CARING BEHAVIORS OF NURSES IN A MILITARY HOSPITAL

A Thesis

Presented to

The Faculty of the College of Graduate Studies

SAMAR STATE UNIVERSITY

Catbalogan City, Samar

In Partial Fulfilment

Of the Requirements for the Degree

Master of Science in Nursing

Major in Nursing Management and Clinical Supervision

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February 2018

APPROVAL SHEET

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ACKNOWLEDGEMENT

The researcher considers the valuable assistance of the following persons for without them, the completion of this study would not have been possible:

The researcher is particularly thankful to her thesis adviser, **Mrs. Maricel M. Tizon**, for the review, comments, suggestions, and constructive criticism; for her concern and help; and for encouraging the researcher to pursue and finish this study; who assumed the good quality of this research study; and to **Dr. Marianne Agnes T. Mendoza** for her assistance in the statistical computation of this study.

To Dr. **Kennedy N. Alaurin**, Commanding Officer, **Maria Cristina V. Villarias**, Chief Nurse of Camp Lukban Sation Hospital; **Dr. Mamerto H. Losa**, Commanding Officer, **Annaliza U. Yanto**, Chief Nurse of Fort Magsaysay Army Station Hospital; **Dr. Ignacio P. Timbol Jr**, Commanding Officer, **Romelia E. Quilo**, Chief Nurse of Camp Melchor F Dela Cruz Station Hospital; and **Dr. Giancarlo L. Cabanag**, Commanding Officer, **Maria Lorela C. Caballes**, Chief Nurse of Camp Lapulapu Hospital for allowing the researcher to conduct the study.

The researcher gratefully acknowledges also the cooperation of the nurses and selected patients of Camp Lukban Station Hospital, Fort Magsaysay Army Station Hospital, Camp Melchor F Dela Cruz Station Hospital, and Camp Lapulapu Hospital in providing the necessary information that were vital for the completion of the study.

Finally, to our Almighty God, who is always faithful in providing for all the graces and blessings, knowledge, wisdom, strengths, endurance, courage, peace of mind, and comfort bestowed upon the researcher to carry her work against all sorts of difficulties.

DEDICATION

"Good, better, best,
never let it rest
until your good is better and
your better is your best!"
(An adage from the sisters at Visitation Academy)

This thesis is lovingly dedicated to my parents; to the hardworking nurses in the healthcare profession; to my friends, colleagues and mentors; to my loved ones and most especially to the Almighty God for without them, the accomplishment of this study would not have been possible.

The Researcher

ABSTRACT

The study assessed and compared the perceptions of military nurses and clients of the provision of caring behaviors in four (4) military hospitals across the country. This study employed the quantitative-qualitative descriptive research design to compare the caring behaviors of nurses in a military hospital as viewed from both nurses and patients based on Watsons' theory of Human Caring. Being a joint quantitative-qualitative research endeavour, focus group discussion was conducted to verify results gathered through the survey. There was a significant difference in the perceptions of the provision of caring behaviors between nurses and military patients. Nurses' perception with a grand mean of 4.54 had a significantly higher rating than patients' perception with a mean score of 4.25 when compared using t-test since the p-value was .019, which was below the significance level of α=0.05. Therefore, the corresponding null hypothesis was rejected. Most of the patients' gave the nurses highest rate in human needs assistance existential/phenomenological spiritual forces, supportive/protective/corrective environment and humanism/faith-hope sensitivity subscales. Military patients value physical, mental, and spiritual caring competencies and the ability of the nurse to deliver a general feeling of well-being and nurse have to incorporate these aspects into practice if they are to promote quality nursing care in this population of patients. The healthcare workers must prioritize the patient's needs and must have good caring behaviour to all patients without any biases.

TABLE OF CONTENTS

Chapter 1

THE PROBLEM AND ITS SETTING

Introduction

Caring comes in all forms, sizes, and shapes in the field of nursing. It is the essence of nursing, and the dominant, distinctive, and unifying feature of nursing. It is what nurses all over the world in all disciplines have professionally sworn to do. There can be no cure without caring but there can be caring without curing (Leininger & McFarland, 2002). The focus of nursing as a discipline has been defined as the study of caring in the human health experience (Newman, Sime, & Corcoran-Perry, 2009). Caring as a central concept has led to the development of several caring theories.

Military care is a new field that is gaining momentum in nursing. Nursing and the military have both been around since ancient times, and it's not surprising that the two professions are so intertwined. Military nurses are healthcare professionals who provide medical care to patients in military clinics and hospitals (Dreater & De Jong, 2002). In peacetime, military nurses care for active-duty personnel and their dependents, military retirees and their dependents, and occasionally, civilian emergency patients. In wartime, military nurses provide medical support around the globe, often in austere environments.

In the Philippines there has been a steady rise in the number of military personnel since 2004 starting with about 145,000 and tripling over time with

500,000 mid-2017 (Trading Economics, 2017). If basing on the 500,000 nurses in the country during the same period (Learning Nurse Resources, 2017), there would be a 1:1 ratio of nurse to military personnel. However, there is only a small proportion of nurses that serve the military force in only 20 hospitals nationwide because of the strict requirements and the rigid screening process. But this is justified because of the uncommon cases of military as compared to the general populace, needing for nurses to have a complex skillset to enable them to cater to varied causes, ranging from wounds to post-traumatic stress disorder.

The experience of dealing with military personnel and their families need a special type of care, which is seldom being taught in nursing school, if not, only in passing. As such, nurses develop their caring behaviors as they go about their duties and responsibilities. Just as each individual is unique, each nurse also has a different way of caring for their clients.

Jean Watson's Human Caring Theory (2007) can serve as backbone to studying the skillset needed by military nurses. This theory can not only lend further understanding to the rising field of military nursing but also the interaction that takes place between military nurse and client. In addition, none of the literature have studied this theory in the context of military nursing. Because discrepancies often exist between nurses' perceptions of nurse caring behaviors and patients' perceptions of nurse caring behaviors (Berg & Danielson, 2007; Chang, & Lin, 2005; Poirier & Sossong, 2010), examining nurse caring behaviors from the perspective of both the nurse and the military patient concurrently

should identify similarities and differences in nurses' and patients' perceptions of nurse caring behaviors.

Military personnel, more than ordinary patients, need utmost care since not only are they confronted with problems relating to physical health, but their condition is exacerbated by the mental trauma of their experiences. The caring they need remains undocumented still. Therefore, the researcher investigated the provision of caring as perceived by military personnel and compared any differences and/or similarities to military nurses' perceptions of the provision of caring behaviors.

Statement of the Problem

This study aimed to compare the perceptions of military nurse and client of the provision of caring behaviors in four (4) military hospitals across the country.

Specifically, it sought to find answers to the following questions:

1. What is the socio-demographic profile of the participant nurses?
2. What is the socio-demographic profile of the participant patients?
3. What are the self-rated caring behaviors by military nurses based on Watson's Theory of Human Caring:
    - 3.1 Humanism/Faith-Hope/Sensitivity;
    - 3.2 Helping/Trust;
    - 3.3 Expression of Positive/Negative Feelings;
    - 3.4 Teaching/Learning;

3.5 Supportive/Protective/Corrective Environment;

3.6 Human Needs Assistance, and

3.7 Existential/Phenomenological Spiritual Forces?

4. What are the caring behaviors of military nurses according to the patients based on Watson's Theory of Human Caring?

5. Is there a significant relationship between the self-rated caring behaviors of military nurses and their socio-demographic profile?

6. Is there a significant difference between the self-rated caring behaviors of the military nurses and according to the patients?

Hypotheses

1. There is no significant relationship between the self-rated caring behaviors of military nurses and their socio-demographic profile.

2. There is no significant difference between the self-rated caring behaviors of the military nurses and according to the patients.

Theoretical Framework

This study is anchored on Jean Watson's Theory of Human Caring (2007).

Watson defines caring as a moral ideal rather than task-oriented behaviour (Basavanthappa, 2007). The theory is applicable to this study because it focuses on the science of caring in nursing and how this applies to the field of military nursing. Watson's (2007) theory is a good springboard in studying the provision

of caring since it covers mostly all dimensions of man's needs and how nurses can address such needs.

According to Watson (2007), the theory constitutes ten elements of caring termed as carative factors that form the basis of nursing interventions in patient care. Even so, caring promotes health more than does curing (Watson, 2007).

The Caring Behaviours Assessment (CBA) tool, which was used in the current study to measure the perception of nurse-caring behaviours, has seven subscales based on the carative factors. These subscales outline the specific actions that constitute caring in nursing.

Watson (2007) views these carative factors as a guide for the core of nursing upon which nursing interventions related to human care should be based upon. The first three carative factors form the philosophical foundation for the science of caring and the remaining seven carative factors spring from the foundation laid by these first three. These carative factors are outlined below.

First, Formation of humanistic-altruistic system of values which describes satisfaction through giving and the extension of the sense of self. Second, Instillation of faith-hope focuses on an effective nurse-patient relationship that promotes health-seeking behaviours. Third, Cultivation of sensitivity to self and another describes self-actualization process on the part of the nurse that allows the nurse to be more sensitive to others. Fourth, establishing a helping-trust relationship is characterised by congruence, empathy and warmth. Fifth, Promotion and acceptance of the expression of positive and negative feelings

which refers to feelings alter thoughts and behaviour, and they need to be considered and allowed for in a caring relationship.

Sixth, the systematic use of the scientific problem-solving method for decision making is the use of nursing process brings scientific problem-solving approach to nursing care. Seventh, promotion of interpersonal teaching-learning aims at encouraging the patient to provide self-care to promote personal growth and wellness. Provision of information enables the patient make informed decisions regarding health and healing. Eight, provision for a supportive, protective and/or corrective mental, physical, socio-cultural and spiritual environment wherein the nurse manipulates this environment in order to provide support and protection for the person's mental and physical well-being. Ninth, assistance to meet human needs is based on a hierarchy of needs similar to that of the Maslow's. The patient must satisfy the lower order needs before attempting to attain higher order needs. And tenth, allowance for existential-phenomenological forces wherein the nurse needs to vie each person's reality through the individual's eyes.

Watson's theory highlights the importance of human caring in the process of bringing back not only the physical health of the patients but all dimensions of health including their mental, emotional, and spiritual health. Watsons' theory stated about the importance of nursing care in the process of bringing back not only the physical health of the patients but also their mental and spiritual health. In all aspects of life health is the most important factor in prolonging people's lives

and the quality of care given by nurses determines the quality of health they would have and furthermore the longer time they would live. Caring is a universal aspect which should be dug deep down the providers soul and should reflect to their behaviors.

Conceptual Framework

Figure 1 shows the conceptual framework of the study. As reflected in the diagram, the study determined and compared the perceived provision of caring behaviors in the context of Watson's 10 carative factors from the point of view of nurses and patients in a military hospital.

The nurses apply different caring behaviors in their day to day experiences with patients. These caring behaviors basically fall under any of the 10 carative factors of Watson's theory as outlined in the theoretical framework.

As seen in the figure below, nurses and military patients serve as respondents in this study. The military nurses render the caring behaviors as outlined in Watson's theory (2007), which served as the independent variable. This leads to the perceptions of caring behaviors by both nurses and patients and the similarities and/or differences in their perceptions, which is the dependent variable. Because both nurses and patients are social beings, this study also believes that the socio-demographic characteristics of respondents play an intervening effect on the dependent variable of this study.

