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Do Oncology Nurses Provide More Care to Patients With High Levels of Emotional Distress?

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This study is part of a project investigating whether discrepancies between oncology nurses and patients with cancer concerning perceptions of the patients' situations have consequences for clinical practice. Earlier findings from the project have shown that nurses have shortcomings in adequately assessing the emotional distress of patients with cancer. The focus of this study is investigating the relationship between nurses' assessment of the emotional distress of patients with cancer and nurses' subsequent caring behavior.

Nurses have described meeting every patient's unique needs as central to cancer care (Botti et al., 2006; Kendall, 2007). Although nurses are part of the professional team responsible for providing care that meets these needs, they also have a front-line role in offering emotional support to patients with cancer (Corner, 2002). Because emotional distress is common among patients with cancer (e.g., the prevalence of anxiety and depression has been reported to vary between 10%–35%) (Aass, Fossa, Dahl, & Moe, 1997; Morse, Kendall, & Barton, 2005; Skarstein, Aass, Fossa, Skovlund, & Dahl, 2000; Strong et al., 2007), nurses in cancer care must be able to identify emotional distress as well as plan and provide nursing care that meets each patient's individual needs.

A widely used and accepted model to ensure individual care for each patient is the Nursing Process (Yura & Walsh, 1988), which is described as a problem-solving model and a confirming interaction between the patient and the nurse. The model involves five sequential and interrelated phases: assessment, diagnosis, planning, implementation, and evaluation. The goal of the first phase is to gather information about the patient's problems and needs, to understand the patient's own experience of the disease or issue (Iyer, Bernocchi-Losey, & Taptich, 1995), and to identify the patient's internal and external resources (Carnevali, 1996). In the second phase, the nurse critically analyzes and interprets the

Purpose/Objectives: To investigate nurses' planning and implementation of individualized patient care in relation to patients' emotional distress as assessed by nurses and whether nurses and patients perceived the implemented care in a similar manner.

Design: Prospective, comparative.

Setting: Five oncologic-hematologic wards in Sweden.

Sample: 90 individual nurse-patient pairs were recruited and 81 were intact after three consecutive days. Each pair consisted of a patient with cancer and a nurse responsible for that patient's care.

Methods: Nurse-patient pairs were followed using questionnaires. Outcome measures were nurses' identification of patients' emotional distress, care planning, and nurse-patient ratings of implemented care.

Main Research Variables: Patients' emotional distress and nurses' implemented care.

Findings: Nurses identified a variety of emotional issues among patients and planned individual nursing interventions. Nurse and patient perceptions of implemented care demonstrated weak correlations for individually planned interventions and nurses' general caring behavior. With one exception, nurse self-reports did not indicate any differences in nurses' caring behavior directed to more and less distressed patients. Nurses reported providing comfort more frequently to patients with high levels of emotional distress, but this was not substantiated in patients' ratings.

Conclusions: Nurses showed an intention to provide individualized care. However, with one exception, nurses did not report providing more care to patients with cancer with high levels of emotional distress than to less distressed patients.

Implications for Nursing: To ensure individualized care, nurses in cancer care should closely validate the accuracy of their interpretation of patients' needs and their planning of care in collaboration with the patients.

patient's problems and needs and identifies nursing diagnoses. Based on the nursing diagnoses, the care is then planned, implemented, and evaluated.

Quick Facts: Sweden

Geography and population: Sweden is a Western European country with an area of 450,000 km², third largest in the region. The population in 2008 was 9.3 million, with 85% living in urban areas.

Government: Sweden is ruled by a constitutional monarchy and a parliamentary democracy.

Healthcare system priorities and programs: Sweden's entire population has equal access to healthcare services. The Swedish healthcare system is government funded and heavily decentralized. The healthcare system is mainly funded by taxes, with nominal fees for patients. The infant mortality is low, and life expectancy is about 83 years for women and 79 years for men.

Education: All education from kindergarten to university degrees is financed by taxes; no fees exist for students (for Swedish as well as foreign citizens). Sweden has about 120,000 RNs. Studies to become an RN are completed over three years (120 weeks). After an additional year of studies (40 weeks), RNs can take a specialist nurse examination (e.g., in oncology).

