients and families with the lowest mean score. This also might be contributed to by the educational level because at a bachelor degree level most of the content focuses on nursing care. In Thailand, there are not national clinical practice guidelines in caring for dying patients and their families.

Seriously, the nurses were less in keeping up to date with gaining more knowledge and skills related to end of life care. This might be because of other factors such as work load. The nurses in this study also reported that they had less ability in using medical technology in caring for the dying patients. This might be due to the

fact that more than half of the samples in this study were working in a general hospital and two thirds of them were working in a general unit which required less medical technology than a regional hospital and intensive care unit.

Furthermore, the nurses in this study also have low collaboration between the nurse and other health care providers in caring for the dying patient and this showed as one of the lowest competencies. The finding in this item supported the results of another study that found a lack of collaboration between nurses and health care providers was a barrier in caring for the dying patients (Beckstrand & Kirchhoff, 2005).

The Relationship between Nurses' Personal Factors and Nurses' Caring Behaviors for Dying Patients

Interestingly, the findings of this study found that there was a moderate positive relationship between nurses' self-awareness and nurses' caring behaviors. It can indicate that higher self-awareness is equal to a higher caring behavior.

Self-awareness is the process of understanding one's own beliefs, thoughts, motivations, feelings, behaviors and recognizing how they affect others (Bernard, 1992). Rungapadiachy (1999) stated that being self-aware should be compulsory for every nurse in the health profession. Several studies have found that self-awareness in a nurse is very important for the nursing profession in providing care for the client (Cook, 1999; Jack & Miller, 2008; Jack & Smith, 2007; Rowe, 1999). The qualitative study also found that to care for the dying patient, the nurse also should have self-awareness (Chaipet, 2008).

This finding supported the statement that awareness is a component of each caring attribute. As O'Connell (1976 as cited in Roach, 2002) provided three helpful distinctions of caring as a general sense of value, awareness of personal responsibility, capacity for self-direction and human responsibility for good direction. Developing self-awareness helps nurses to be less of a victim and enables them to take control and responsibility for the situation and it also help nurses to cope when confronted with a difficult situation while taking care of the clients (Bernard, 1992; Smith, 2007). In addition, self-awareness is an important key to improving the nurse-client relationship via the communication/counseling technique (Rowe, 1999). The understanding and acceptance of one's own self will allow the nurse to acknowledge a client's differences and uniqueness which can help the nurse to express more compassionate care (Townsend, 2003).

Surprisingly, the results reported that there was a low positive relationship between moral distress and caring behaviors for dying patients. This can indicate that low moral distress will lead to good caring behaviors of the nurses in caring for dying patients. The lack of research study in this field describes the relationship between moral distress and caring behaviors. However, some studies explained that moral distress has an impact on nursing care in a negative way which was inconsistent with the results of this study.

According to Harding (1980) telling stories of moral suffering is important because they contain the most highly valued notions of good patient care. Benner (1991) suggested that being open to new experiences implies learning from failure. This hard-won lesson lingers to color future experiences, adding built-in emotional responses along with a resolve to avoid this painful lesson again. Because

the nurse-patient relationship is so complex, there is no way to get it right, without sometimes getting it wrong. Rushton (1992) too, saw a beneficial effect from nurse distress, in that it facilitated personal and professional growth and led to more skill in compassionate care. Therefore, the nurses in this study had high caring level.

In addition, religion is also significantly related to moral distress. Morality is commonly part of religious belief, a primary role of religion is to exert control over its followers by setting and promoting rules and customs for people to follow (Ratanakul, 2004). Religion has been found to help individuals cope with their stressors. This might be because of finding meaning, purpose and hope, which may nurture individuals in their suffering (Baldacchino & Draper, 2001). Meltzer and Huckabay (2004) found that nurses who didn't consider religion to be important in their lives were significantly more emotionally exhausted than nurses who reported that religion was very important in their lives. According to the demographic data of the subjects in this study which found that two- thirds of the nurses (75.4%) were strict in their religion practice at a moderate level. It can be assumed that nurses in this study can cope with a situation well. Therefore, the caring behaviors are good.

Furthermore, the Shortened Form of Corley's Moral Distress Scale that was used to measure moral distress of the nurses in this study was developed based on the western culture. Therefore, there were many items that were rated as not applicable. The top three items that were rated as not applicable were "respond to a patient's request for assistance with suicide when the patient has a poor prognosis", "ask the patient's family about donating organs when the patient's death is inevitable", and "Ignore situations of suspected patient abuse by caregivers", respectively.

To expected, three factors including age, professional experience, and training experience were found to have a positive relationship with caring behaviors of the nurses. Older nurses, higher professional experience, and training are important factors resulting in higher caring behaviors for dying patient.

According to Erikson's psychosocial development theory which helps understanding and explaining how personality and behavior develop in people, Erikson (1993) stated that age is associated with development and maturity level. A person who was 30-65 years old extended themselves to other productive activities such as work, creativity, and responsibility for their own social wellbeing. Nearly seventy percent of the samples of this study were 30-60 years old (Table 2). This finding supported other studies that found senior nurses have higher levels of caring behaviors for dying patients compared to younger nurses (Amonprompukdee, 2004). In addition, a study on family, work and personal factors related to the performance of professional nurses found that age was a personal factor which related to the competence in caring for patients (Suginunkul, 1998).

Regarding professional experience, this had a positive relationship with age. The older nurse would have more professional experience, since they have more opportunities of learning and practicing, gaining better understanding in EOLC in both a theoretical and practical way. Hence, nurses will eventually gain more knowledge which is a component of competence as showing a positive relationship (r = .14, p < .01) (Table 13, Appendix H). Roach (2002) stated that professional experience affected caring behaviors. The amount of experience transformed a nurse's way of being with the patients and their families. Alongside experience, there was

indeed personal growth and self-enhancement which can help a nurse to understand the patients and extend her or his self to the patients.