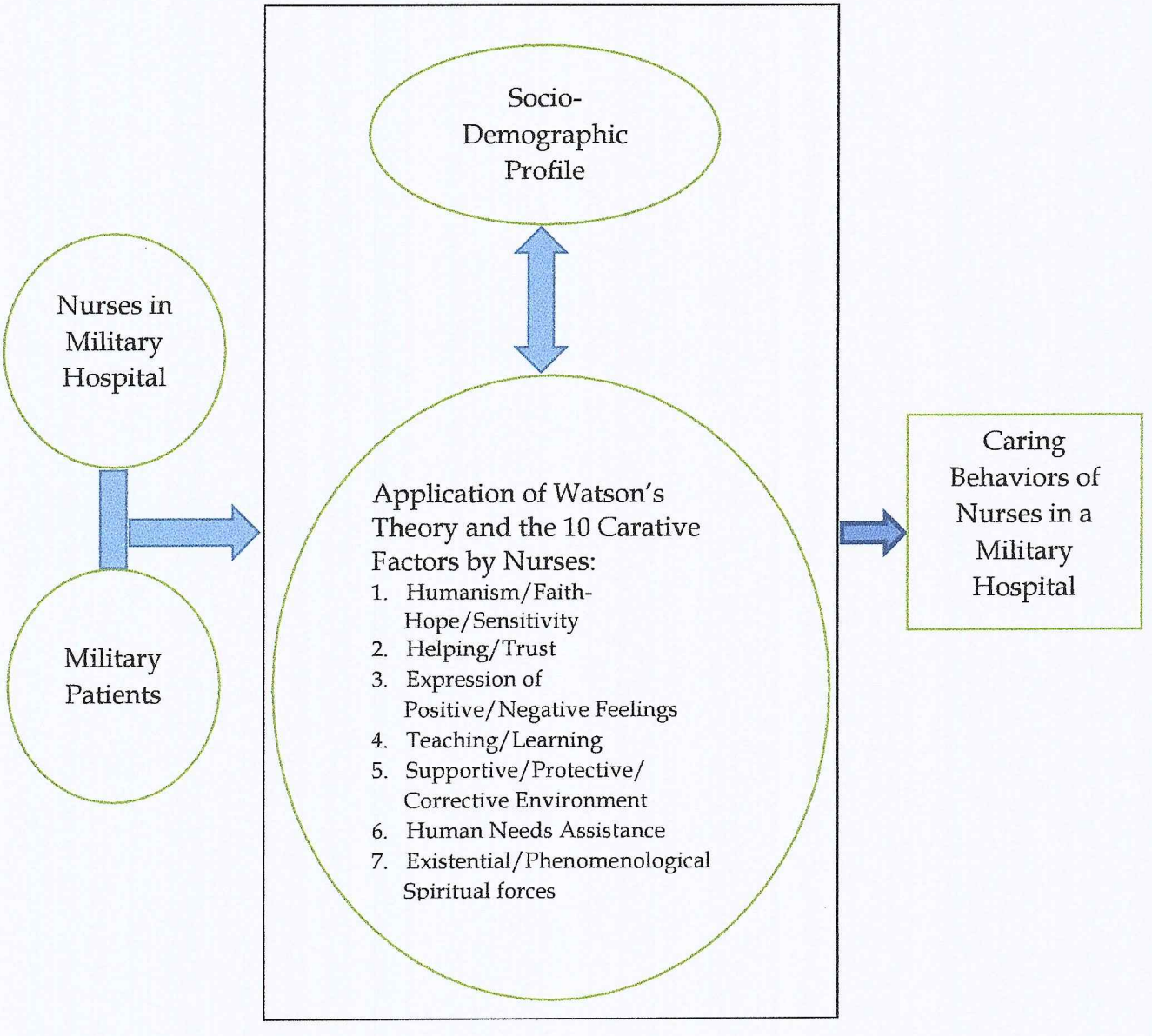

Figure 1. The Conceptual Framework of the Study

Significance of the Study

This study was conducted to document the caring behaviors of nurses in military hospitals across the country. The findings of this study will be useful to the patients, nurses, student nurses, hospital administrators, nursing department, and future researchers.

Patients. This study will help patients in giving them knowledge about the nurses' clinical functions to meet their needs and expectations.

Nurses. This study will help nurses in understanding what the caring behaviors are needed by military patients. For those deciding to pursue a career as military nurse, knowing what is in store for them can help them become better equipped with handling the different unique needs of military patients.

Student Nurses. This study will provide valuable information about what military nurses are actually experiencing with emphasis on caring behaviors required in this special health care setting especially since this is a topic that is not dealt with in detail in the classroom setting.

Hospital Administrator. This study will serve as their basis on how they can better their service to the men and women that serve and protect the country. Data from military patients' of whether or not nurses are really providing the caring behaviors they require will serve as valuable monitoring and evaluation inputs.

Nursing Department. This study will provide valuable inputs about the behaviors of nurses and how they would produce enough and competent nurses to improve this rising field.

Future Researchers. This study will serve as their guide in uncovering knowledge in new fields of nursing and can serve to spark interest in similar undertaking.

Scope and Delimitations

The study has two different respondents from four (4) military (Army) hospitals in the Philippines (Camp Lukban Station Hospital, Fort Magsaysay Army Station Hospital, Camp Melchor F Dela Cruz Station Hospital and Camp Lapulapu Hospital) including the nurses and the military patients which both total to 45.

The primary focus of the study was to compare the perceptions of nurses and patients of the provision of caring behaviors in four (4) military (Army) hospitals. Furthermore, this study was guided by Watson's Theory of Human Caring specifically her 10 carative factors. As such, caring behaviors not covered by these theory were not investigated.

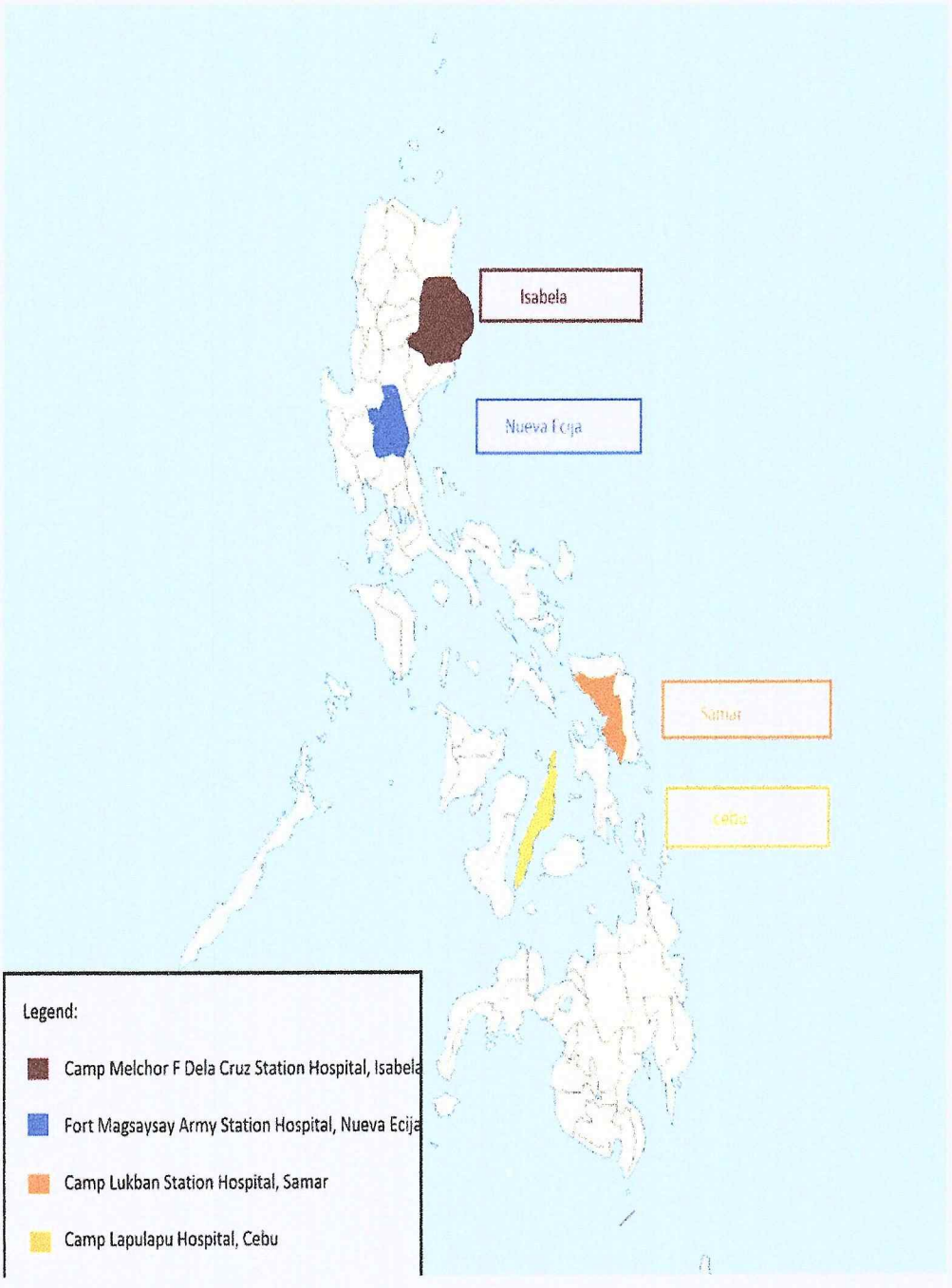

Figure 2. Locale of the Study

The locale of the study (Figure 2) was in four (4) military (army) hospitals across the country. Camp Lukban Station Hospital of the 8th Infantry Division Philippine Army during the time of conduct was a Level I hospital with 50-bed capacity in Catbalogan City, Samar Philippines. Camp Lapulapu Hospital of the Armed Forces of the Philippines Health Service Command was a Level 2 hospital with 100-bed capacity in Cebu City, Philippines. Camp Melchor F Dela Cruz Station Hospital of the 5th Infantry Division, Philippine Army was a Level 1 hospital with 50-bed capacity in Gamu, Isabela. Fort Magsaysay Army Station Hospital was a Level 2 hospital with 50-bed capacity in Palayan City, Nueva Ecija. The hospitals catered to the health needs of military personnel, their dependents, and authorized civilians across the country. The researcher chose these hospitals since these were among the biggest military (army) hospitals in the country.

The standardized Caring Behavior Assessment (CBA) questionnaire by Cronin and Harrison (1988) was used to gather pertinent data. Only the qualitative method of focus group discussion (FGD) served to gather in-depth information to validate quantitative data. This study was limited to the clinical conditions existing at Camp Lukban Station Hospital, Fort Magsaysay Army Station Hospital, Camp Melchor F Dela Cruz Station Hospital and Camp Lapulapu Hospital in so far as caring is concerned. All nurses, whether civilian or military officer working in the same military hospital were considered as the same because of the similar job description in terms of patient care. Military patients that were admitted at the

time of conduct of the study were medical-surgical, orthopaedic-EENT cases only. This study was conducted on the month of November 2017 to January 2018.

Definition of Terms

In order to provide common reference among the readers, the following terms are defined:

Caring. A nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility (Wojnar, 2010). In this study this term is used to denote the application of Jean Watson's 10 carative factors to provide and meet the optimum quality of health of military patients.

Carative Factors. This refers to the factors of human caring as anchored on Jean Watson's Theory of Human Caring (2007). In this study, this pertains to the day to day dealings of nurse participants in caring for military patients.

Caring Behaviors. This refers to the nursing attitudes, skills, and knowledge employed in the care of patients (Watsons, 2007). In this, study this pertains to actions of nurses which falls within Watson's 10 carative factors that show care to the military patients in the hospital and measured through the Caring Behavior Assessment Tool by Cronin and Harrison.

Nurse. This refers to a person who is trained to care for sick or injured people and who usually works in a hospital or doctor's office (Merriam-Webster Dictionary). In this study, these are nurses tasked in the care of military patients.

Military Hospital. This refers to a hospital for the care and treatment of sick and wounded military personnel (Merriam-Webster Dictionary). In this study, this term refers to hospitals across the country reserved for the health needs of military personnel, their dependents and authorized civilians.

Humanism/Faith-Hope Sensitivity subscale. This refers to the satisfaction through giving and the extension of the sense of self (Watsons, 2007). In this study, this refers to the nurses' respect, sensitivity and capacity to view military patients through their own perceptual systems.

Helping/Trust subscale. This refers to establishing a relationship characterised by congruence, empathy and warmth (Watsons, 2007). In this study, this refers to development of a therapeutic nurse-patient relationship.

Expression of Positive/Negative Feelings subscale. This refers to nurses' acceptance of patients' feelings facilitates deeper self-understanding and connectedness with the patient (Watsons, 2007). In this study, this refers to the nurses' facilitation and acceptance of the ventilation of military patients' feelings.

Teaching/Learning subscale. This refers to encouraging the patient to provide self-care to promote personal growth and wellness (Watsons, 2007). In this study, this refers to how the nurse impart information and facilitate learning.

Supportive/Protective/Corrective Environment subscale. This refers to nurse manipulation of the environment in order to provide support and protection for the person's mental and physical well-being (Watsons, 2007). In this study, this

refers to how nurses manipulated internal and external environment to promote health and well-being.

Human Needs Assistance subscale. This refers to assistance of the needs which is important for quality nursing care and the promotion of optimal health (Watsons, 2007). In this study, this refers to dealing with how the nurses assisted military patients in meeting human needs.