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Despite the goal of individualized care proposed in the Nursing Process, several studies have shown discrepancies between nurses' and patients' perceptions of individual patient's problems and needs (Adamsen & Tewes, 2000; Florin, Ehrenberg, & Ehnfors, 2005; Lauri, Lepisto, & Kappeli, 1997; Löfmark, Hannersjö, & Wikblad, 1999). In cancer care, these discrepancies are well known. Nurses (as well as other healthcare professionals) have a tendency to ascribe more problems to patients with cancer than the patients themselves report (Brunelli et al., 1998; Mårtensson, Carlsson, & Lampic, 2008; Sneeuw, Sprangers, & Aaronson, 2002; Sprangers & Aaronson, 1992), particularly with respect to psychosocial issues (Brunelli et al.; Lampic & Sjöden, 2000; Sneeuw et al.). Although nurses in cancer care tend to overestimate patients' emotional distress at the group level (Lampic & Sjöden), studies investigating agreement between individual nurse-patient pairs show that a substantial proportion of nurses fail to identify clinically significant cases of depression and anxiety, as indicated by patient ratings (Lampic, von Essen, Peterson, Larsson, & Sjöden, 1996; Mårtensson et al.; von Essen, Burström, & Sjöden, 1994).

Discrepancies between patients' and nurses' perceptions of emotional distress for patients with cancer may have several potential explanations related to the healthcare organization, the nurses, and the patients. Time pressure has been suggested as an explanation for nurses' limited ability to adequately assess the psychosocial issues of patients with cancer (Kruijver, Garssen, Visser, & Kuiper, 2006), whereas continuity in care has

been shown to increase nurses' abilities to make correct assessments (Mårtensson et al., 2008). Another possible explanation is that nurses fail to correctly assess the emotional distress of patients because they misjudge or are unaware of the patients' coping with their illnesses. This explanation is supported in earlier findings (Mårtensson et al.; Merluzzi & Martinez Sanchez, 1997) showing that nurses underestimate the ability of their patients to cope with their disease. In addition, previous findings have shown that nurses consider that the emotional distress, particularly anxiety, of patients with cancer causes them the greatest issues in clinical practice (Fitch, Bakker, & Conlon, 1999; Rustöen, Schjölberg, & Wahl, 2003). The findings indicate that nurses perceive difficulties in assessing patients' needs for emotional support or, alternatively, are not fully confident in assessing and offering effective emotional support.

Nurses' limited ability to assess the emotional distress of patients with cancer may constitute an issue in cancer care because nursing actions should be based on an assessment of an individual patient's problems and needs. To the best of the authors' knowledge, no previous study has prospectively followed nurse-patient pairs to examine how nurses assess, plan, and perform care that is directed at the emotional needs of individual patients with cancer.

The main focus of this study was to investigate nurses' planning and implementation of individualized patient care in relation to patients' emotional distress as assessed by nurses. Another aim was to investigate whether nurses and patients perceive the implemented care in a similar manner. The following specific research questions were posed.

- What are, according to nurses, the most troublesome emotional issues of individual patients with cancer?
- What are, according to nurses, the most important nursing interventions for emotional issues for individual patients with cancer, and are nurses confident about these interventions?
- Do nurses and patients with cancer perceive nurses' implemented care in a similar manner?
- Do nurses' caring behaviors differ between patients with high versus low levels of emotional distress?

Methods

Study Sample and Setting

The study has a prospective and comparative design, and the problem-solving structure in the Nursing Process was used as a guide when designing and planning the study (i.e., selection of the situation for data collection, and selection and development of instruments for data collection). The study sample included 90 individual nurse-patient pairs, each consisting of a patient with cancer with a planned hospital stay