In addition, the duration of nurses' working hours increased their learning both directly and indirectly. Learning from observing and practicing in a clinical base helps nurses enhance their working experience. Thus, a person could combine new experience with previous learning. Therefore, the nurses who get more experience will have a high level of knowledge, understanding, and skill in taking care of the patient (Clark et al., 2003). Moreover, experiences can help the person have wider vision, creation, and imagination, in taking care of patients which is part of the art of caring (Orem, 1995). According to previous studies which mentioned that an expert nurse, who works for several years gains working experience in taking good care of the EOL patient more than the beginner nurse which can be reflected in their better caring behaviors (Apaiwong, 2000; Brunton & Beaman, 2000; Lange et al., 2008; Mateprasart, 1991; Noh et al., 2002; Suwanmalee, 1996; Wattanachot, 1997).

Regarding training experience, it can be explained that training might improve knowledge, attitude, and caring behaviors of people. The training process could allow the opportunity of nurses to exchange their learning experience with others. The exercise or activity in training might help the nurses to possess more skills in caring for patients (Pokpalagon, 2005). Previous studies found that special training and coursework about death and dying improved caring behaviors toward terminally ill patient and families (Tsai et al., 2005; Wong et al., 2001). Similarly, ICU nurses perceived that the training is an important method that can improve the skills of caring for EOL patients and their families (Chaipet 2008). It was found that the lack of

training course is the main barrier for ICU staff nurses and health care providers to provide the optimal care for the end of life patients (Carlet et al., 2004; Chaipet 2008).

Unbelievably, experience of caring for dying patients did not correlate with nurses' caring behaviors for dying patients. This might be because the number of dying patients is significantly less than the time spent in contact with the patients. This explanation was supported by Dunn, Otten and Stephens's (2005) study which found that nurses who reported spending a higher percentage of time in contact with terminally ill or dying patients reported more positive attitudes which led to good caring behaviors. The finding of this study was inconsistent with Pokpalagon's (2005) study which found that taking on more numbers of dying patients can enhance the caring behaviors in a positive way.

The Relationship between Nurses' Environmental Factor (Working Unit) and Nurses' Caring Behaviors for Dying Patients

The result of this study revealed that the unit of work did not correlate with nurses' caring behaviors for dying patients. However, the total mean score of ICU nurses was higher than nurses who worked in general units. It might be due to ICU, where a critically ill patient needs to be taken care of, the ratio of nurse to patient is 1:2 which increases the opportunity for ICU nurses to provide care for the dying patient. Inadequate nurse can lead to low quality of care due to the work load. Nurses cannot pay more attention to only one patient because of lack of time (Beckstrand et al., 2006).

Interestingly, nurses' responsibility about end of life programs and self study were found to be relating factors to caring behaviors for dying patients. The

finding showed that two-thirds (66.6%) of the subjects had a responsibility about end of life programs in their unit. Some of the subjects were the head of the program and some of the subjects were members of the program. As same as the study on the status of end of life in Thailand which found that palliative and end of life care initiatives are already underway in Thailand and involve governmental and non-governmental hospitals. Therefore, several hospitals have established palliative care working groups and are in the process of developing palliative and end of life care programs for their patients (Nilmanat & Phungrassami, 2006). In addition, this reason was confirmed with additional analysis on the relationship between nurses' responsibility about end of life programs and nurses' caring behaviors for dying patients which showed a significant mean difference of nurses' caring behaviors for dying patients between the responsibility group and the non responsibility group ($t = 2.87$, $p < .01$) (Table 21, Appendix H). This could be explained in that nurses who had responsibility in end of life programs could have caring behaviors better than nurses with no program responsibility due to their realization that the performances she or he performs during providing care for the dying patients were important for the dying patients.

For self-study, although only forty percent of the nurses in this study had self directed learning but the additional analysis which found the mean difference was confirmed by its relationship ($t = 4.71$, $p = .00$) (Table 23, Appendix H). This might be because self study leads to better motivation, willingness, concentration, perseverance, and attempting to learn by themselves. Inner desires to learn make learning easy to understand (Pokpalagon, 2005).

In summary, the findings from this present study presented that caring behaviors for dying patients of southern Thai nurses was at a high level. Only a

nurse's personal factors were found to be factors relating to nurses' caring behaviors for a dying patient which included age, professional experience, training experience about end of life care, self-awareness, and moral distress. Moreover, the responsibility of a nurse about end of life programs and self study were found to be new personal factors relating to nurses' caring behaviors for dying patients.

CHAPTER 5

CONCLUSION AND RECCOMMENDATIONS

This chapter presents the summary of the study findings, strengths and limitations of the study, and implications and recommendations for further studies. This descriptive study was to describe the level of caring behaviors of nurses for dying patients in southern Thailand, to examine the relationship between a nurse's personal factors and an environmental factor and the nurse's caring behaviors for dying patients. Three hundred and sixty questionnaires were distributed to nurses who were randomly selected and 353 returned questionnaires were used for data analysis. The participants were registered nurses who worked in general wards and ICUs of eight general hospitals, two regional hospitals, and one university hospital. Data were collected in January to February, 2011. The subjects were requested to complete a set questionnaire which consisted of four main parts, namely Demographic Data Questionnaire (DDQ), Nurse's Caring Behaviors for Dying Patients Questionnaire (NCBDPQ), Nurse's Self-Awareness Questionnaire (NSAQ), and the Shortened Form of Corley's Moral Distress Scale. NCBDPQ was developed by the researcher based on Roach's six C caring concept in Thai language. The NSAQ and the Shortened Form of Corley's Moral Distress Scale were applied from other studies. These instruments were evaluated for content validity by three experts which were a head nurse, from Songklanagarind Hospital and two nursing educators, from the Faculty of Nursing, Prince of Songkla University, Thailand. The statistical test of Cronbach's Alpha was used to analyze the reliability of the instruments NCBDPQ, NSAQ, and the Shortened Form of Corley's Moral Distress Scale, the results were .97, .93 and

.94, respectively. Collected data were analyzed by using descriptive statistic, parametric and nonparametric statistics.