Existential/Phenomenological Spiritual forces subscale. This refers to nurses needs to view each person's reality through the individual's eyes (Watson, 2007). In this study, this refers to nurses' acknowledgement of the identity of each military patient.

Chapter 2

REVIEW OF RELATED LITERATURE AND STUDIES

This chapter contains a review of the literature related to the concept of caring as applied to the nursing field within the context of the study objectives. Highlighting the concept of caring to nursing is integral since the field is essentially a caring profession. This chapter also describes the work of a military nurses, a field which is still starting to gain momentum. Sensory perception is also described since this is basically a perception study. In addition, a review of related literature about studies pertinent to the methods and results of this research is detailed.

Related Literature

The following related literature was taken from different materials that are relevant to the present endeavor of the researcher.

As summarized by Meleis (2012) from available literature, caring is the essence of nursing. Nurses are in a unique position to create a more relationship-centered health care system (Berman & Snyder, 2012). Thus, the focus of nursing as a discipline has been defined as the study of caring in the human health experience (Newman, Sime, & Corcoran-Perry, 2009).

In professional nursing care, connection, mutual recognition, and involvement is shared between nurse and client (Berman & Snyder, 2012). Just as

clients benefit from caring practices, the nurses involved in these situations experience caring through knowing that they have made a difference in their clients' lives. Major ingredients of professional caring provide structure and further description of this process: (a) knowing means understanding the other's needs and how to respond to these needs; (b) alternating rhythms signifies moving back and forth between the immediate and long-term meanings of behavior, considering the past; (c) patience enables the other to grow in his own way and time; (d) honesty includes awareness and openness to one's own feelings and a genuineness in caring for the other; (e) trust involves letting go, to allow the other to grow in his own way and own time; (f) humility means acknowledging that there is always more to learn, and that learning may come from any source; (g) hope is belief in the possibilities of the other's growth; and (h) courage is the sense of going into the unknown, informed by insight from past experiences.

The focus of nursing as a discipline has been defined as the study of caring in the human health experience (Newman, Sime, & Corcoran-Perry, 2009). Nurse scholars have reviewed literature, conducted research, and analyzed nurses' experiences, resulting in the development of theories and models of caring. Each theory develops different aspects of caring, describing how caring is unique in nursing (Berman & Snyder, 2012). Several nursing theorists focus on caring: Leininger, Ray, Roach, Boykin and Schoenhofer, Watson, Swanson, *etc.*

For instance, based on studies in nursing and anthropology, Leininger notes that caring, as nurturing behavior, has been present throughout history and

is one of the most critical factors in helping people maintain or regain health (Leininger & McFarland, 2007). Leininger emphasizes care as the "essence and central dominant construct of nursing." Her theory of culture care diversity and universality is based on the assumption that nurses must understand different cultures in order to function effectively.

Ray's theory of bureaucratic caring focuses on caring in organizations (e.g., hospitals) as cultures. The theory suggests that caring in nursing is contextual and is influenced by the organizational structure. In Ray's research (Coffman & Carpenter, 2010), the meaning of caring varied in the emergency department, intensive care unit, oncology unit, and other areas of the hospital. Furthermore, the meaning of caring was further influenced by the role and position a person held.

Roach (2014) focuses on caring as a philosophical concept and proposes that caring is the human mode of being, or the "most common, authentic criterion of humanness." All persons are caring, and develop their caring abilities by being true to self, being real, and being who they truly are. Thus, caring is not unique to nursing. Roach visualizes caring to be unique in nursing, however, because caring is the center of all attributes used to describe nursing.

Boykin and Schoenhofer suggest that the purpose of the discipline and profession of nursing is to know persons and nurture them as persons living and growing in caring (Purnell, 2010). Respect for persons as caring individuals and respect for what matters to them are assumptions underlying the theory of nursing

as caring. Similar to Roach's idea that all persons are caring, Boykin and Schoenhofer emphasize the importance of the nurse knowing self as a caring person. Through knowing self as a caring person, the nurse can be authentic to self, freeing oneself to truly be with others.

Swanson defines caring as "a nurturing way of relating to a valued 'other,' toward whom one feels a personal sense of commitment and responsibility" (Wojnar, 2010). An assumption of her theory is that a client's well-being should be enhanced through the caring of a nurse who understands the common human responses to a specific health problem.

Lastly, Watson believes the practice of caring is central to nursing; it is the unifying focus for practice. Her major assumptions about caring are detailed in the theoretical framework of this study. Accordingly, nursing interventions related to human care originally referred to as carative factors have now been translated into clinical caritas processes (Watson, 2007).

Through history, wars have accentuated the need for nurses (Berman & Snyder, 2012). In fact, it was during the Crimean War that Florence Nightingale, the mother of nursing, played pivotal role in transforming military hospitals by setting up sanitation practices such as hand washing and washing clothes regularly. The need for educated health care providers to function in humanitarian missions, wartime, military operations other than war is well documented in the literature (Rivers, 2006). Today, military nurses hold military rank and can be part

of any of the Nurse Corps of any major military branch, including the Navy, Air Force, and Coast Guard.

As cited by (Dreater & De Jong, 2002), in some ways, a military nursing career is very similar to a traditional nursing career. The main goal of all nurses is to care for their patients and help them get better, for instance. However, in many ways, a military nursing career is very different than a traditional nursing career. For instance, it's not uncommon for military nurses to work right alongside military personnel in war zones.

One of the most dangerous and difficult aspects of a military nursing career is caring for deployed members of the military during wartime (National Minority AIDS Education & Training Center, 2014). This often includes treating severe life-threatening injuries, such as gunshot wounds or lost limbs. Because of the severity of the injuries that they may encounter as well as the volatile work environment, military nurses must be able to keep a cool head under pressure. Life-saving skills are also essential skills for those in the military nursing career.

As such, military nursing personnel fulfill several roles and must maintain competency skills and functions critical to these roles in field situations (Rivers, 2006). Among such roles are critical care, preoperative/postoperative care, anesthesia care, radiology, laboratory, pharmacy, nursing/personnel management, emergency trauma management, and other diverse medical nursing roles.

As with all nursing careers, there are a number of disadvantages and advantages to working as a military nurse (Dreater & De Jong, 2002). First of all, a military nursing career can be very stressful and sometimes heart-breaking. It can also be somewhat dangerous, since it's not uncommon for military nurses to be deployed to foreign war zones with troops.

Despite the drawbacks of the career, there are also a number of benefits. For instance, as a military nurse, you will have the chance to travel and see the world (Dreater & De Jong, 2002). You will also have access to a first class education and be well compensated for your time. Also, excellent benefits, such as free healthcare, often go hand in hand with a military career. However, one of the biggest rewards of working as a military nurse is the experience your gain and the respect you earn from colleagues and loved ones.

Nursing personnel have relied on clinical experiences in a military treatment facility to maintain their competency for deployment status. However, there are differences in the experience and nursing skills between a facility and field situations. But the military treatment facility like hospitals serve as preparation ground for what is in store for nurses in the field.

The sensory process involves two components: reception and perception. As described by Berman and Snyder (2012), Sensory reception is the process of receiving stimuli or data. These stimuli are either external or internal to the body. External stimuli are visual (sight), auditory (hearing), olfactory (smell), tactile (touch), and gustatory (taste) (Marieb & Hoehn, 2007). Other types of internal

stimuli are kinesthetic or visceral. Kinesthetic refers to awareness of the position and movement of body parts. A related sense is stereognosis, the ability to perceive and understand an object through touch by its size, shape, and texture. Visceral refers to any large organ within the body. Visceral organs may produce stimuli that make a person aware of them (e.g., a full stomach). Sensory perception involves the conscious organization and translation of the data or stimuli into meaningful information.

For an individual to be aware of the surroundings, four (4) aspects of the sensory process must be present (Berman & Snyder, 2012). 1) Stimulus which is an agent or act that stimulates a nerve receptor. 2) Receptor wherein a nerve cell acts as a receptor by converting the stimulus to a nerve impulse. Most receptors are specific, that is, sensitive to only one type of stimulus, such as visual, auditory, or touch. 3) Impulse conduction wherein the impulse travels along nerve pathways either to the spinal cord or directly to the brain. For example, auditory impulses travel to the organ of Corti in the inner ear. From there the impulses travel along the eighth cranial nerve to the temporal lobe of the brain. 4) Perception which is the awareness and interpretation of stimuli, takes place in the brain, where specialized brain cells interpret the nature and quality of the sensory stimuli. The client's level of consciousness affects the perception of the stimuli.

A number of factors affect sensory reception and perception, including a person's developmental stage, culture, level of stress, medications and illness, and lifestyle and personality. The following describes these factors in detail:

First, developmental stage. Perception of sensation is critical to the intellectual, social, and physical development of infants and children. Infants learn to recognize the face of their mother or caregiver and establish bonding essential to later emotional development. Young children respond to music by singing and dancing as they begin to interact with their peers in groups. As children grow, they learn to interpret visual and auditory signals when preparing to cross the street. Adults have many learned responses to sensory stimuli. The sudden loss or impairment of any sense, therefore, has a profound effect on a person of any age. Normal physiological changes in older adults put them at higher risk for altered sensory function. The diminishing of sensory perception that may come with chronic disease or aging is generally gradual. Hearing loss is common in older adults. More than 30% of persons ages 65 to 74 and 40% to 66% of those over age 75 have some degree of hearing loss (Tabloski, 2010).

Second, culture. An individual's culture often determines the amount of stimulation that a person considers usual or "normal." For example, a child reared in a big-city Latino neighborhood where extended families share responsibilities for all the children may be accustomed to more stimulation than a child reared in a European-American suburb of scattered single-family homes. In addition, the normal amount of stimulation associated with ethnic origin, religious affiliation, and income level, for example, also affects the amount of stimulation an individual desires and believes to be meaningful. The sudden change in cultural surroundings experienced by immigrants or visitors to a new country, especially

where there are differences in language, dress, and cultural behaviors, may also result in sensory overload or cultural shock. Cultural deprivation, or cultural care deprivation, is a lack of culturally assistive, supportive, or facilitative acts. It is important that nurses be sensitive to what stimulation is culturally acceptable to a client. For example, in some cultures touching is comforting, whereas in others it is offensive. Some clients find the presence of cultural or religious symbols reassuring, and their absence a source of anxiety. Nurses should encourage clients who want to have such symbols present to do so, and to follow practices with which they are comfortable, provided that these practices do not endanger their health (Berman & Snyder, 2012).

Third, stress. During times of increased stress, people may find their senses already overloaded and thus seek to decrease sensory stimulation. For example, a client dealing with physical illness, pain, hospitalization, and diagnostic tests may wish to have only close support people visit. In addition, a client may need the nurse's help to decrease unnecessary stimuli (e.g., noise) as much as possible. On the other hand, clients may seek sensory stimulation during times of low stress (Wilkinson & Ahem, 2009).

Fourth, medications and illness. Certain medications can alter an individual's awareness of environmental stimuli. Narcotics and sedatives, for example, can decrease awareness of stimuli. Some antidepressants can also alter perceptions of stimuli. Anyone taking several medications concurrently may show alterations in sensory function; older adults are especially at risk for such

alterations and need to be monitored carefully. Some medications, if taken in large doses or over a long period of time, become ototoxic, injuring the auditory nerve and causing hearing loss that may be irreversible. Some of these medications are aspirin, furosemide (Lasix), the aminoglycosides, and certain drugs given for cancer chemotherapy. Certain diseases, such as atherosclerosis, restrict blood flow to the receptor organs and the brain, thereby decreasing awareness and slowing responses. Some central nervous system diseases cause varying degrees of paralysis and sensory loss. Diseases of the inner ear can affect the kinesthetic sense (Tabloski, 2009).

Lastly, lifestyle and personality. Lifestyle influences the quality and quantity of stimulation to which an individual is accustomed. A client who is employed in a large company may be accustomed to many diverse stimuli, whereas a client who is self-employed and works in the home is exposed to fewer, less diverse stimuli. People's personalities also differ in terms of the quantity and quality of stimuli with which they are comfortable. Some people delight in constantly changing stimuli and excitement, whereas others prefer a more structured life with few changes (Berman & Snyder, 2012).

Related Studies

This portion details researches, which in any way show similarities to the present undertaking, forming basis to its methodological pursuits.