Table 1. Patient Characteristics

Characteristic	n	%
Gender		
Male	51	57
Female	39	43
Family situation		
Single	27	30
Married or living together	57	64
Separated	5	6
Education level		
Compulsory school	31	35
Senior high school, two years	28	32
Senior high school, three years	13	15
University	17	19
Time as inpatient (days)		
Less than 5	42	47
5–10	20	23
11–15	3	3
More than 15	24	27
Type of cancer		
Lymphoma	17	19
Myeloma	11	12
Leukemia	10	11
Liver or kidney	8	9
Sarcoma	7	8
Prostate or testis	5	6
Mouth or esophagus	5	6
Lung	5	6
Stomach, intestine, or colon rectal	4	4
Brain	3	3
Breast	3	3
Cervix, uterus, or ovary	2	2
Other	10	11
Aim of current treatment		
Palliative	44	51
Curative	43	49

N = 90

Note. Because of missing data and rounding, not all n values total the sample size and not all percentages total 100.

and a nurse responsible for the patient's care. Inclusion criteria for patients were aged 18 years or older (the units were primarily adult), a cancer diagnosis known to the patient, new admittance to the ward, a planned hospital stay of at least three days, as well as the ability to speak, read, and understand Swedish. Two patients, who were considered by the head nurse in too poor condition (physically or mentally) were excluded. Inclusion criteria for nurses included RNs working regular hours, having worked on the ward for a minimum of three months, and scheduled to work three consecutive days.

A consecutive series of patients with cancer who had been newly admitted to five oncology or hematology wards in two hospitals in Sweden were recruited during the period from January–December 2005. During the study period, 185 patients were eligible. Eighty-six patients were not approached because it was impossible to match them with a nurse (no nurse accessible who worked three consecutive days), one patient was

included in another research project, and eight declined participation. In total, 90 of 98 invited patients were included in the first data collection (T1) (response rate: 92%). Among the nurses who fulfilled the inclusion criteria, three declined participation. In total, 52 of 55 invited nurses participated at T1 (response rate 94%). Sixteen nurses assessed only one patient, 34 nurses assessed two patients, and two nurses assessed three patients. Of the 90 individual pairs at T1, 81 were intact at the second assessment after three consecutive days (T2). At T2, five patients had been discharged, two patients could not participate because of deteriorated health, and one nurse and one patient failed to complete the questionnaire. Patient and nurse characteristics are presented in Tables 1 and 2. The patients had a variety of cancer diagnoses and a mean age of 59.7 years (SD = 12.3; range 31–87). The median number of months since diagnosis was six (range 1–384 months). All but two of the nurses were women, the mean age was 38.6 years (SD = 9.7; range 24–65), and their experience as a nurse in cancer care varied between three months and 25 years.

Procedure

The study was approved by the regional ethical review board in Uppsala, Sweden. The nurses were repeatedly informed about the study at staff meetings. The patients were approached regarding study participation by the first author on the day of their arrival at the ward. All participants received written and oral information about the study and gave their written consent. After receiving the written informed consent, the head nurse matched each patient with a participating nurse. The following procedure applied to all nurse-patient pairs.

According to routine procedure on the ward, the nurse performed an admission interview with the patient. Directly after the admission interview (T1), nurses were requested to identify the patient's most troublesome emotional issue and to plan individual nursing interventions that would alleviate the problem. The nurses also completed a standardized questionnaire concerning the patient's emotional distress. Therefore, data collected at T1 covered nurse assessment, diagnosis, and planning of care. During the following three days, the nurse was responsible for the patient's care and was expected to implement the nursing interventions. On the patient's third day on the ward (T2), the patient and the nurse completed corresponding questionnaires concerning the care the patient had received from the nurse (i.e., nurse implementation of care to a specific patient).

Data Collection

Patients' emotional distress and nurses' care planning: A study-specific instrument was developed to assess nurses' identification and care planning regarding the emotional distress of individual patients. To

Table 2. Nurse Characteristics

Characteristic	n	%
Gender		
Female	50	96
Male	2	4
Family situation		
Single	10	20
Married or living together	39	76
Separated	2	4
Education level		
RN	38	75
Bachelor in nursing science	8	16
Master in nursing science	1	2
Specialist nurse in oncology	4	8
Previously responsible for the patient's care (during earlier stay)^a		
Yes	33	37
No	57	63
Knew their matched patient^a		
Not at all	51	59
Somewhat	28	33
Rather well	7	8
Very well	–	–
Implemented the individual nursing intervention as planned^a		
Yes	47	60
No	32	40

N = 52

^a Thirty-six nurses made assessments for more than one patient.