Summary of the Study Findings

The subjects consisted of 353 registered nurses. The mean age of the samples was 34.36 years. The majority of the subjects were female (98%), were Buddhist (85.6%) and were educated to bachelor level (92.4%). The hospitals that the samples were employed in were: Chumphon Khet Udomsakdi Hospital, Ranong Hospital, Phang-nga Hospital, Vachira Phuket Hospital, Krabi Hospital, Phatthalung Hospital, Naradhiwasrajanagarindra Hospital, Songkla Hospital, Trang Hospital, Maharaj Nakhon Si Thammarat Hospital, and Songklanagarind Hospital. Regarding working experience after graduating at bachelor degree level, the mean professional experience of the sample population was 9.76 years. Approximately 54.4 percent had experience in caring for dying patients in more than fifteen cases within the last year. For training experience of the subjects in caring for the dying patient, approximately sixty percent of the subjects had received training experience in this area. More than half of the subjects had no self study (58.07%). Around three-fourths of them perceived their knowledge about caring for dying patients in the middle range (77.1%). Obviously, 66.6 percent of the subjects had responsibility for end of life programs in their unit.

The total mean score of nurses' caring behaviors for dying patients was at a high level (M = 2.12, SD = 0.43). The five dimensions of nurses' caring behaviors for dying patients namely, compassion, confidence, conscience, commitment and comportment were (M = 2.29, SD = 0.50; M = 2.08, SD = 0.59; M =

2.39, SD = 0.47; M = 2.18, SD = 0.52, M = 2.11, SD = 0.52, respectively), which were classified as a high level. Only the competence dimension was at a moderate level (M = 1.82, SD = 0.51).

In addition, this study found five personal factors which consisted of age, professional experience, training experience about end of life care, self-awareness, and moral distress correlated to caring behaviors for dying patients (r_s = .12, p <.05, r_s = .12, p < .05, t = 1.44, p < .05, r = .37, p < .001, and r = .16, p <.01, respectively)

Only the experience of caring for dying patients was found to be a personal factor which did not correlate with caring behaviors for dying patients (F = 1.32, p > .05). Regarding the environmental factor, the working unit was found to have no significant relationship with caring behaviors for dying patients (t = -0.71, p > .05). Furthermore, additional analysis found that the responsibility of the nurses about end of life programs and self study also correlated to nurses' caring behaviors for dying patients (t = 2.87, p < .01, t = 4.71, p =.00, respectively).

Strength and Limitation of the Study

The strengths of the findings of this study provide evidence regarding the caring behaviors of nurse in caring for dying patients. It also provides information and direction for improvement and maintenance of a nurse's caring behaviors for dying patients. On the other hand, there are five limitations that should be mentioned. Firstly, most of the nurses in the present study were female, thus, it could not be generalized to male nurses. Secondly, this study was conducted in the southern part of Thailand therefore, this may limit the generalizability of the findings. Thirdly, this

study used a single method of a self-report to collect data. This method has limitations in itself, particularly when it is used for rating human action. There is a trend toward social desirability of response. Fourthly, the questionnaires used have a total of 81 items which may lower the subjects' concentration levels to answer all items thoroughly (Smith, Olah, Hansen, & Cumbo, 2003). Lastly, the Shortened Form of Corley's Moral Distress Scale which was in this study was developed from a western country which might not apply to the Thai population. Thus, further study is recommended.

Implications and Recommendations

The findings of the study offer the following implications and recommendations.

Nursing practice

It is evident in this study that nurses' caring behaviors are moderate in the competence dimension especially when applying practice guidelines and gaining more knowledge and skills related to EOLC. Hence, work shops or training courses should be held in order to enhance knowledge and skills related to EOLC for nurses. The experience of moral distress that was reported indicates the need for encouragement in the sharing of moral concerns.

Nursing administration

The nursing administrators should address mission and vision related to the outcomes of EOLC by evaluating the caring behaviors of nurses. In addition, the nursing administrators should provide teaching and training courses for the nurses, especially the junior nurses. Moreover, the administrators should provide more

resources for self-study such as books, journal, and document, about EOLC and motivate nurses to take advantage of further study. Furthermore, high self-awareness of nurses should be maintained. Therefore, the administrators should provide activities, such as doing portfolio for nurses to maintain self-awareness and often evaluate the nurses' self-awareness.

Nursing education

Nursing education should consider integrating the content of the EOLC in the undergraduate courses. EOLC might be a core subject that requires competency prior to practice. The instructors should teach their students about taking care of EOL patients through experimental, interactive, and didactic methods. Moreover, at master's level the curriculum should produce advance practice nursing in EOLC field. Furthermore, the content related to end of life care should be available in an online data base for self directed learning.

Nursing research

Factors analysis for the Nurses' Caring Behaviors for Dying Patients Questionnaire is recommended. Further study should employ other methods for data collection such as a focus group or in-depth interviews, which could get more significant details and insight. In addition, developing clinical practice guidelines in caring for dying patients at a national level is also needed.