In terms of studies also studying the application of Jean Watson's Theory of Human Caring, Ozan, Okumus, and Lash (2015) detailed the application and outcome of the Watson's Theory of Human Caring to an infertile woman receiving in vitro fertilization treatment. The implementations of the 10 carative factors, inherent in the theory, to provide a supportive nursing care were chronicled. The sustained nurse-patient interaction and the achievement of the ultimate goal of having the patient reach the phase of "health healing-wellness" (carative factor #7) were detailed. This case study is an example of the value of a theory-based nursing practice that can enhance human health and healing in stressful life events, such as "the moment" when the patient in this case study realized her inability to have conceived a much desired child, even with promising medical treatments, and turned to her nurse for healing.

The study is the same with the current study since they both applied the Watson's Theory of Human Caring and used the implementations of the 10 carative factors, inherent in the theory, to provide nursing care.

Elbahnasawy, Lawend, and Mohammed (2016) evaluated the effect of application of Watson caring theory for nurses in pediatric critical care unit. A convenience sample of 70 nurses of Pediatric Critical Care Unit in El-Menoufya University Hospital and educational hospital in ShebenElkom completed the demographics questionnaire and the Caring Behavior Assessment (CBA) questionnaire. More than two-thirds of nurses in study group and majority of control group had age less than 30 years. There were highly significant differences

related to mean scores for Caring Behavior Assessment (CBA) as rated by nurses. Also, near to two-thirds (64.3%) of the nurses stated that doing doctor orders acted as a barrier to apply this theory. In addition, there were a statistical significance differences between educational qualifications of nurses and a supportive/protective/corrective environment subscale with mean score for master's degree of 57, also between years of experiences and human needs assistance. Program instructions for all nurses to apply Watson Caring theory for children in pediatric critical care unit were therefore successful and effective, and this study provided evidence for application of this theory for different departments in all settings.

The study of Elbahnasawy, Lawend, and Mohammed (2016) is similar to the current study since both studies evaluated the application of Watsons Caring Theory and used the Caring Behavior Assessment questionnaire in evaluating the caring behaviors of nurses.

In Slovenia, a study was conducted by Pajnkihar, Štiglic, and Vrbnjak (2017). Carative factor sensibility was related to the level of nursing education. Patients were satisfied with the care received from nurses, nursing assistants and hospitals, although differences between the perceptions of nurses and nursing assistants of carative factors and patient satisfaction were found. By comparing only the perceptions of nurses and nursing assistants of carative factors in health care institutions, differences were found for seven out of 10 carative factors.

The study of Pajnkihar, Štiglic, and Vrbnjak (2017) is different from the study in the sense that the purpose of the paper was to assess the patient satisfaction on the care rendered by nurses while the present study is only focused on the perceptions on the provision of caring behaviors of nurses in military hospitals.

Suliman *et al.* (2009) explored Saudi patient perceptions of important caring behaviors and those most frequently attended to by staff nurses in a multicultural environment. Patients rated overall caring behaviors as important (97.2%) and frequently experienced (73.7%). The discrepancy between the importance of and frequency of attendance to caring behaviors by nurses was statistically significant ($t = -4.689$, $p = .001$). The caring behaviors based upon Jean Watson's theory were valued by Saudi patients irrespective of their cultural differences with the caregiver. However, the frequency of caring attended to by nurses in teaching/learning and helping/trust behavior subcategories were rated lower.

The study of Suliman *et al.* (2009) is similar to the current study since both studies aimed to determine the caring behaviors of nurses needed by patients.

In terms of research endeavors having military personnel as their subject Donelan *et al.* (2014) drew data by from three populations (military personnel, nursing students located nearby major military bases and young adults aged 18–39, in the general public) which were different in several demographic characteristics. The perceptions of military careers, nursing careers and barriers, and incentives to pursue military nursing careers in all populations were

investigated. Perceptions differed among the groups. The results of this study may help to inform strategies for reaching out to specific populations with targeted messages that focus on barriers and facilitators relevant to each to successfully recruit a diverse Nurse Corps for the future.

The study of Donelan *et al.* (2014) is different from the present study in the sense that the purpose of their paper was to investigate the perceptions of military careers, nursing careers and barriers, and incentives to pursue military nursing careers in all populations, while the present study focused on the caring behaviors of nurses in military hospitals.

The research question guiding the study of Agazio (2010) was "what are the nursing practice challenges for Army nurses in military operations other than war (MOOTW), or humanitarian missions and wartime?" Nurses recounted challenges and adjustments made to deliver high quality patient care to soldiers and civilian casualties especially for multi-level traumatic injuries. Specialized skill sets and personal adaptation were necessary for practice under austere conditions in these environments. By understanding the practice of nursing in MOOTW and wartime, nurses can best prepare and train to effectively function and care for patients in these challenging settings.

The study of Agazio (2010) is different from the current study as it focused on the nursing practice challenges for Army nurses in military operations other than war while the current study focused on the provision of caring behaviors of nurses in military hospitals.

The study by Leinonen *et al.* (2003) compared surgical patients' (n = 874) and perioperative nurses' (n = 143) perceptions of the quality of perioperative nursing care. Patients tended to give significantly higher ($P < .001$) ratings than nurses, but for some items the patients had more critical perceptions. The results provide important clues for improving the quality of patient care so that staff activities better serve the needs of patients.

The previous study is different from the current study since the purpose of the former was to describe the perceptions of the quality of perioperative nursing care, while the latter was to describe the provision of caring behaviors of nurses.

Lemonidou *et al.* (2003) investigated and compared Greek patients' and nurses' perceptions of the realisation of autonomy, informed consent, and privacy in surgical nursing care. Nurses perceived that information-giving was realised more than any other concept and that they had given patients an opportunity to decide on alternative treatments, length of stay, eating and drinking, pain relief, sleeping pills, bladder and bowel function, hygiene, and wound care. Patients who had never been operated on previously and had a planned admission felt more that they were offered the opportunity to make decisions. Those with a planned admission who had been offered informed consent believed that they had received information, their privacy had been protected and they had given informed consent. Nurses with training on ethics believed more strongly that patients had received information and informed consent.

The study of Lemonidou *et al.* (2003) is different from the current study since it focused on the perceptions of the realisation of autonomy, informed consent, and privacy in surgical nursing care while the present study focused on the caring behaviors of nurses.

Two studies focusing on caring behaviours from critical care nurses' perspective were done by Beeby (2000) and Wilkins and Slevin (2004) on nurse-caring behaviours. On factors influencing nurses' perception of nurse-caring behaviours, correlation was discovered between the experience of the nurse and the perception nurse-caring behaviours. Nurses with less work experience tended to place less emphasis on nurse/family interactions. Experience also seemed a determinant in the ability of the nurse to provide emotional support. Investigation revealed that the less experienced nurses focussed on developing expertise in physical caring of the patient first before dealing with emotional care of the family (Beeby, 2000).

This study has a similar undertaking to the current study in correlating the socio-demographic profile of nurses to their caring behaviors since these factors may or may not affect the nurses' perception of nurse-caring behaviors.

Rafii, Hajinezhad, and Haghani (2008) carried out a study to determine the relationship between patients' reports of nurse-caring and patient satisfaction with nursing care in Iran among patients who had been hospitalized because of medical conditions or surgical procedures. Results indicated that male patients

were more satisfied with nursing care than female patients. Admission to the hospital during the last five years was positively correlated with patients' perceptions of nurse-caring and satisfaction with nursing care.

The previous study differs from the current study since it focuses on determining the relationship of the nurse-caring to the patient satisfaction while the current focuses on the similarities and differences on the perception of the provision of caring behaviors of nurses.

Zamanzadeh et al (2010) conducted a research in an Iranian oncology centre on oncology patients' and professional nurses' perceptions of important nurse-caring behaviours. The results showed that both groups considered the same order of importance of caring. They ranked highly "Monitors and follows through" and "Being accessible", and ranked low "Comforts" and "Trusting relationships". Additionally, patients rated "Being accessible" and "Explains and facilitates" higher than nurses. The oncology patients and nurses perceived the instrumental aspects of caring as very important.

The preceding study is similar with the current study in the sense that it both aims to identify the caring behaviors of nurses from the patients' point of view as well as the nurses by comparing both their perceptions.

The above mentioned literature and results of the related studies served as the foundation of the study, from the initial phase which included conceptualization to the formation of the questionnaire to discussion of results.

Chapter 3

METHODOLOGY

This chapter is concerned with the research methods and procedures employed to systematically answer the specific problems posed for this study. Specifically, the chapter elucidates on the research design, instrumentation, sampling and data gathering procedure and the corresponding techniques used for accurate data analysis and interpretation.

Research Design

This study follows the quantitative-qualitative descriptive research design. This design was used to describe the caring behaviors of nurses in a military hospital as viewed from both nurses and patients based on Watsons' theory of Human Caring. Being a joint quantitative-qualitative research endeavor, focus group discussion was conducted to verify results gathered through the survey.

Furthermore, the study used the descriptive and inferential statistical tools needed for the analysis of the frequency count, percentage distribution, weighted mean, standard deviation, Cronbach's alpha, t-test, and one-way analysis of variance. All of these mentioned statistical tools are described in the statistical treatment of data in this chapter. The statistical software was generated from Microsoft Excel and SPSS version 21 for data analysis.

Instrumentation

In this study, the researcher used a questionnaire type of instrument in gathering more appropriate data needed.

There were 2 sets of questionnaires used, one to be answered by the nurses and the other by the military patients in the hospitals. Each set was composed of 2 parts. Part I of questionnaire was utilized to survey nurses' socio-demographic profile such as age, sex, marital status, monthly income, and number of years in service and also the patients' socio-demographic profile such as age, sex, marital status, educational attainment, and monthly income.

The main questionnaire (Part II) utilized the standardized Caring Behaviors Assessment (CBA) questionnaire by Cronin and Harrison (1988) adapted to this study. This tool is a 63-item questionnaire that used a 5-point Likert scale. After asking permission from the authors, Cronin and Harrison's CBA tool was used to collect data.

The Caring Behavior Assessment (CBA) was developed by Cronin and Harrison (1988) to assess the relative contribution of identified nursing behaviors to the patient's sense of feeling cared for and about. Since the original questionnaire focused on nursing as perceived by myocardial infarction patients in a coronary care unit, the questionnaire was modified to become a self-assessment tool from the point of view of the nurses. The CBA listed 63 nursing behaviors ordered in 7 subscales that were conceptually congruent with Watson's 10 Carative Factors. Since the 6th carative factor of using creative problem-solving

caring process is imperceptible to patients, this has been eliminated in this study arriving at only a total of 62 items.

The instrument included 7 subscales: 1) "Humanism/Faith-Hope/Sensitivity" (16 items), related to the nurses' respect, sensitivity and capacity to view patients through their own perceptual systems. 2) Helping/Trust (11 items) which dealt with the development of a therapeutic nurse-patient relationship. 3) Expression of Positive/Negative Feelings (4 items) corresponding to the facilitation and acceptance of the ventilation of patients' feelings. 4) Teaching/Learning (8 items) dealing with how nurses impart information and facilitate learning. 5) Supportive/Protective/ Corrective Environment (12 items), corresponding to how nurses manipulated internal and external environment to promote health and well-being. 6) Human Needs Assistance (9 items), dealing with how the nurses assisted patients in meeting human needs. 7) Existential/Phenomenological Spiritual forces (3 items) related to nurses' acknowledgment of the identity of each patient (Watsons, 2007). In each item, patients were requested to answer using a 5-point Likert scale ranging from "very satisfactory" (=5) to "poor" (=1).

Validation of the Instrument

The Caring Behavior Assessment (CBA) is a standardized questionnaire used to measure the caring behaviour of nurses to the patients. The researcher presented the questionnaire to the adviser for ratification. Validity was established

by a panel of four experts familiar with Watson's theory. To make sure that the questionnaire was reliable, the researcher conducted a pilot testing to the nurses and patients of Camp Lukban Station Hospital. The researcher consulted a statistician for assistance in the statistical computation of the reliability of the questionnaire. Using the test-retest method, the statistician computed the reliability of the prepared questionnaires from the responses of the pilot testing. Reliability was evaluated by examining the internal consistency of nursing behaviors against Cronbach's alpha. The coefficient of reliability for each of the seven subscales of the questionnaire ranged from .80 to .97 in a pilot sample of fifteen (15) nurses and fifteen (15) military patients.