Note. Because of missing data and rounding, not all n values total the sample size and not all percentages total 100.

suit the nurse perspective in a care planning situation, emotional distress was operationalized as having an emotional issue. The study-specific instrument consists of five questions. The nurse was asked to identify his or her matched patient's most troublesome emotional issue (open response format), and the nurse was asked to rate how troublesome that problem is for the patient (from 0 [not at all] to 6 [unbearable]). After this, the nurse was requested to plan the most important nursing intervention for the identified problem (open response format), and rate her confidence in implementing the planned nursing intervention (from 0 [not at all confident] to 6 [totally confident]). Finally, the nurse rated her confidence in whether the planned nursing intervention would alleviate the patient's problem (from 0 [not at all confident] to 6 [totally confident]). The instrument was tested in a pilot study with experienced nurses in cancer care and showed good content validity.

To compare nurses' caring behavior directed at patients they judged as having different levels of emotional distress, the authors used the study-specific instrument and the established Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983). HADS has shown good psychometric properties (Bjelland, Dahl, Haug, & Neckelmann, 2002; Herrmann, 1997). The scale consists of two subscales, anxiety (seven

items) and depression (seven items), with four options (scores from 0 [no distress] to 3 [high distress]). The cutoff scores for subscales suggested by Zigmond and Snaith are 0–7 for "noncases," 8–10 for "doubtful cases," and 11–21 for "clinically significant cases." In this study, "non-cases" and "doubtful cases" have been combined. Nurses completed a nurse version of HADS in which the words *I*, *my*, and *you* are replaced with *the patient*, and instructions to indicate how they thought their matched patient felt were added (von Essen et al., 1994). The nurse version of HADS has shown satisfactory internal consistency (Lampic et al., 1996). In this study, the subscale Cronbach alpha values were anxiety 0.87 and depression 0.89.

Implemented care: Nurses' caring behaviors were measured using the Caring Assessment Report Evaluation (CARE)-How Often questionnaire (von Essen & Sjöden, 1995). CARE-How Often was developed based on the CARE-Q (Larson, 1981) and measures the occurrence of caring behaviors. The instrument consists of 50 caring behaviors rated on a seven-point scale, from 1 (very seldom) to 7 (very often), with the addition of one response alternative (0 [not applicable]). The instrument has six subscales: accessible (six items), explains and facilitates (six items), comforts (nine items), anticipates (five items), trusting relationship (16 items), and monitors and follows through (eight items). An example of the instruction is: "How often has/have the nurse/you performed the following caring behaviors in caring for me/the patient during the past three days?" Mean subscale scores were calculated by summing the individual items and dividing the sum by the number of items in each subscale. Both the patient and the nurse versions of CARE-How Often have shown cross-cultural and content validity as well as satisfactory internal consistency (von Essen & Sjöden, 1995). In the nurse sample, the Cronbach alpha values for subscales were: accessible, 0.74; explains and facilitates, 0.8; comforts, 0.65; anticipates, 0.5; trusting relationship, 0.7; and monitors and follows through, 0.67.

Because 12 patients had difficulty identifying and distinguishing the nursing actions of the specifically mentioned nurse (they had also received care from other nurses during these three days), only the CARE-How Often data from 69 pairs are presented.

For each nurse-patient pair, the nurse's individually planned nursing intervention for alleviating the patient's emotional issue (T1) was transferred (handwritten, verbatim) to the patient's and the nurse's questionnaires at T2. This intervention was then evaluated along with, and in the same manner as, the items of CARE-How Often (from 1 [very seldom] to 7 [very often]). The procedure of writing the nursing intervention by hand made it obvious to the patient and the nurse that this intervention was planned specifically for this patient.