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APPENDICES

APPENDIX A

Informed Consent Form

My name is Chuleeporn Prompahakul, a master student at the Faculty of Nursing, Prince of Songkla University. You are being asked to participate in this research study about "Factors influencing nurses' caring behaviors for dying patients in southern Thailand". This study aims to describe the level of caring behaviors of nurses for dying patients in southern Thailand and examine the factors influencing nurses' caring behaviors for dying patients in southern Thailand. The expected outcomes from this study will be of benefit to the nursing profession in order to improve the quality of care for dying patients and families at an administrative level, practical level, and educational level. This study has been approved by the Institutional Review Board of Prince of Songkla University, Thailand.

If you are interested in participating in this study, you will be asked to complete the demographic data questionnaire, nurse's caring behaviors for dying patient questionnaire, nurse's self awareness, and moral distress questionnaire. This will take about 20-30 minutes of your time. During this study you have the right to withdraw anytime without any effect on your work. All information in this study will remain confidential. No names will be mentioned, the information gathered will be reported as a thesis, which is a requirement of a master degree.

Your decision to participate in this study will be greatly appreciated. Thank you for your cooperation. If you agree to participate in this research study, please sign this form and please do not hesitate to ask me if you find difficulties in understanding each item.

.....

( )

(Participant)

.....

(Chuleeporn Prompahakul)

(Researcher)

Contact information

Chuleeporn Prompahakul

Master of Nursing

Faculty of Nursing

Prince of Songkla University

Hat Yai Campus, Thailand

Tel: (086)9688372

E-mail: nongni_nurse@hotmail.com

APPENDIX B

Demographic Data Questionnaire (DDQ)

Code ☐☐☐

Please answer by marking √ in the space available or filling in the blank space that is appropriate for you.

1. Age ..... Years
2. Gender:

   1 ( ) Male 2 ( ) Female
3. Religion:

   1 ( ) Buddhist 2 ( ) Christian

   3 ( ) Islamic 4 ( ) Other (identify).....
4. Religious practice

   1 ( ) very strict 2 ( ) moderately strict 3 ( ) not strict
5. Educational level

   1 ( ) Bachelor degree 2 ( ) Master degree

   3 ( ) Doctoral degree
6. Working experience in nursing after finishing bachelor degree .....
7. Working hospital .....
8. Working unit and the duration that you have worked until now

   1 ( ) General medical ward .....years.....months

   2 ( ) General surgical ward .....years.....months

   3 ( ) Intensive care unit .....years.....months

9. The number of dying patient that you have taken care of in the last year

   1 ( ) 1-5 cases 2 ( ) 6-10 cases

   3 ( ) 10-15 cases 4 ( ) > 15 cases

10. Have you ever studied or attended meetings or conferences related to end of life care? (you can choose more than 1 answer)

    1 ( ) Yes, I have attended meetings or conferences related to end of life care (please identify the organization that set up the meeting) .....

    2 ( ) No, I have never attended

11. Do you have self study related to end-of-life-care?

    1 ( ) Yes (please identify source of self study).....

    2 ( ) No

12. What is the level of your knowledge in care for dying patients and their families?

    1 ( ) High 2 ( ) Moderate 3 ( ) Low

13. Do you have a responsibility about end of life care programs in your working unit?

    1 ( ) Yes (Please indentify) .....

    2 ( ) No

APPENDIX C

Nurse's Caring Behaviors for Dying Patients Questionnaire (NCBDPQ)

Explanations

1. Please carefully read each statement which consists of 40 items and answer by marking √ in the space available that is appropriate for you only one answer per question.

2. The answer scale is categorized into four levels as follows:

Never	means	the participants never performed that behavior to dying patients.
Sometimes	means	the participants performed that behavior to dying patients occasionally
Often	means	the participants performed that behavior to dying patients frequently
Regularly	means	the participants performed that behavior to dying patients regularly

*** N/A (Not applicable) means have not experienced a situation that has lead to that behavior

3. Please read the meaning of the following words before answering the questions

Dying patient refers to acute or chronically ill patients (such as cancer patient, heart disease patient, diabetic patient, or kidney disease patient etc.) who are in the last stage of the disease and tend to die in that admission.

Caring behaviors for dying patients refers to actions or performances that nurse performs while providing care for dying patients based on Roach's six Cs caring attributes.

No.	Behaviors	Never	Sometimes	Often	Regularly	N/A
	Compassion (7 items)					
1	I pay attention to the needs of caring for dying patients and families					
2	I am with the dying patients and families when they are in mourning					
3	I touch the dying patients when they feel pain or suffering					
	. . . .					
40	I express the need of respect and honor from the dying patient, their families, and the health care team					

APPENDIX D

Nurse's Self-Awareness Questionnaire (NSAQ)

Explanations

1. Please carefully read each statement which consists of 20 items and answer by marking √ in the space available that is appropriate for you and only one answer per question.
2. The answer scale is categorized into four levels as the follows:

Disagree	means	the participant does not agree with the statement at all
Slightly agree	means	the participant neither disagrees nor Agrees with the statement
Mostly agree	means	the participant agrees with the statement
Strongly agree	means	the participant agrees with the statement to a considerable extent

No.	Items	Disagree	Slightly agree	Mostly agree	Strongly agree
	Private self- awareness				
1	While taking care of a patient, I know what I am thinking				
2	While taking care of a patient, I know what I am doing for the patient				
3	While taking care of a patient, I always consider my actions				
	. . . .				
20	While taking care of a patient, I always do activities without considering how the patient feels about me				

APPENDIX E

Shortened Form of Corley's Moral Distress Scale

Explanations

1. Please carefully read each statement which consists of 21 items and answer by marking √ in the space available that is appropriate for you and only one answer per question.
2. The scale of the answer is categorized into four levels as the follows:

None	means	there is no moral distress from the situation
A little	means	the level of moral distress in the situation is more than 0%
Moderate	means	the level of moral distress in the situation is more than 25%
Much	means	the level of moral distress in the situation is more than 50%
Great	means	the level of moral distress in the situation is more than 75%

*** N/A (Not applicable) means do not have a related situation that led to that distress

No	Situations	None	A little	Moderat-ely	Much	Great
1	Provide less than optimal care due to pressures to reduce costs					
2	Ask the patient's family about donating organs when the patient's death is inevitable					
3	Follow the family's wishes to continue life support even though it is not in the best interest of the patient					
	. . . . .					
21	Follow orders for pain medication even when the medications prescribed do not control the pain					

APPENDIX F

List of Experts

Three experts validated the content validity of the instruments: Nurse's Caring Behaviors for Dying Patients Questionnaire (NCBDPQ), Nurse' Self-Awareness Questionnaire (NSAQ), and Shortened Moral Distress Scale (SMDS).

1. Assistant professor Dr. Wongchan Petpichetchain

   Nursing Lecturer, Faculty of Nursing, Prince of Songkla University, Thailand

2. Assistant professor Dr. Tippamas Chinnawong

   Nursing Lecturer, Faculty of Nursing, Prince of Songkla University, Thailand

3. Miss Orapan Chaipetch

   Head nurse of Surgical Ward I, Songklanagarind Hospital

APPENDIX G

Permission for Using the Instruments

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล
๒๕/๒๕ ถ.พุทธมณฑลสาย ๔ ศาลายา นครปฐม ๗๓๑๗๐
โทร. ๐๒๔๔๑-๔๑๒๕ ต่อ ๑๐๙-๑๑๑ โทรสาร ๐๒-๔๔๑๙๘๓๔

ที่ ศธ ๐๕๑๗.๐๒ / ๐๙๓๒
วันที่ ๒๑ มกราคม ๒๕๕๔
เรื่อง อนุญาตให้ใช้เครื่องมือวิจัย
เรียน นางสาวชุลีพร พรหมพาหกุล

ตามที่ นางสาวชุลีพร พรหมพาหกุล นักศึกษาหลักสูตรระดับปริญญาโท สาขาวิชาการพยาบาลผู้ใหญ่ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ มีความประสงค์จะขออนุญาตใช้เครื่องมือวิจัย แบบสอบถามความตระหนักในตนเองของพยาบาล ของ นางสาวสุภาพร ดาวดี ซึ่งเป็นส่วนหนึ่งของวิทยานิพนธ์ตามหลักสูตรพยาบาลศาสตรมหาบัณฑิต สาขาวิชาการพยาบาลผู้ใหญ่ คณะพยาบาลศาสตร์ และบัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล พ.ศ. ๒๕๓๗ เรื่อง "ศึกษาความตระหนักในตนเองของพยาบาลและพฤติกรรมการดูแลผู้ป่วยระยะสุดท้าย (THE STUDY OF NURSES' SELF AWARENESS AND CARING BEHAVIOR FOR TERMINALLY Ill PATIENTS)" ซึ่งมี รศ.ฟาริดา อิบราฮิม ทำหน้าที่อาจารย์ที่ปรึกษาวิทยานิพนธ์หลัก

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล ได้พิจารณาแล้วไม่ขัดข้องอนุญาตให้ นางสาวชุลีพร พรหมพาหกุล ใช้เครื่องมือวิจัยดังกล่าวได้ เนื่องจากเป็นการศึกษาวิจัยทางด้านวิชาการ แต่ทั้งนี้ขอได้โปรดระบุให้ชัดเจนด้วยว่าใช้เครื่องมือวิจัยทุกแบบสอบถามหรือบางส่วน และให้ระบุว่าเครื่องวิจัยดังกล่าวมาจากวิทยานิพนธ์ของนักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล ถ้าหากมีการละเมิดเกิดขึ้นข้าพเจ้ายินยอมให้ คณะพยาบาลศาสตร์ ดำเนินการตามกฎหมาย และขอให้ดำเนินการชำระค่าบริการขอใช้เครื่องวิจัยดังกล่าวข้างต้น จำนวน ๒๐๐ บาท (สองร้อยบาทถ้วน) ต่อเครื่องมือวิจัย ๑ ชุด โดยส่งธนาณัติสั่งจ่าย ป.ณ. ศิริราช ในนาม

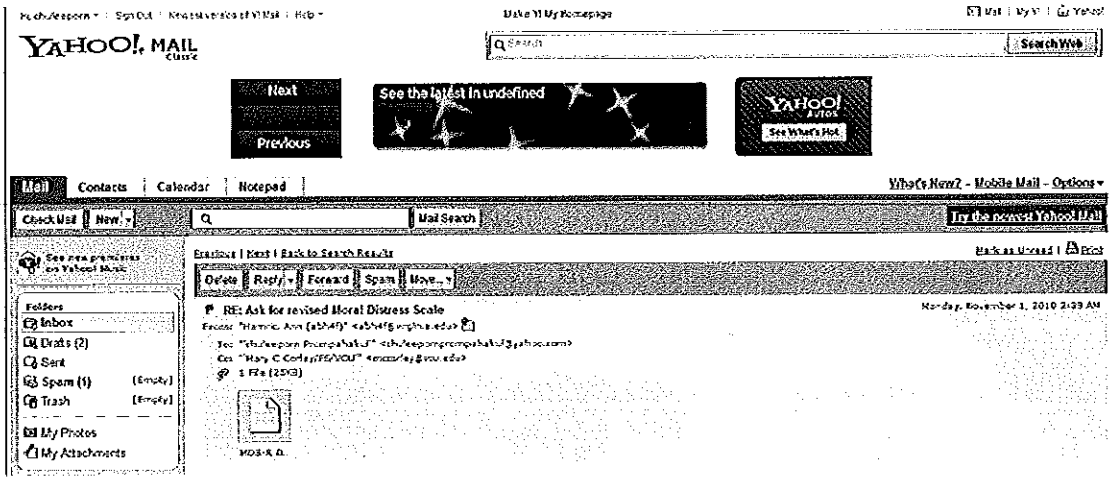
หลักสูตรบัณฑิตศึกษา (เพื่อการขอใช้เครื่องมือวิจัย)
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล
เลขที่ ๒ ถนนพรานนก แขวงศิริราช
เขตบางกอกน้อย กรุงเทพมหานคร ๑๐๗๐๐
โทร. ๐-๒๔๑๙-๗๔๖๖-๘๐ ต่อ ๑๔๑๑, ๑๔๑๒