Sampling Procedure

The respondents of the study included nurses and military patients of Camp Lukban Station Hospital, Camp Lapulapu Hospital, Camp Melchor F Dela Cruz Station Hospital, and Fort Magsaysay Army Station Hospital.

The researcher utilized the simple random sampling technique to choose participant nurses and military patients of the hospitals from the month of November 2017 to January 2018. The number of respondents in this study was computed using an online sample size calculator developed by Raosoft, Inc. (2004). To obtain the population size, the number of military nurses in all government military (Army) hospitals across the country was obtained from hospital administrators using a letter of request. To select the participants to be included,

the probability sampling of simple random sampling was used. The same number of patients was also selected from each military hospital using the same sampling method.

The following inclusion criteria were set for study participation among patients: (1) military patients and (2) military patients that were admitted for at least 3 days in the military hospitals.

The following shows the sample population of the respondents per hospital:

Hospital	Nurses		Patients	
	Total Population	Sample	Total Population	Sample
1. Camp Lukban Station Hospital	16	15	25	15
2. Camp Lapulapu Hospital	15	10	40	10
3. Fort Magsaysay Army Station Hospital	16	10	30	10
4. Camp Melchor F Dela Cruz Station Hospital	15	10	25	10

Data Gathering Procedure

The conduct of the study started at the time after the approval of the proposed title and validation of the instrument used.

The researcher sought approval from the hospital administrators and chief nurses of the four (4) hospitals for the conduct of the study. The researcher gathered the pertinent data during the month of November 2017 to January 2018. The researcher obtained the informed consent of the participants and

administered the questionnaire. For participants in the remote hospital, the researcher asked the help of a colleague in that hospital to administer the questionnaire. The study was done with strict ethical considerations observing autonomy, privacy, and confidentiality.

To understand the job of military nurses, a focus group discussion was also conducted with all military nurses in Camp Lukban Station Hospital. Data gathered through focused group discussion served to explain study results.

Statistical Treatment

To ensure better and reliable results, the following statistical treatments were employed in analyzing the raw data collected. This was upon the recommendation of the statistician. Data gathered through the use of questionnaires were collated and coded using the spreadsheet program Excel. The descriptive statistics of frequency counts, means, and percentages were used

Frequency count. This descriptive statistical measure was used to present the profile of the respondent-nurses in military hospitals such as age, sex, marital status, monthly income, and years of hospital experience and the profile of the respondent-patients such as age, sex, marital status, educational attainment, and monthly income.

Percentage distribution. This statistics was used in presenting of the respondent- patients' personal data in the analysis of data on age, sex, marital status, educational attainment, and monthly income and the profile of the

respondent-nurses in military hospitals such as age, sex, marital status, monthly income and years of hospital experience.

Mean. This statistical measure was used to determine overall satisfactory caring behaviour of nurses in a military hospital.

Standard Deviation. This was used when the mean is the preferred measure of central tendency. This showed whether the scores or not the scores were grouped closely around the mean of the distributions.

One-way ANOVA. This statistical tool was done to determine whether the socio-demographic profile of respondents affected their perception.

T-test. This statistical tool was used to compare the perceived provision of caring behavior of both nurses and patients.

Chapter 4

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

This chapter presents the data gathered, the analysis undertaken as well as the interpretation made.

Socio-demographic Profile of Nurses-Respondents

The socio-demographic profiles of the nurses working in military hospitals across the country are represented in terms of age, sex, marital status, monthly income, and years of hospital experience (Table 1).

Age. As seen in the table, 20 respondents or 44.4 percent were between the ages of 21–29 years old. This was followed by 15 respondents or 33.3 percent aged 30–38 years old. Then, 3 respondents or 6.7 percent was between the ages 39–47 years old. Followed by 4 respondents or 8.9 percent aged 48-56 years old. The oldest respondents belonged to the age of 57–65 years old with 3 respondent or 6.7 percent. The mean age is 34 years old.

Many of the studies conducted in the Philippines (i.e. Perrin *et al.*, 2007) found out that majority of RNs in the hospitals were aged 40 years and female. This was because many of the younger nurses have gone abroad to find areas of greener pastures. Middle-aged nurses of 40 years old and above already have families in the Philippines and so they tend to find work near their homes. The results of this study is contrary to the study by Perrin *et al.* (2007), with nurses in

the military hospital mostly in the young adult age bracket perhaps because working in the military arena offers higher compensation and so nurses do not have to leave home.

Table 1

Socio-demographic Profile of Nurses-Respondents

	Category	n	%
		45	**100**
Age	21-29 years old	20	44.4
	30-38 years old	15	33.3
	39-47 years old	3	6.7
	48-56 years old	4	8.9
	57-65 years old	3	6.7
	MEAN	**34**	
Sex	Male	8	17.8
	Female	37	82.2
Marital Status	Single	16	35.6
	Married	27	60.0
	Separated	2	4.4
Monthly Income	Less than P5000	2	4.4
	P 5,000 to less than P 15,000	3	6.7
	P 15,000 to less than P 25,000	21	46.7
	P 25,000 to less than P 35,000	7	15.6
	P 35,000 to less than P 50,000	6	13.3
	P 50,000 or more	6	13.3
	MEAN	**31,800**	
Experience	0–5 years	10	22.2
	6–10 years	9	20.0
	11–15 years	12	26.7
	16–20 years	3	6.7
	21–25 years	3	6.7
	26 and above	8	17.8

Sex. As seen in the, table 37 respondents or 82.2 percent of them were females while 8 respondents or 17.8 percent of them were male.

This is also the same with several studies (i.e. Perrin *et al.*, 2007) conducted in the Philippines showing that majority of the nursing workforce in the Philippines were females as expected since data also shows that majority of the

students who take up nursing are also females. This is not surprising since the nursing profession is mainly attributed as a career for females (Abbot & Wallace, 1990), which should not be the case since males also have a lot to contribute to the field.

Marital Status. As seen on the table, 16 respondents or 35.6 percent were single. Then, 27 respondents or 60.0 percent were married. And the last 2 respondents or 4.4 percent were separated.

Since many of the nursing respondents were in the young adult category, it was also to be expected that many were still single. Because of the responsibility of being a nurse employed in the military arena, needing to work for 24 hours and unforeseen transfers, many nurses think twice before settling down because of the demands of work which might hinder family life. This conforms to the study that nurses working in hospitals is even more demanding as they have less work autonomy (Aiken *et al.*, 2013).

Monthly Income. The table above denotes that majority of the nurses working in military hospitals had an average monthly income ranging in the 15,000 to 25,000 bracket. The mean monthly income of the nurses is 31,800. A report by the Department of Labor and Employment (2011) cited that on the average nurses earn between Php 8,000.00 to 13,500.00 per month. This means that military nurses earn more than the average with a few even in salaries above Php 50,000.00. This confirms the study of May, Bazzoli, & Gerland (2006) that

increasing wage solves institutional workforce recruitment and retention problems.

Years of Hospital Experience. This denotes that majority of the nurses working in military hospitals were employed as nurse for 11 to 15 years already and a little less than this number (10 respondents or 22.2 percent) were new as nurses working in the military field. Experience also seemed a determinant in the ability of the nurse to provide emotional support. Investigation revealed that the less experienced nurses focused on developing expertise in physical caring of the patient first before dealing with emotional care of the family (Beeby, 2000).

Socio-demographic Profile of Patients-Respondents

The socio-demographic profiles of the military patients in military hospitals across the country are represented in terms of age, sex, marital status, educational attainment, and monthly income (Table 2).

Table 2

Socio-demographic Profile of Patients-Respondents

	Category	n	%
		45	**100**
Age	18-25 years old	20	44.4
	26-33 years old	13	28.9
	34-41 years old	7	15.6
	42-49 years old	4	8.9
	50-56 years old	1	2.2
	MEAN	**29**	
Sex	Male	39	86.7
	Female	6	13.3
Marital Status	Single	27	60.0
	Married	15	33.3
	Widowed	3	6.7
Educational Attainment	High School Graduate	12	26.7
	College Undergraduate	11	24.4
	College Graduate	22	48.9
	Masters	0	0
Monthly Income	P 25,000 to less than P 35,000	22	48.9
	P 35,000 to less than P 45,000	15	33.3
	P 45,000 to less than P 55,000	5	11.1
	P 55,000 or more	3	6.7
	MEAN	**41,950**	

Age. As seen in the table, 20 respondents or 44.4 percent were between the ages 18-25 years old. This is followed by 13 respondents or 28.9 percent having the age between 26-33 years old. Then, 7 respondents or 15.6 percent were between the ages 34-41 years old. This was followed by 4 respondents or 8.9 percent having

the age between 42-49 years old. The oldest respondent belonged to the age of 50-56 years old with 1 respondent or 2.2 percent.

The mean age of military patients is pegged at 29 years old. This denotes that the majority of the military patients that were hospitalized in the month of November 2017 to January 2018 were in the 18–25 age bracket wherein this age is the average age for military enlistment according to the Serafino (2014).

Sex. As seen in the table 39 respondents or 86.7 percent of them were males while 6 respondents or 13.3 percent of them were females.

This denotes that the majority of military patients hospitalized in military hospitals were more males than females. This conforms to the findings of Lutz (2008) that more men enlist in the military. Similar to being a nurse, working as a military personnel have been attributes as being a men's job but increasingly, more women have been shown to also enlist working side by side with men.

Marital Status. As seen in the table, 27 respondents or 60.0 percent of them were single. Then, 15 respondents or 33.3 percent of them were married. And 3 respondents or 6.7 percent of them were widowed.

Similar to the field of nursing, working in the military arena is also a very demanding job. But more than nursing, the dangers involved are higher. This is similar to the study of Rosen & Durand, (2000) spouses of service members name deployments as one of the most significant challenges of life in the military.

Educational attainment. This denotes that majority of the military patients that were hospitalized during the month of November 2017 to January 2018 were college graduate. Higher educational attainment is prioritized in the enlisting military personnel (Lutz, 2008). But unlike other fields, it can be seen that working as a military personnel does not require being a college graduate but is rather encouraged. As such, a portion of the patients were high school graduates, which is the minimum requirement for enlistment, and a few college level.

Monthly Income. The table above denotes that majority of the military patients hospitalized in the month of November 2017 to January 2018 had an average monthly income ranging in the 25,000 to 35,000 bracket. Further reflected is the mean monthly income of 41,950. This shows that military personnel earned more than the poverty threshold based on the data from the National Statistical Coordination Board (2017). Hence, the military personnel were earning more than enough to provide food and non-food requirements for their families.

Caring Behavior Assessment. Table 3 to 16 presents the assessment of the caring behaviors by nurses in military hospitals. The instrument includes seven subscales as Humanism/Faith-Hope Sensitivity, Helping/Trust, Expression of Positive/Negative feelings, Teaching/Learning, Supportive/Protective/Corrective Environment, Human needs assistance, and Existential/Phenomenological Spiritual forces.

The first subscale of the CBA which is Humanism/Faith-Hope Sensitivity has a mean score of 4.60, which was deemed as very satisfactory. The highest ranked item was "Treat patient with respect" (m=4.84) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Tries to see things from the patients' point of view" (m=4.42) which is interpreted as Satisfactory Caring Behavior (SCB).

This indicates that nurses gave highest rate in regards to Humanism/faith-hope/sensitivity subscale in terms of treating the patients with respect. This implies that military nurses gave importance to respecting the patients. This is similar with the study wherein the importance of these affective processes of caring has previously been demonstrated by O'Connell and Landers (2008), among critical care nurses. A possible explanation for nurses ranking the affective aspects of caring highly is that caring is mutually enriching and nurses who consciously practice it find themselves re-energised for the more demanding aspects of their practice (Taylor *et al.*, 2008).