Table 3. Patients' Emotional Issues Identified by Nurses

Emotional Issue	n	%	\bar{X}	SD
Worry	32	44	3.8	1.1
Upset by bodily changes	15	21	4	0.8
Depression	8	11	4.5	1.1
Avoidance	5	7	4.8	0.8
Isolation or loneliness	5	7	4	0.7
Relationship issues	5	7	4.8	0.4
Other	3	4	3.3	0.6

Note. Scores ranged from 0 (not troublesome) to 6 (unbearable).

Data Analysis

Nurses described the patients' emotional issues in an open-response format. The statements were analyzed and qualitatively sorted into seven categories (see Table 3). The individually planned nursing interventions (open response format) were categorized into the keywords of nursing interventions described in the Well-Being, Integrity, Prevention, and Safety (VIPS) model, which is a widely used and validated model for nursing documentation in Sweden (Darmer et al., 2006; Ehnfors, Thorell-Ekstrand, & Ehrenberg, 1991; Ehrenberg, Ehnfors, & Thorell-Ekstrand, 1997). The keywords, covering all possible nursing interventions, are *participation, information/education, support, environment, general care, training, observation/surveillance, special care, drug administration, and coordination*. The first author, who has extensive experience as a nurse in cancer care, qualitatively sorted the nurses' statements into categories. To reach agreement, the interpretations of the emotional issues and the categorizations were discussed in the research group until consensus was achieved.

Frequencies, percentages, mean values, and standard deviation were used for description. Associations between nurse and patient ratings of implemented care were calculated using Pearson's correlation coefficient (r). Because the data showed a normal distribution (Kolmogorov-Smirnov test), the authors used independent sample t tests for comparisons between subgroups of nurses and patients, respectively. Corresponding nonparametric tests (Mann-Whitney) also were performed and supported the findings. Because of the risk for making a type 1 error, significance levels of 0.01 were set for all tests. Missing values within subscales were replaced when more than 50% of the items in the subscale had been answered. Missing values were replaced with the mean for the individual in the subscales for HADS, and with the mean of the item for the group for CARE-How Often.

Results

The results show that the nurses did plan various nursing interventions directed at patients' individual

emotional needs, but that this individual approach was scarcely reflected in nurses' subsequent caring behavior. With one exception, no significant differences existed between nurses' implemented caring behaviors when directed at more, as compared to less, distressed patients. In addition, nurses and patients did not perceive nurses' implemented care in a similar manner.

Patients' Emotional Issues Identified by Nurses

Nurses responded to the open question regarding emotional issues for 73 of 90 patients. They identified a variety of problems that were categorized into worry (e.g., anxiousness regarding the future), depressive issues (e.g., hopelessness), isolation or loneliness (e.g., loss of independence), issues related to bodily changes (e.g., weight gain), avoidance (e.g., does not want to communicate emotions), issues related to relations (e.g., missing children and family), and other (e.g., conditioned nausea). In almost 50% of the cases, nurses identified "worry" as patients' most troublesome emotional issue, followed by "issues related to bodily changes." When scoring the severity of problems, nurses rated "avoidance" and "issues related to relations" as those that troubled the patients most. On average, most identified problems were rated as rather troublesome for the patients.

Nurses' Planned Interventions for Patients' Emotional Issues

Nurses planned a nursing intervention for 68 of 73 identified problems (see Table 4). These were categorized into participation (e.g., promoting patient's participation in caring), information (e.g., providing information regarding treatment), support (e.g., listening and encouraging), environment (e.g., providing treatment at outpatient unit), general care (e.g., providing good care), training (e.g., mobilization), special care (e.g., wound care), drug administration (e.g., increase drugs

Table 4. Nurses' Individually Planned Interventions for Patients' Emotional Issues

Intervention	n	%	Implement		Alleviate	
			\bar{X}	SD	\bar{X}	SD
Support	30	44	3.9	1.3	3.6	1.3
Information	17	25	4.5	1.1	3.6	0.9
Coordination	9	13	4.7	1.2	3.6	1.1
Environment	5	7	5.5	0.6	4.6	0.9
Drug administration	3	4	4.5	0.6	4	1
General care	1	2	5	–	2	–
Training	1	2	5	–	4	–
Special care	1	2	2	–	1	–
Participation	1	2	2	–	1	–

Note. Scores ranged from 0 (not confident) to 6 (totally confident).

to alleviate anxiety), and coordination (e.g., consulting other healthcare professionals). The most frequently planned nursing intervention for the patients' problems was some type of "support" followed by "information" and "coordination." The nurses were confident of their abilities to implement the intervention and that the planned interventions would alleviate the patients' problems.