จึงเรียนมาเพื่อโปรดทราบ และดำเนินการต่อไปด้วย จักขอบพระคุณยิ่ง

ขอแสดงความนับถือ

(ศาสตราจารย์ นายแพทย์บรรจง มไหสวริยะ)
คณบดีบัณฑิตวิทยาลัย

สำเนาเรียน คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์
หมายเหตุ ผู้ที่มาติดต่อเรื่องเครื่องมือวิจัยที่หลักสูตรฯ ให้ติดต่อตั้งแต่เวลา ๘.๓๐-๑๔.๓๐



Dear Chuleeporn,

Thank you for your interest in the Shortened Form of Corley's Moral Distress Scale. If you wish to use the instrument, please see the conditions for use in the attached document. If you agree to adhere to them, I am happy to give you permission to use the scales. If you decide to change items for particular specialty purposes or for different settings or outside the USA, Dr. Corley and I request that you keep us informed of the changes you make and the results you obtain.

Best of luck with your research,

Ann Hamric

From: chuleeporn Prompahakul [mailto:chuleepornprompahakul@yahoo.com]
Sent: Monday, October 18, 2010 9:17 AM
To: Hamric, Ann (abh4f)
Subject: Ask for revised Moral Distress Scale

Dear...Dr. Ann Hamric

My name is Chuleeporn. I am master student at Faculty of Nursing, Prince of Songkla University, Thailand. Now I conduct my research about factors relating nurses' caring behaviors for dying patients in southern Thailand. One of the factors is moral distress level. Previously, I contacted Dr. Corley about the questionnaire. She gave me two versions. After proposal defense, the committees suggested me to used shorten moral distress scale. Dr. Corley informed me that you completed a revision of the Moral Distress Scale. Therefore, I'd like to ask you for the revised Moral Distress Scale and the permission to use and translate in to Thai language. I am looking forward to see the revised Moral Distress Scale and allowing from you.

Sincerely,

Chuleeporn

APPENDIX H

Table 12

Mean and Standard Deviation on Each Item of Nurses' Caring Behaviors for Dying (N = 353)

Items	Behaviors	M	SD
1	I intend to take care of dying patients	2.56	0.55
2	I give honor and pay respect to the dying patients	2.55	0.55
3	I provide equal care	2.53	0.57
4	I am willing to listen to the dying patients	2.52	0.60
5	I respect the decisions of dying patients	2.50	0.61
6	I give chance for the dying patients and their families to express their feelings	2.43	0.64
7	I pay attention to the needs of caring	2.42	0.64
8	I facilitate religious practice	2.38	0.69
9	I give information and perform as a good counselor	2.34	0.63
10	I do everything possible for dying patients to get the appropriate care	2.32	0.62
11	I provide care for the dying patients and their families like I would to my own family	2.31	0.65
12	I respond to their needs as soon as possible	2.28	0.6

Table 12 (Continued)

Items	Behaviors	M	SD
13	I am aware in my expression and my voice	2.26	0.62
14	I show the dying patients and families that I understand their feeling of pain and suffering	2.24	0.67
15	I admire the families for taking care of dying patients	2.23	0.69
16	I relieve pain and other symptoms of suffering of the dying patients	2.22	0.59
17	I provide good care for dying patients and their families	2.22	0.65
18	I give information based on the reality of the dying patients and their families at the appropriate time	2.20	0.69
19	What I should provide to dying patients and their families is what I always want to do	2.18	0.66
20	I communicate with their families and other related health care providers	2.17	0.70
21	I strongly hold ethical principles along with the law when I confront ethical issues	2.17	0.70
22	I never give up when I confront obstacles	2.17	0.64

Table 12 (Continued)

Items	Behaviors	M	SD
23	I make the dying patients and their families believe that I will be with them and will not abandon them	2.16	0.68
24	I express the need of respect and honor from the dying patient, their families, and the health care team	2.15	0.75
25	I touch the dying patients	2.14	0.72
26	I keep the promises	2.14	0.76
27	I always take care of myself to be strong and healthy	2.14	0.73
28	I tell dying patients and their families that I will provide the best care for them	2.12	0.74
29	I help patients' families have confidence in the help I provide for dying patients	2.11	0.70
30	I seek solutions to overcome obstacles	2.08	0.64
31	I am with the dying patients and families	2.06	0.70
32	I assess the needs of the dying patients and families, concurrently	1.95	0.68
33	I diagnose nursing problems	1.85	0.72
34	I provide professional care for dying patients	1.84	0.71
35	I introduce myself to the dying patients	1.75	0.85

Table 12 (Continued)