Table 3

Self-Rated Caring Behaviors of Nurses in Military Hospital Humanism/Faith-Hope Sensitivity

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. I treat patients as individual.	4.80	.404	VSCB
2. Tries to see things from the patient's point of view.	4.42	.753	SCB
3. Knows what I'm doing.	4.69	.514	VSCB
4. Reassures the patient.	4.69	.514	VSCB
5. Makes the patient feel someone is there if needed.	4.67	.564	VSCB
6. Encourages the patient to believe in oneself.	4.67	.522	VSCB
7. Praises the patient's efforts.	4.56	.586	VSCB
8. Understands the patient.	4.67	.477	VSCB
9. Asks the patient how things should be done.	4.40	.688	SCB
10. Accepts the way the patient is.	4.49	.694	SCB
11. Sensitive to the patient's feelings and moods.	4.60	.539	VSCB
12. Kind and considerate.	4.51	.626	VSCB
13. Knows when the patient has "had enough" and acts accordingly (for example, limiting visitors).	4.51	.661	VSCB
14. Maintains a calm manner.	4.56	.586	VSCB
15. Treats the patient with respect.	4.84	.366	VSCB
Mean	**4.60**	**.566**	**VSCB**

Legend:

4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

The second subscale of CBA which is Helping/Trust had a mean score of 4.38 which was only Satisfactory Caring Behavior (SCB). The highest ranked item was "Answers quickly when the patient calls for me" (m=4.71) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Visits the patient when he/she moves to another hospital unit" (m=3.73) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.38, interpreted as Satisfactory Caring Behavior (SCB).

Table 4

Helping/Trust

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Really listens to the patient when he/she talks.	4.69	.514	VSCB
2. Accepts the patient's feelings without judging them.	4.58	.543	VSCB
3. Come into the room just to check on the patient.	4.56	.755	VSCB
4. Talks to the patient about his/her life outside the hospital.	4.18	.806	SCB
5. Asks what the patient likes to be called.	4.04	.737	SCB
6. Introduces self to the patient.	4.42	.657	SCB
7. Answers quickly when the patient calls for me.	4.71	.458	VSCB
8. Gives the patient my full attention when with me.	4.67	.564	VSCB
9. Visits the patient when he/she moves to another hospital unit.	3.73	1.27	SCB
10. Touches the patient when he/she needs it for comfort.	4.18	.886	SCB
11. Does what I say I will do.	4.44	.659	SCB
Mean	**4.38**	**.714**	**SCB**

Legend:

4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

This denotes that the nurses gave high scores with regards to helping/trust subscale in terms of answering quickly when the patient calls for the nurse and low rates in terms of visiting the patient in another hospital. The findings is similar to that of O'Connell & Landers (2008) wherein talking about past life experiences, talking about life outside the hospital, and visiting the patient when the patient leaves the unit were rated to as least important caring behaviors by the nurses, because the priority of care had been to stabilize the patient in the Intensive Care unit.

Table 5

Expression of Positive/Negative Feelings

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Encourages patient to talk about how he/she feels.	4.62	.614	VSCB
2. I don't become upset when the patient is angry.	4.22	.765	SCB
3. Helps the patient understand his/her feelings.	4.47	.588	SCB
4. I don't give up on the patient even when he/she is difficult to get along with.	4.40	.688	SCB
Mean	**4.43**	**.664**	**SCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

The mean score of the third subscale of which is Expression of positive/negative feelings CBA was 4.43. The highest ranked item was "Encourages patient to talk about how he/ she feels" (m=4.62) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "I don't become upset when the patient is angry" (m=4.22) which is interpreted as Satisfactory Caring Behavior (SCB).

These findings indicated that majority of the nurses rated themselves the highest in regards to expression of positive/negative feelings in terms of encouraging patient to talk about how he/she felt. This can be expected since nurses are trained in use of therapeutic self, which is a major function of being a nurse. It is in this function that the nurse is able to find out how to treat not just the physical dimension of the patient but other aspects as well. This conforms to the study of O'Connell and Landers (2008) which revealed that emotional

dimensions of care (expression of positive\negative feelings) were the most important as perceived by critical care nurses rather than any other care components and a relationship of trust based on truth and respect.

Table 6

Teaching/Learning

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Encourages the patient to ask questions about his/her illness	4.69	.468	SCB
2. Answers the patient's questions clearly.	4.67	.522	VSCB
3. Teaches the patient about his/her illness.	4.64	.570	VSCB
4. I ask the patient questions to be sure he/she understands.	4.71	.458	VSCB
5. Asks the patient what he/she wants to know about his/her illness	4.55	.659	VSCB
6. Helps the patient set realistic goals for his or her health.	4.40	.687	SCB
7. Helps the patient plan ways to meet those goals.	4.13	.894	SCB
8. Helps the patient plan for his/her discharge from the hospital.	4.35	.712	SCB
Mean	**4.52**	**.621**	**VSCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

The mean score of the fourth subscale of CBA which is Teaching/Learning was 4.52 interpreted as Very Satisfactory Caring Behavior (VSCB). The highest ranked item was "I ask the patient questions to be sure he/she understands" (m=4.71) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Help the patient plan ways to meet those goals" (m=4.13), which is interpreted as Satisfactory Caring Behavior (SCB).

These findings indicated that majority of the nurses believed that they were very satisfactory when it came to teaching/learning specifically in terms of asking the patient questions to be sure he/she understood. In contrast to these findings, the caring behavior of helping the patient not feel dumb by giving the patient adequate information was ranked among the three most important nurse-caring behaviours in a study among nurses working in a Japanese hospital (Mizuno *et al.*, 2005). The importance of patient education cannot be overemphasised since it is crucial in enabling the patient to better care for him/herself and make informed decisions regarding care and treatment (White, 2005).

Mean Scores of the fifth subscale of CBA which is Supportive/Protective/Corrective Environment indicated that the highest ranked item was "Respects the patient's modesty" (m=4.84) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Offers things to make the patient more comfortable" (m=4.47) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.62, interpreted as Very Satisfactory Caring Behavior (VSCB). This denotes that the nurses rated themselves as highest in regard to Supportive/Protective/Corrective Environment in terms of respecting the patient's modesty.

Table 7

Supportive/Protective/Corrective Environment

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Tells the patient what to expect during the day.	4.51	.549	VSCB
2. Understands when the patient needs to be alone.	4.49	.589	SCB
3. Offers things (position changes, blankets, back rub, lighting, etc.) to make the patient more comfortable.	4.47	.842	SCB
4. Leaves the patient's room neat after working with him/her.	4.58	.543	VSCB
5. Explains safety precautions to the patient and family.	4.69	.468	VSCB
6. Gives the patient pain medication when he/she needs it.	4.80	.457	VSCB
7. Encourages the patient to do what he/she can for him/herself.	4.60	.618	VSCB
8. Respects the patient's modesty (, keeping him/her covered).	4.84	.367	VSCB
9. Checks with the patient before leaving the room to be sure he/she has everything needed within reach.	4.76	.435	VSCB
10. Considers the patient's spiritual needs.	4.60	.618	VSCB
11. Is gentle with the patient.	4.62	.490	VSCB
12. Is cheerful.	4.51	.589	VSCB
Mean	**4.62**	**.547**	**VSCB**

Legend:

4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

In contrast to this finding with regards to the environment, Ulrich and Zimring (2004) stated that trying to find one's way around a hospital is a stressful experience especially to new patients and visitors who are often unfamiliar with the hospital and are otherwise stressed and disoriented. This fact clearly points to the reason for nurses indicating orientation of patients to the hospital environment as an important indicator of caring.

Table 8

Human Needs Assistance

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Helps the patient with his/her care until able to do it for oneself.	4.58	.543	VSCB
2. Knows how to give shots, IVs, etc.	4.87	.343	VSCB
3. Knows how to handle equipment (for example, monitors).	4.82	.387	VSCB
4. Gives the patient treatments and medications on time.	4.84	.366	VSCB
5. Keeps the patient's family informed of the progress.	4.67	.522	VSCB
6. Let's the patient's family visit as much as possible.	4.44	.586	SCB
7. Checks the patient's condition very closely.	4.76	.484	VSCB
8. Helps the patient feel like he/she has some control.	4.42	.621	SCB
9. Knows when it's necessary to call the doctor.	4.82	.387	VSCB
Mean	**4.69**	**.471**	**VSCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the sixth subscale of CBA which is Human needs assistance indicated that the highest ranked item was "Knows how to give shots, IVs, etc." (m=4.87) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Helps the patient feel like he/she has some control" (m=4.42) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.69, interpreted as Very Satisfactory Caring Behavior (VSCB).

This denotes that the nurses were rated highest in regard to human needs assistance in terms of knowledge on how to give shots. These findings indicated that nurses in military hospitals also considered the instrumental aspects of caring

in nursing, which involve substantive actions, as important in demonstrating caring to patients. The nurses' views on the importance of the instrumental aspects of caring is supported by Linton (2007) who pointed out that nursing is a skill-oriented field requiring efficiency and safety, which necessitates the need to master skills required to carry out nursing interventions including handling of a variety of equipment.

Table 9

Existential/Phenomenological Spiritual forces

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Seems to know how the patient feels.	4.53	.588	VSCB
2. Helps the patient see that his/her past experiences are important.	4.44	.693	SCB
3. Helps the patient feel good about oneself.	4.62	.535	VSCB
Mean	**4.53**	**.615**	**VSCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the seventh subscale of CBA which is Existential/Phenomenological Spiritual forces indicated that the highest ranked item was "Helps the patient feel good about oneself" (m=4.62) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Helps the patient see that his/her past experiences are important" (m=4.44) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.53, interpreted as Very Satisfactory Caring Behavior (VSCB).

Nurses' perceptions of nurse caring behaviors are as diverse as the areas in which care is delivered. For example, nurses in the Emergency Department and Critical Care (O'Connell & Landers, 2008) suggested that knows what you are doing and being knowledgeable are important nurse caring behaviors. Nurses working on Medical-Surgical units recognized that getting to know the patient as a person, being able to sit and listen, and holding a patient's hand are important nurse caring behaviors (Pearcey, 2010; Sumner, 2008; Walsh & Dolan, 1999).

Watson (2010) defined assistance with ratification of human needs as reverently and respectfully assisting with basic needs, with an intentional caring consciousness, administering human care essentials, which potentiate alignment of mind-body-spirit, wholeness and unity of being in all aspects of care, allowing for spirit-filled connection. This means that nurse participants considered their care very satisfactory in terms of assisting with all dimensions of health—physical, emotional, and spiritual—of the patient.

Patients. Table 10–16 shows the perceived caring behavior from military patients' perspective both for single-item and subscale analyses. In general, patients rated nurses as satisfactory to very satisfactory in all of the items in the CBA with a grand mean score of 4.25, which is considered as satisfactory.

Table 10

Military Patients' Perceived Caring Behaviors in Military Hospitals Humanism/Faith-Hope Sensitivity

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Treat me as individual.	4.44	.755	SCB
2. Try to see things from my point of view.	4.24	.802	SCB
3. Know what they're doing.	4.38	1.03	SCB
4. Reassure me.	4.18	1.07	SCB
5. Make me feel someone is there if I need them.	4.27	1.21	SCB
6. Encourage me to believe in myself.	4.29	.843	SCB
7. Praise my efforts.	4.22	1.06	SCB
8. Understand me.	4.29	.815	SCB
9. Ask me how I like things done.	4.24	.908	SCB
10. Accept me the way I am.	4.40	.780	SCB
11. Sensitive to my feelings and moods.	4.17	.860	SCB
12. Kind and considerate.	4.40	.720	SCB
13. Know when I've "had enough" and act accordingly (for example, limiting visitors).	4.09	.848	SCB
14. Maintain a calm manner.	4.33	.738	SCB
15. Treat me with respect.	4.51	.727	SCB
Mean	**4.29**	**.878**	**SCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the first subscale of CBA which is Humanism/Faith-Hope Sensitivity indicated that the highest ranked item was "Treat patient with respect" (m=4.51) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and

the lowest ranked item was "Know when I've "had enough" and act accordingly" (m=4.09) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.29, interpreted as Satisfactory Caring Behavior (SCB).

This denotes that the patients rated nurses highest in regards to humanism/faith-hope/sensitivity in terms of treating them patient with respect. This is consistent with Watson's carative factor number two, which proposes that nurses provide individualized care for their patients and are able to make the difference in their care (Watson, 2007).

Table 11

Helping/Trust

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Really listen to me when I talk.	4.33	.798	SCB
2. Accept my feelings without judging them.	4.29	.787	SCB
3. Come into my room just to check on me.	4.44	.755	SCB
4. Talk to me about my life outside the hospital.	3.89	.982	SCB
5. Ask me what I like to be called.	3.98	.892	SCB
6. Introduce themselves to me.	3.87	1.03	SCB
7. Answer quickly when I call for them.	4.24	.908	SCB
8. Give me their full attention when with me.	4.18	.912	SCB
9. Visit me when I move to another hospital unit.	3.89	.959	SCB
10. Touch me when I need it for comfort	4.00	.953	SCB
11. Do what they say they will do.	4.13	.869	SCB
Mean	**4.11**	**.895**	**SCB**

Legend:

4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the second subscale of CBA which is Helping/Trust indicated that the highest ranked item was "Come into my room just to check on

me" (m=4.41) which is interpreted as Satisfactory Caring Behavior (SCB) and the lowest ranked item was "Introduce themselves to me" (m=3.87) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.11, interpreted as Satisfactory Caring Behavior (SCB).