Perceptions of Implemented Care

No significant correlation existed between nurses' and patients' ratings of implemented, individually planned nursing interventions (see Table 5). This indicates that nurses and patients did not rank the occurrence of nurses' care directed at patients' emotional issues in a similar manner. Significant but weak correlations were found for three of the CARE-How Often subscales.

Nurses' Rated Caring Behavior With Patients

Sixty-nine nurse-patient pairs responded to the CARE-How Often. In 59 of these pairs, the nurses had identified an emotional issue. On the basis of nurses' ratings of the severity of the emotional issues of individual patients, the patients were divided into two subgroups: less troubled (severity scores 0–4) and highly troubled (severity scores 5–6). Nurses' self-reported caring behavior was shown to differ significantly between these subgroups on the comfort subscale (see Table 6). This means that nurses reported that they had comforted, listened to, and talked to highly troubled patients more often than they had comforted, listened to, and talked to patients they rated as being less troubled by emotional issues. No corresponding group difference was found in patients' ratings of the occurrence of nurses' caring behavior.

Nurses' ratings of patients' HADS indicated 14 clinically significant cases of anxiety and 11 clinically significant cases of depression. No significant differences were found between the nurses' caring behaviors when

caring for patients they rated as clinically significant cases of anxiety or depression and their caring behavior when caring for patients rated as noncases or doubtful cases. The results were valid for nurse self-reports and for patient ratings of implemented caring behaviors.

Discussion

The results show that nurses identified emotional issues for most patients and planned individual nursing interventions that would alleviate the problems. Nurse-patient perceptions of implemented care demonstrated weak correlations for these individually planned interventions as well as for nurse caring behavior in general. With one exception, nurse self-reports did not indicate any significant differences in nurses' caring behavior when it was directed at more as compared to less distressed patients. Nurses reported providing more comfort to patients they rated as highly troubled by their emotional issues than they did to less troubled patients, but this was not substantiated in the patients' ratings.

Identification of patients' problems involves the first two phases of the Nursing Process (i.e., assessment and diagnosis) (Yura & Walsh, 1988). Worry was most frequently identified as the patients' emotional issue, a somewhat expected finding because worry and anxiety are well-known issues for patients with cancer (Larsen, Nordström, Björkstrand, Ljungman, & Gardulf, 2003; Montgomery, Pocock, Titley, & Lloyd, 2003; Skarstein et al., 2000). Interestingly, one of the problems the nurses rated as troubling the patients most was "avoidance," including statements that the patient "puts off dealing with the problems" and "does not want to communicate emotions." Although these statements seem to describe distracting strategies for managing emotions, often referred to as emotional coping (Folkman & Greer, 2000; Lazarus & Folkman, 1984), nurses in the current study regarded these patient behaviors as an emotional issue for the

patient. This suggests a valuation of patients' coping behavior, indicating that nurses regard patients' coping as "good" or "bad" for the patient and for nursing care (Kahn, Steeves, & Benoliel, 1994). Nurses should be aware that many patients with cancer use distracting strategies to maintain a normal life, and that patients do not always wish to talk with nurses about difficult emotions (Kvåle, 2007).

Planning is the third phase of the Nursing Process and involves development of strategies

Table 5. Correlations Between Patient- and Nurse-Implemented Care Ratings

Variable	Patients		Nurses		r	p
	\bar{X}	SD	\bar{X}	SD		
Caring Assessment Report Evaluation-How Often subscales (N = 69)						
Monitors and follows through	4.87	1.12	5.18	1.22	0.21	0.088
Accessible	4.64	1.36	4.34	1.26	0.49	<0.001
Comforts	3.86	1.1	3.75	0.96	0.35	0.003
Trusting relationship	3.27	1.04	3.55	0.95	0.29	0.015
Explains and facilitates	2.98	1.57	3.07	1.7	0.36	0.003
Anticipates	1.91	1.27	1.99	1.32	0.15	0.212
Individually planned nursing interventions (N = 54)	4.72	2.65	4.5	1.85	0.17	0.227

Note. Correlations ranged from 0 (not applicable) to 7 (very often).