Items	Behaviors	M	SD
36	I apply clinical practice guidelines and research outputs	1.29	0.82
37	I study to keep up my knowledge	1.53	0.73
38	I practice some skills of caring for dying patients	1.57	0.74
39	I have competence in using medical equipment and technologies	1.67	0.87
40	I collaborate and work with other health care providers	1.70	0.81

Table 13

The Relationship between Nurses' Caring Behaviors for Dying Patients Sub-Dimensions and Age, Professional Experience, Nurses' Self- Awareness, and Moral Distress (N = 353)

Related factors	Six dimensions of nurses' caring behaviors for dying patients					
	1	2	3	4	5	6
1. Age****	.100*	.139**	.058	.120*	.076	.065
2. Professional experience****	.119*	.121*	.096*	.149**	.083	.124*
3.Nurses' self-awareness*****	.244***	.268***	.313***	.362***	..375***	.339***
4. Moral distress*****	.103*	.153**	.129*	.024	.208**	.157**

* $p < .05$ ** $p < .01$ *** $p < .001$

**** Spearman rank-order correlation coefficient (rho, r_s)

***** Pearson product-moment correlation coefficients (r)

Note: 1 = Compassion 2 = Competence 3= Confidence

4 = Conscience 5 = Commitment 6 = Comportment

Table 14

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions Based on Training Experience, Using Independent Sample Test (N = 353)

Variable	Training experience				*t*	*p*-value
	Yes		No			
	M	SD	M	SD		
Compassion	2.38	0.50	2.23	0.49	2.79	.003
Competence	1.87	0.53	1.78	0.49	1.50	.068
Confidence	2.12	0.60	2.05	0.58	1.01	.157
Commitment	2.18	0.54	2.18	0.51	-0.03	.49
Comportment	2.13	0.53	2.09	0.51	0.72	.236

Note. Degree of freedom = 351

* $p < .05$

Table 15

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions (Conscience) Based on Training Experience, Using Man Whitney U test (N = 353)

Subscale	Trained			Untrained			*Z*	*p*-value
	Mean Rank	Min	Max	Mean Rank	Min	Max		
Conscience	183.29	1	2	172.72	1	2	-0.96	$.168^{NS}$

NS = $p > .05$

Table 16

Mean and Standard Deviation of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions Based on Experience of Caring for Dying Patients (N = 353)

Nurses' caring behaviors for dying patients	Experience of caring for dying patients							
	1-5 cases		6-10 cases		10-15 cases		>15 cases	
	M	SD	M	SD	M	SD	M	SD
Compassion	2.25	0.47	2.22	0.52	2.24	0.51	2.33	0.50
Competence	1.77	0.52	1.80	0.46	1.79	0.50	1.84	0.52
Confidence	2.01	0.64	2.06	0.61	1.97	0.59	2.13	0.57
Commitment	2.16	0.49	2.17	0.49	2.04	0.51	2.22	0.54
Comportment	2.13	0.61	2.07	0.48	2.01	0.52	2.13	0.51

Table 17

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions Based on Experience of Caring for Dying Patients, Using One-way Analysis of Variance (N = 353)

Subscale	Source of variance	SS	df	MS	*F*	*p*-value
Compassion	Between groups	0.91	3	0.30	1.22	0.30^{NS}
	Within groups	86.91	349	0.25		
Competence	Between groups	0.30	3	0.10	0.39	0.76^{NS}
	Within groups	90.71	349	0.26		
Confidence	Between groups	1.26	3	0.42	1.21	0.31^{NS}
	Within groups	121.17	349	0.35		

Table 17 (Continued)

Subscale	Source of variance	SS	df	MS	*F*	*p*-value
Commitment	Between groups	1.35	3	0.45	1.64	0.18 ^{NS}
	Within groups	95.42	349	0.27		
Comportment	Between groups	0.63	3	0.29	0.78	0.51 ^{NS}
	Within groups	94.09	349	0.27		

NS = $p > .05$

Table 18

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions (Conscience) Based on Number of Dying Patient, Using Kruskal Wallis H Test (N = 353)

Number of dying patients	Conscience				
group	n	Mean rank	df	*H*	*p*-value
1-5	47	170.23			
6-10	67	169.84			
11-15	47	151.95	3	5.41	.144 ^{NS}
>15	192	187.29			

NS = $p > .05$

Table 19

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions Based on Working Unit, Using Independent Sample Test (N = 353)

Subscale	Working units				*t*	*p*-value
	General ward		ICU			
	M	SD	M	SD		
Compassion	2.25	0.50	2.39	0.50	-2.45	.008**
Competence	1.82	0.51	1.82	0.52	-0.12	.493 NS
Confidence	2.01	0.60	2.56	0.56	-1.65	.05*
Commitment	2.17	0.51	2.20	0.56	-0.59	.277 NS
Comportment	2.13	0.52	2.04	0.50	1.50	.067 NS

*$p = .05$ NS $p > .05$

Table 20

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions (Conscience) Based on Working Unit, Using Man Whitney U test (N = 353)

Subscale	General ward			ICU			*Z*	*p*-value
	Mean Rank	Min	Max	Mean Rank	Min	Max		
Conscience	175.80	1	2	179.69	1	2	-0.33	.369 NS

NS $P > .05$

Table 21

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions Based on Nurses' Responsibility about End of Life Program, *Using Independent Sample Test (N = 353)*

Subscale	nurses' responsibility about end of life program				*t*	*p*-value
	No program		Program			
	M	SD	M	SD		
Compassion	2.15	0.52	2.36	0.48	3.76	.000***
Competence	1.69	0.52	1.88	0.49	3.44	.001**
Confidence	1.97	0.56	2.13	0.6	2.41	.009**
Commitment	2.11	0.52	2.22	0.53	1.71	.044**
Comportment	2.10	0.52	2.11	0.52	0.24	.406 NS
Total	2.03	0.42	2.16	0.43	2.87	.002*