This denotes that the patients rated nurses highest in regards to helping/trust in terms of coming into the room just to check on the patient. For Watson (2010), this means developing and sustaining a helping-trusting authentic caring relationship with the patients.

Table 12

Expression of Positive/Negative Feelings

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Encourage me to talk about how I feel.	4.16	1.02	SCB
2. Don't become upset when I'm angry.	4.18	.912	SCB
3. Help me understand my feelings.	4.18	.936	SCB
4. Don't give up on me when I'm difficult to get along with.	4.22	.850	SCB
Mean	**4.18**	**.929**	**SCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the third subscale of CBA which is Expression of positive/negative feelings indicated that the highest ranked item was "Don't give up on me when I'm difficult to get along with" (m=4.22) which is interpreted as Satisfactory Caring Behavior (SCB) and the lowest ranked item was "Encourage me to talk about how I feel" (m=4.16) which is interpreted as Satisfactory Caring

Behavior (SCB). The total grand mean is 4.18, interpreted as Satisfactory Caring Behavior (SCB).

This denotes that the patients rated nurses highest in regards to Expression of positive/negative feelings in terms of not giving up when the patient is difficult to get along with. This conforms to the study of O'Connell and Landers (2008) which revealed that emotional dimensions of care (expression of positive\negative feelings) were the most important as perceived by critical care patients rather than any other care components and a relationship of trust based on truth and respect.

Table 13

Teaching/Learning

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Encourage me to ask questions about my illness and treatment.	4.24	.933	SCB
2. Answer my questions clearly.	4.31	.848	SCB
3. Teach me about my illness.	4.27	.914	SCB
4. Ask me questions to be sure I understand.	4.29	.920	SCB
5. Ask me what I want to know about my illness/health.	4.27	.863	SCB
6. Help me set realistic goals for my health	4.31	.820	SCB
7. Help me plan ways to meet those goals.	4.33	.853	SCB
8. Help me plan for my discharge from the hospital.	4.16	.878	SCB
Mean	**4.27**	**.879**	**SCB**

Legend:

4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the fourth subscale of CBA which is Teaching/Learning indicated that the highest ranked item was "Help me plan ways to meet those

goals" (m=4.33) which is interpreted as Satisfactory Caring Behavior (SCB) and the lowest ranked item was "Help me plan for my discharge from the hospital" (m=4.16) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.27, interpreted as Satisfactory Caring Behavior (SCB).

The findings denotes that the patients rated highest in regards to teaching/learning subscale in terms of helping them plan ways to meet those goals. This means that effective communication is required between patient and nurse and this is in line with a study by Liu *et al.* (2006), in which patients reported that they required adequate explanations and that these explanations helped them feel more secure and safe and less anxious.

Table 14

Supportive/Protective/Corrective Environment

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Tell me what to expect during the day.	4.13	.968	SCB
2. Understand when I need to be alone.	4.09	.874	SCB
3. Offer things (position changes, blankets, back rub, lighting, etc.) to make more comfortable	4.29	.843	SCB
4. Leave my room neat after working with me.	4.27	.889	SCB
5. Explain safety precautions to me and my family.	4.31	.821	SCB
6. Give me pain medication when I need it.	4.44	.785	SCB
7. Encourage me to do what I can for myself.	4.27	.940	SCB
8. Respect my modesty (for example, keeping me covered).	4.20	.757	SCB
9. Check with me before leaving the room to be sure I have everything I need within reach.	4.42	.783	SCB
10. Consider my spiritual needs.	4.31	.848	SCB
11. Are gentle with me.	4.38	.777	SCB
12. Are cheerful.	4.40	.780	SCB
Mean	**4.29**	**.838**	**SCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)

2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the fifth subscale of CBA which is Supportive/Protective/Corrective Environment indicated that the highest ranked item was "Give me pain medication when I need it" (m=4.44) which is interpreted as Satisfactory Caring Behavior (SCB) and the lowest ranked item was "Understand when I need to be alone" (m=4.09), which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.29, interpreted as Satisfactory Caring Behavior (SCB).

Table 15

Human Needs Assistance

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Help me with my care until I'm able to do it for myself.	4.27	.939	SCB
2. Know how to give shots, IVs, etc	4.20	.944	SCB
3. Know how to handle equipment (for example, monitors).	4.24	1.03	SCB
4. Give me treatments and medications on time.	4.51	.727	VSCB
5. Keep my family informed of my progress	4.13	.869	SCB
6. Let my family visit as much as possible.	4.16	.903	SCB
7. Check my condition very closely.	4.53	.726	VSCB
8. Help me feel like I have some control.	4.27	.780	SCB
9. Know when it's necessary to call the doctor.	4.33	.769	SCB
Mean	**4.29**	**.854**	**SCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

This denotes that the patients rated highest in regards to supportive/protective/corrective environment subscale in terms of giving them pain medications when they need it. These findings concur with those from a previous study by Suliman *et al.* (2009) among patients admitted to medical-surgical wards in three hospitals in Saudi Arabia. This subscale involves the nurse manipulating the environment in order to provide support and protection for the patients' mental and physical well-being. Additionally, this subscale incorporates nursing interventions aimed at promoting the patients' comfort, privacy, and safety (Basavanthappa, 2007). These findings indicated that this carative factor is considered an important indicator of caring to military patients.

Mean Scores of the sixth subscale of CBA which is Human needs assistance indicated that the highest ranked item was "Check my condition very closely." (m=4.53) which is interpreted as Very Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Keep my family informed of my progress" (m=4.13) which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.29, interpreted as Satisfactory Caring Behavior (SCB).

The findings indicated that the patients gave nurses highest rate in regards to human needs assistance subscale in terms of checking their condition very closely. This supports the findings of another study using the CBA instrument (Kimble, 2003) which showed Human needs assistance subscale as the highest ranked by patients. This subscale encompasses the technical aspects of nursing care, which include among others, assisting the patient with his/her care when

necessary, competence in procedures and timely provision of nursing services. Medical-Surgical patients tend to value more physical caring competencies and the ability of the nurse to deliver a general feeling of well-being (Henderson *et al.*, 2007), and nurses have to incorporate these aspects into practice if they are to promote quality nursing care in this population of patients.

Table 16

Existential/Phenomenological Spiritual Forces

Caring Behavior Subscales	Mean Scores	SD	Interpretation
1. Seem to know how I feel.	4.36	.802	SCB
2. Help me see that my past experiences are important.	4.07	.914	SCB
3. Help me feel good about myself.	4.44	.785	SCB
Mean	**4.29**	**.834**	**SCB**

Legend:
4.51–5.0 Very Satisfactory Caring Behavior (VSCB)
3.51–4.50 Satisfactory Caring Behavior (SCB)
2.51–3.50 Moderately Satisfactory Caring Behavior (MSCB)
1.51–2.50 Fair Caring Behavior (FCB)
1.00–1.50 Poor Caring Behavior (PCB)

Mean Scores of the seventh subscale of CBA which is Existential/Phenomenological Spiritual forces indicated that the highest ranked item was "Helps the me feel good about myself" (m=4.44) which is interpreted as Satisfactory Caring Behavior (VSCB) and the lowest ranked item was "Helps the patient see that his/her past experiences are important" (m=4.07), which is interpreted as Satisfactory Caring Behavior (SCB). The total grand mean is 4.29, interpreted as Satisfactory Caring Behavior (SCB).

This denotes that the patients rated nurses high in regards to Existential/Phenomenological Spiritual forces in terms of helping them feel good about themselves. Watson (2010) defines this subscale as opening and attending to spiritual-mysterious, and unknown existential dimensions of one's own life-death-suffering, soul care for self and the one being-cared for, allowing for a miracle.

These results are more or less similar to the original study of Cronin and Harrison (1988), wherein myocardial infarction patients revealed that nursing actions that focused on the physical care and monitoring of patients were seen as most indicative of caring. Teaching activities were also perceived as significant whereas extra, individualized aspects of care were viewed as less important in the critical care setting. Both this study and that of Cronin's and Harrison's (1988) study is contradictory that Suliman *et al.* (2009) wherein supportive/protective/corrective environment subscale was rated as most important by patients in multicultural environment.

In summary, patients' perceptions of nurse caring behavior in this study were supported by the previous literature. In general there was an overall positive perception of nurse caring behaviour as rated by the military patients.

The Correlation between the Self-Rated Caring Behaviors of Military Nurses and their Socio-Demographic Profile. Table 17 shows relationship of the Self-rated caring behaviors of military nurses and their socio-demographic profile.

Table 17

Correlation between the Self-Rated Caring Behaviors of Nurses and their Socio-Demographic Profile

Characteristics		Overall Perception		F-test	P-value
		Grand Mean	SD		
Age	21-29 years old	4.55	.369	.048	.828
	30-38 years old	4.52	.446		(ns)
	39-47 years old	4.54	.416		
	48-56 years old	4.54	.392		
	57-65 years old	4.52	.446		
Sex	Male	4.54	.416	.000	.992
	Female	4.54	.392		(ns)
Marital Status	Single	4.47	.354	.559	.576
	Married	4.59	.406		(ns)
	Separated	4.41	.629		
Monthly Income					
	Less than P5000	4.07	.119	1.504	.211
	P 5,000 to less than P 15,000	4.64	.586		(ns)
	P 15,000 to less than P 25,000	4.44	.427		
	P 25,000 to less than P 35,000	4.67	.360		
	P 35,000 to less than P 50,000	4.71	.296		
	P 50,000 or more	4.68	.133		
Experience	0 – 5 years	4.33	.278	2.551	.043
	5 – 10 years	4.49	.472		(s)
	11 – 15 years	4.76	.150		
	16 – 20 years	4.92	.056		
	21 – 25 years	4.31	.600		
	26 and above	4.47	.482		

Significance Level $\alpha = 0.05$
Legend: S-Significant Relationship NS- No Significant Relationship

As can be seen in the table, only experience shows a significant relationship (p=0.043) with nurses mean self-ratings. Nurses with longer experience of 16–20 years and 11–15 years had higher means ratings compared to nurses who have been a military nurse for a fewer years. Therefore, the corresponding null hypothesis was rejected. Meaning, the self-rated caring behaviors of nurses is influenced by their socio-demographic profile specifically their experience.

In a study by Salimi and Azimpour (2013), they developed and tested a valid and reliable questionnaire to find out determinants of caring behavior. One of the strong determinants the authors have established was experience along with self-respect, beliefs, and workplace circumstances. Nursing care plays a prominent role in determining the overall satisfaction of patients' hospitalization experience (Wagner & Bear 2009). And the relationship of patients to nurses form part of the overall experience of nurses. When nurses are satisfied with their work, this radiates to their dealings with patients. In addition, longer experience produces more understandings in nurses to the plight of their patients (Rafii, Hajinezhad, & Haghani, 2009). On the other hand, there are other studies that have found out that nurses having longer hospital experience have an overall reduction in the quality of care resulting from burnout. So in the case of military nurses, it can be that their experience in military care is satisfactory so as to have higher self-ratings for nurses who have worked a longer time.

Comparison of Nurse and Patient Perception of the Caring Behaviors of Nurses in Military Hospitals. Table 18 compares the mean scores per subscale for both nurse and military patient participants. This is what makes this study unique from those already present in literature since not many if not, none at all, compares the perceptions of these two.

Table 18

Comparison of Nurse and Patient Perception of the Caring Behaviors of Nurses in Military Hospitals

Caring Behavior Assessment Subscale	Mean Scores	SD	Mean Scores	SD
Humanism/Faith-Hope Sensitivity	4.60	.566	4.29	.878
Helping/Trust	4.38	.714	4.11	.895
Expression of positive/negative feelings	4.43	.664	4.18	.929
Teaching/Learning	4.52	.621	4.27	.979
Supportive/Protective/Corrective Environment	4.62	.547	4.29	.838
Human needs assistance	4.69	.471	4.29	.854
Existential/Phenomenological Spiritual forces	4.53	.615	4.29	.834
GRAND MEAN	**4.54**		**4.25**	

Table 19

Difference in the perceptions of nurses and patients (n=90)

Variable	*N*	*M*	*SD*	*t*	*df*	*p-value*	Evaluation
Perception				2.392	88	.019	S/Reject Ho
Nurses	45	4.54	.391				
Patients	45	4.25	.716				

Significance Level: 0.5
Legend: S- Significant Difference NS- No Significant Difference

As reflected above Table 19, there was a significant difference in the perceptions of the provision of caring behaviors between nurses and military patients since the p-value .019 resulting from the t-test run on the data is below the significance level of $\alpha = 0.05$. Therefore, the corresponding null hypothesis was

rejected. Meaning, there is a significant difference between the nurse and patient perception of caring behaviors.