Table 6. Caring Assessment Report Evaluation-How Often Subscales: Nurses' Caring Behaviors Directed at Patients' Levels of Emotional Distress

Subscale	Less Troubled ^a (N=34)		Highly Troubled ^b (N=25)		t	p	HADS Anxiety Non-Cases ^c (N=54)		HADS Anxiety Cases ^d (N=14)		t	p	HADS Depression Non-Cases ^c (N=57)		HADS Depression Cases ^d (N=11)		t	p
	Nurse Ratings		Nurse Ratings				Nurse Ratings		Nurse Ratings				Nurse Ratings		Nurse Ratings			
	\bar{X}	SD	\bar{X}	SD			\bar{X}	SD	\bar{X}	SD			\bar{X}	SD	\bar{X}	SD		
Monitors	5.05	1.36	5.5	0.92	1.43	0.16	5.24	1.16	4.86	1.45	-1.03	0.3	5.05	1.14	5.75	0.99	1.77	0.08
Accessible	4.19	1.25	4.55	1.04	1.19	0.24	4.37	1.25	4.18	1.34	-0.5	0.62	4.33	1.31	4.33	1.07	0.007	0.99
Trusting	3.47	1.02	3.86	0.76	1.58	0.12	3.53	0.92	3.6	1.08	0.25	0.8	3.47	0.95	3.93	0.87	1.49	0.14
Comforts	3.46	0.86	4.22	0.88	3.34	0.002	3.66	0.89	3.95	1.1	1.03	0.31	3.63	0.88	4.18	1.28	1.81	0.07
Explains	2.75	1.71	3.45	1.67	1.56	0.12	3.07	1.69	2.88	1.81	-0.38	0.71	2.93	1.71	3.56	1.58	1.21	0.27
Anticipates	1.71	1.35	2.5	1.25	2.27	0.03	1.88	1.27	2.28	1.47	1.02	0.31	1.86	1.3	2.47	1.3	1.42	0.16

Subscale	Patient Ratings		Patient Ratings		t	p	Patient Ratings		Patient Ratings		t	p	Patient Ratings		Patient Ratings		t	p
	Patient Ratings		Patient Ratings				Patient Ratings		Patient Ratings				Patient Ratings		Patient Ratings			
	\bar{X}	SD	\bar{X}	SD			\bar{X}	SD	\bar{X}	SD			\bar{X}	SD	\bar{X}	SD		
Monitors	4.9	1.11	5.07	1.15	0.57	0.57	4.88	1.17	4.89	0.96	0.03	0.97	4.85	1.18	5.04	0.08	0.52	0.61
Accessible	4.73	1.47	4.67	1.33	-0.18	0.85	4.69	1.4	4.63	1.14	-0.57	0.86	4.63	1.3	4.94	1.54	0.69	0.49
Comforts	3.76	1.07	4.16	1.21	1.33	0.19	3.88	1.11	3.95	1.02	0.22	0.82	3.85	0.99	4.12	1.48	0.76	0.45
Trusting	3.24	0.98	3.57	1.17	1.16	0.25	3.3	1.1	3.22	0.84	-0.25	0.8	3.23	1.06	3.54	0.93	0.89	0.38
Explains	3.2	1.67	2.99	1.53	-0.5	0.62	2.97	1.56	3.07	1.73	0.2	0.84	2.98	1.56	3.05	1.8	0.14	0.89
Anticipates	2.19	1.47	1.69	1.11	-1.42	0.16	1.92	1.3	1.95	1.2	0.09	0.93	1.9	1.23	2.03	1.53	0.31	0.76

^a Severity scores of emotional problem in the study-specific questionnaire 0–4; ^b Severity scores of emotional issue in the study-specific questionnaire 5 and 6; ^c Non- and doubtful cases;