*$p < .01$ **$p < .01$ ***$p < .001$ NS$p > .05$

Table 22

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions (Conscience) Based on Nurses' Responsibility about End of Life Program, Using Man Whitney U test (N = 353)

Subscale	No program			Program			*Z*	*p*-value
	Mean Rank	Min	Max	Mean Rank	Min	Max		
Conscience	161.42	1	2	184.82	1	2	2.05	.021*

*$P < .01$

Table 23

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions Based on Nurses' Self Study, Using Independent Sample Test (N = 353)

Subscale	Nurses' self study				*t*	*p*-value
	Yes		No			
	M	SD	M	SD		
Compassion	2.40	0.46	2.21	0.51	3.74	.000***
Competence	1.95	0.50	1.72	0.50	4.42	.000***
Confidence	2.22	0.56	1.98	0.59	3.82	.000***
Commitment	2.32	0.51	2.08	0.52	4.30	.000***
Comportment	2.20	0.48	2.04	0.54	2.97	.000***
Total	2.24	0.41	2.03	0.42	4.71	.000***

***$p < .001$

Table 24

The Comparison of Nurses' Caring Behaviors for Dying Patients Sub-Dimensions (Conscience) Based on Nurses' Self Study, Using Man Whitney U test (N = 353)

Subscale	Yes			No			*Z*	*p*-value
	Mean Rank	Min	Max	Mean Rank	Min	Max		
Conscience	199.94	1	2	160.44	1	2	3.62	.000***

***$p < .001$

Table 25

Mean and Standard Deviation on Each Item of Self-Awareness (N = 353)

No.	Items	M	SD
1	I know what I am thinking	3.27	0.77
2	I know what I am doing for the patient	3.56	0.58
3	I always consider my actions	3.15	0.76
4	I frequently do not intend with activities	3.42	0.86
5	I know how I am feeling	3.39	0.61
6	I know how my mind is	3.22	0.67
7	I know about the changes in my emotions	3.26	0.76
8	I think about the inspiration in doing the activities	2.93	0.82
9	I never stop considering myself	2.61	0.91
10	I feel that I am attempting to look for my standpoint	2.63	0.82
11	I pay attention to my physical neatness and uniform	3.13	0.83
12	I pay attention to my manner	3.18	0.72
13	I am aware of my words and my facial expression	3.32	0.61
14	I am aware of using body language	3.32	0.60
15	I pay attention to the response of the patient	3.14	0.68
16	I recognize how the patient feels about me	3.03	0.73

Table 25 (Continued)

No.	Items	M	SD
17	I know that I am making the patient impress in me	2.77	0.82
18	I remind myself that my actions and my words can affect the patient	3.32	0.65
19	I never think how the patient is feeling about me.	3.09	0.97
20	I always do activities without considering how the patient feels about me	3.21	0.92

Table 26

Mean and Standard Deviation on Each Item of Moral Distress (N = 353)

No	Situations	M	SD
1	Provide less than optimal care due to pressures to reduce costs	2.32	0.96
2	Ask the patient's family about donating organs when the patient's death is inevitable	2.04	0.91
3	Follow the family's wishes to continue life support even though it is not in the best interest of the patient	2.45	0.91

Table 26 (Continued)

No	Situations	M	SD
4	Initiate extensive life-saving actions when I think it only prolongs death	2.29	0.96
5	Follow that family's request not to discuss death with a dying patient who asks about dying	2.14	0.94
6	Carry out the physician's orders for what I consider to be unnecessary tests and treatments for terminally ill patients	2.59	0.97
7	Continue to participate in care for a hopelessly injured person who is being sustained on a ventilator, when no one will make a decision to "pull the plug"	2.19	0.9 8
8	Follow the physician's order not to tell the patient the truth when he/she asks for it.	2.49	0.94
9	Assist a physician who in my opinion is providing incompetent care	2.47	0.98
10	Prepare an elderly person for surgery to have a gastrostomy tube put in who is severely demented and a "No Code"	2.08	0.95

Table 26 (Continued)

No	Situations	M	SD
11	Let medical students perform painful procedures on patients solely to increase their skill	2.67	0.93
12	Provide care that does not relieve the patient's suffering because I fear that increasing the dose of pain medication will cause death	2.37	0.91
13	Follow the physician's request not to discuss Code status with the family when the patient becomes incompetent	2.66	0.88
14	Increase the dose of intravenous morphine for an unconscious patient that I believe will hasten the patient's death	2.24	0.91
15	Respond to a patient's request for assistance with suicide when the patient has a poor prognosis	2.92	0.91
16	Follow the physician's request not to discuss death with a dying patient who asks about dying	2.53	0.92
17	Work with physicians/nurses who are not as competent as the patient care requires	2.64	0.98

Table 26 (Continued)

No	Situations	M	SD
18	Ignore situations of suspected patient abuse by caregivers	3.07	0.86
19	Ignore situations in which patients have not been given adequate information to insure informed consent	2.90	0.92
20	Follow the physician's request not to discuss Code status with the patient	2.72	0.95
21	Follow orders for pain medication even when the medications prescribed do not control the pain	2.35	0.99

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List of Publication and Proceedings

Prompahakul, C., Nilmanat, K., & Kongsuwan, W. (2011). Factors Relating to Nurses' Caring Behaviors for Dying Patients: A Literature Review. *Nurse Media Journal of Nursing, 1*(1), 15-27.

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