^d Significant cases according to cutoff scores (Zigmond & Snaith, 1983)

HADS—Hospital Anxiety and Depression Scale

Note. Correlations for the Caring Assessment Report Evaluation-How Often subscales ranged from 0 (not applicable) to 7 (very often).

to minimize and correct identified problems (Iyer et al., 1995). "Support" and "information" directed at the patients were the nurses' principal interventions to alleviate their emotional issues. These interventions appear to be relevant for most identified problems. The nurses were confident in their abilities to implement planned interventions and also were rather confident that the outcome would entail alleviation of the patients' problems. The results contradict earlier findings based on nurses' self-reports that emotional issues (e.g., anxiety) for patients with cancer cause problems for nurses when providing daily care (Fitch et al., 1999; Rustöen et al., 2003).

The goal of the fourth phase, implementation, is achievement of the desired outcome (Iyer et al., 1995). Nurse-patient perceptions of implemented care demonstrated weak, if any, correlations for individually planned interventions and for nurse caring behavior in general. Although nurses' self-reports indicated somewhat differentiated caring behavior with respect to patients' levels of emotional distress, patient ratings did not substantiate these findings. If the patient does not perceive a nursing intervention when it occurs, then the intervention has probably not served its particular purpose and may fail to achieve the desired outcome.

The most striking finding was that, with one exception, no significant differences appeared in nurses' self-reported caring behavior directed at patients whom the nurse perceived as being highly versus less troubled by the emotional issue. In addition, no differences emerged in nurses' caring behavior when it was directed at patients the nurses rated as "nondoubtful cases" as compared to those rated as "clinically significant cases" of anxiety and depression (HADS). The findings are in line with results from two earlier studies in which nursing staff ratings of the anxiety and depression (HADS) of patients with cancer were not associated with the

importance staff placed on performing specific caring behaviors (CARE-Q subscales) for that patient (Larsson, Widmark Peterson, Lampic, von Essen, & Sjöden, 1998; Widmark-Petersson, von Essen, & Sjöden, 2000). The results may be interpreted as showing that nurses predominantly provide standard care to patients with cancer irrespective of their assessment of individual patients' levels of anxiety and depression and, therefore, as challenging nurses' statements concerning the importance of meeting every individual patient's needs (Botti et al., 2006; Kendall, 2007). Another interpretation is that the often-reported shortcomings on the part of nurses regarding adequate assessment of the emotional distress of patients with cancer probably have minor consequences for nursing practice.

Methodologic Considerations

The main strength of the current study was its prospective design, following individual pairs over three consecutive days. One condition for addressing the research questions was a design including individual nurse-patient pairs. This design has the disadvantage of a limited sample size. One limitation is the study-specific questionnaire used, and additional testing of reliability and validity is required. The remaining instruments used have been shown to be reliable and valid. With regard to the instrument, CARE-How Often, patients and nurses may have different perspectives on the occurrence of caring behaviors. Patients likely base their assessments on expectations and individual needs, and nurses make their assessments in relation to how often they have performed a specific behavior with other patients. However, systematic discrepancies between patients' and nurses' perceptions of the response alternatives should not influence the strength of correlations between patient and nurse ratings. In addition, such potential systematic discrepancies

between patients' and nurses' perceptions had no influence when subgroups of patients or nurses were compared.

Conclusions

Nurses identified a variety of emotional issues in patients with cancer and planned individual nursing interventions to alleviate the problems. The results indicate an intention to provide individual care and no stereotyping of patients when nurses assess and plan patient care. Despite this, with one exception, nurses did not provide more care to the patients with cancer rated as having high levels of emotional distress than to patients rated as being less distressed. In addition, nurses and patients did not perceive nurses' implemented care in a similar manner. Taken together, the findings reveal a potential risk that patients with cancer will not receive the individual care they need, and that nursing interventions may fail to achieve the desired outcome. To decrease this risk and ensure individualized care, nurses in cancer care should closely validate the accuracy of their interpretation of patients' needs and their planning of care in collaboration with the patients.

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