It can be seen that patients' mean ratings were lower in all subscales as compared to nurse participants. This resulted in a grand mean rating of 0.29 points lower for patients in comparison to nurses. This means that the perception of nurses and patient differ in the provision of caring behavior with patients perceiving inadequacy of care coming from nurses with respect to the subscales listed in the CBA.

Many studies in the nursing field have tried to document what factors might affect perceptual differences. These factors are mostly socio-demographic variables (i.e. Alrubaiee & Alkaaida, 2011; Szynkiewicz *et al.*, 2013) that play intervening roles. More important of the socio-demographic variables are those that shape experience, thereby, determining patient satisfaction in future experiences such as being hospitalized. For instance, the study by Johansson and colleagues (2002) suggest that the higher patients' educational level is, the higher their expectations of nursing care. Patients with a higher educational level may have higher expectations regarding the information they are given and their overall care. If these expectations are not met, patients rate their satisfaction with nursing care as low.

In this study, the lower ratings were given by patients as compared to nurses. Congruent to the study of Papastavrou *et al.* (2011), it reported that surgical nurses consistently rated their caring behaviors more highly than patients rated

the nurses and there were significant differences in the subscales of assurance and respectfulness ($p<.001$). It could mean that military personnel expect higher care from nurses as what nurses believe they are already giving. This might stem from military personnel spending a considerable portion of their time in hospitals with the dangers they have in their line of work. Therefore, they have already formed expectations as to the type of care they should be receiving from not only the nursing personnel but the health care team as a whole. This is especially since they have the knowledge that the hospital is specialized to cater to their specific health care needs.

For caring to be meaningful, it needs to be based on mutual agreement between nurses and patients on what constitutes important nurse-caring behaviours. As a result of having this insight, nurses in clinical practice can enhance patients' satisfaction with nursing care by providing caring that is informed by patients' needs (Zamanzadeh *et al.*, 2010). Therefore, improving the nurses' caring behaviors may increase the quality of care and patient satisfaction, and this may also help the military patients to recover faster.

Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the summary of findings, the corresponding conclusion and recommendation based on the result of the study.

Summary of Findings

The following are salient findings of the study:

1. There were 45 nurse-respondents in the study, with the age ranges from 21 to 65 years old. Majority of nurses respondents were aged 21 to 29 years (44.4%). Most of the respondents are females (n=37) and married (n=27). In terms of monthly income, the average ranged from Php 15,000–25,000 with a frequency of 21 or 46.7%. In terms of hospital experience, most of them had 11 to 15 years already (26.7%).

2. There were 45 patient-respondents in the study, with the age from 18 to 56 and above years. Majority of patient respondents were aged 18 to 25 years (44.4%). Most of the respondents were males (n=39) and single (n=27). Majority of the patients were college graduate about 22 or 48.9%. In terms of monthly income, the average ranged from Php 25,000–35,000 with a frequency of 22 or 48.9%.

3. The self-rated caring behavior assessment of military nurses was categorized into 7 subscales: Humanism/Faith-Hope/Sensitivity, Helping/Trust, Teaching/Learning, and Expression of positive / negative feelings,

Supportive/Protective / Corrective Environment, Human needs assistance, and Existential/Phenomenological Spiritual forces. Of the (15) items with regards to the subscale of humanism/faith-hope sensitivity the mean was 4.60 and the SD was .566. Next, of the (11) items of the subscale helping/trust, the mean was 4.38 and the SD was .664. Then, on the (4) items of expression of positive/negative feelings subscale, the mean was 4.43 and the SD was .664. Next, on the (8) items with regards to the teaching/learning subscale the mean was 4.52 and the SD was .621. Then, on the (12) items of the subscale supportive/protective/corrective environment the mean was 4.62, and the SD was .547. Next, on the (9) items in the human needs assistance subscale, the mean was 4.69 with an SD of .471. Lastly, on the (3) items with regards to the subscale existential/phenomenological spiritual forces, the mean was 4.53, and the SD was .615.

4. The caring behavior assessment of patients was categorized into 7 subscales: Humanism/Faith-Hope/Sensitivity, Helping/Trust, Teaching/Learning, and Expression of positive / negative feelings, Supportive/Protective / Corrective Environment, Human needs assistance, and Existential/Phenomenological Spiritual forces. Of the (15) items with regards to the subscale of humanism/faith-hope sensitivity the mean was 4.29 and the SD was .878. Next, of the (11) items of the subscale helping/trust, the mean was 4.11 and the SD was .895. Then, on the (4) items of expression of positive/negative feelings subscale, the mean was 4.18 and the SD was .929. Next, on the (8) items with regards to the teaching/learning subscale the mean was 4.27 and the SD was

.879. Then, on the (12) items of the subscale supportive/protective/corrective environment the mean was 4.29, and the SD was .838. Next, on the (9) items in the human needs assistance subscale, the mean was 4.29, with an SD of .854. Lastly, on the (3) items with regards to the subscale existential/phenomenological spiritual forces, the mean was 4.29, and the SD was .615.

5. There was a significant relationship between the self-rated caring behaviors of military nurses and their socio-demographic profile specifically experience with a p value of .043 from the one-way analysis of variance. Therefore, the corresponding null hypothesis was rejected.

6. There was a significant difference in the perceptions of the provision of caring behaviors between nurses and military patients. Nurses' perception with a grand mean of 4.54 had a significantly higher rating than patients' perception with a mean score of 4.25 when compared using t-test since the p-value was .019, which was below the significance level of $\alpha = 0.05$. Therefore, the corresponding null hypothesis was rejected.

Conclusions

The following conclusions can be generated from the study:

1. Majority of the nurses in military hospitals were aged between twenty to twenty-nine years old, most of them were females, and sixty percent of them were married. Most of them had a monthly income that ranged from Php 15,000–25,000. Many of the nurses have eleven to fifteen years hospital experience already.

2. Majority of the military patients-respondents were between eighteen to twenty-five years old, most of them were males and sixty percent were single. Most of the respondents were college graduate. And about forty-eight percent of the respondents had a monthly income between Php 25,000–35,000.

3. Most of nurses' self-rated caring behaviour had the highest rating in human needs assistance subscale. Nurses in military hospital settings considered the instrumental aspects of caring in nursing, which involve substantive actions, as important in demonstrating caring to patients. Nursing is a skill-oriented field requiring efficiency and safety which necessitates the need to master skills required to carry out nursing interventions.

4. Most of the patients' gave the nurses highest rate in human needs assistance existential/phenomenological spiritual forces, supportive/protective/ corrective environment and humanism/faith-hope sensitivity subscales. Military patients value physical, mental, and spiritual caring competencies and the ability of the nurse to deliver a general feeling of well-being and nurses have to

incorporate these aspects into practice if they are to promote quality nursing care in this population of patients.

5. There is significant relationship between the self-rated caring behavior of nurses and their socio-demographic profile specifically their experience.

6. There is a significant difference between the self-rated caring behaviors of nurses and according to the patients. The patients rated the caring behaviors of nurses satisfactory which is significantly lower than the self-rated caring behavior of nurses of very satisfactory.

Recommendations

The following are the recommendations based on the findings and conclusions.

1. The hospitals catering to the care of the country's military personnel should look into evaluating the care rendered in perhaps a stakeholders' meeting or quality control check since as found out in this study, patients gave a significantly lower ratings compared to nurses. This can surely help in increasing the quality of care received by the men and women who serve to protect and defend this country and who only deserve the best.

2. The nurses must have a caring behaviour that will satiate the patient's needs.

3. The healthcare workers must prioritize the patient's needs and must have a good caring behaviour to all patients without any biases.

4. Nursing staff should incorporate the nursing behaviours which patients considered most important into patient management to enable provision of care that is more patient-centred.

5. Further studies can be done in the form of developing a specific tool like the CBA specifically made for evaluating the type and quality of care received by military personnel.

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A P P E N D I C E S

APPENDIX A

Letter Request to Conduct Survey

SAMAR STATE UNIVERSITY
COLLEGE OF GRADUATE STUDIES
Catbalogan City

December 2017

CPT KENNEDY N ALAURIN MC
Officer in Charge
Camp Lukban Station Hospital
8th Infantry Division, Philippine Army
Catbalogan City, Samar

Thru: MAJ MARIA CRISTINA V VILLARIAS NC
Chief Nurse

Dear Sir/Madam:

Good day! The undersigned is presently working on a research study entitled "**Caring Behaviors of Nurses in a Military Hospital**" as a final requirement for Thesis Writing in Master of Science in Nursing (MSN) in Samar State University. The purpose of this study is to assess the provision of caring behaviors of nurses working in a military hospital. The result that could be gained from this study would provide essential and useful inputs to the institution to improve the quality of health service delivery.

In this connection, I would like to ask from your good office to allow me or my representative to distribute my questionnaires to nurses and patients at Camp Lukban Station Hospital, 8ID, PA. Attached herein is a copy of my proposal and questionnaire for your perusal.

I am hoping for your kind approval. May God bless you.

Respectfully yours,

(Sgd.) JHOANNA RAE T. RELI, RN
Researcher

Noted By:

(Sgd.) MARICEL M. TIZON, RN, MAN
Research Adviser

Recommending Approval:

(Sgd.) FELISA E. GOMBA, Ph.D
Acting Dean, College of Graduate Studies/
Vice President for Academic Affairs

APPROVED BY:

(Sgd) CPT KENNEDY N ALAURIN MC
OIC, Camp Lukban Station Hospital

APPENDIX B

Letter Request to Conduct Survey

SAMAR STATE UNIVERSITY
COLLEGE OF GRADUATE STUDIES
Catbalogan City

December 2017

MAJ GIANCARLO L CABANAG MC
Officer in Charge
Camp Lapulapu Hospital, Health Service Central
Armed Forces of the Philippines Health Service Command
Cebu City

Thru: LTC MARIA LORELA C CABALLES NC (GSC)
Chief Nurse

Dear Sir/Madam:

Good day! The undersigned is a staff nurse of Camp Lukban Station Hospital, 8ID, PA, presently working on a research study entitled "**Caring Behaviors of Nurses in a Military Hospital**" as a final requirement for Thesis Writing in Master of Science in Nursing (MSN) in Samar State University. The purpose of this study is to assess the provision of caring behaviors of nurses working in a military hospital. The result that could be gained from this study would provide essential and useful inputs to the institution to improve the quality of health service delivery.

In this connection, I would like to ask from your good office to allow me or my representative to distribute my questionnaires to nurses and patients at Camp Lapulapu Hospital, AFPHSC. Attached herein is a copy of my proposal and questionnaire for your perusal.

I am hoping for your kind approval. May God bless you.

Respectfully yours,

(Sgd) JHOANNA RAE T. RELI, RN
Researcher

Noted By:

(Sgd) MARICEL M. TIZON, RN, MAN
Research Adviser

Recommending Approval:

(Sgd) FELISA E. GOMBA, Ph.D
Acting Dean, College of Graduate Studies

APPROVED BY:

(Sgd) MAJ GIANCARLO L CABANAG MC
OIC, Camp Lapulapu Hospital

APPENDIX C

Letter Request to Conduct Survey

SAMAR STATE UNIVERSITY
COLLEGE OF GRADUATE STUDIES
Catbalogan City

December 2017

COL MAMERTO H LOSA MC (GSC)
Commanding Officer
Fort Magsaysay Army Station Hospital
7th Infantry Division, Philippine Army
Palayan City, Nueva Ecija

Thru: LTC ANNALIZA U YANTO NC
Chief Nurse

Dear Sir/Madam:

Good day! The undersigned is a staff nurse of Camp Lukban Station Hospital, 8ID, PA, presently working on a research study entitled "**Caring Behaviors of Nurses in a Military Hospital**" as a final requirement for Thesis Writing in Master of Science in Nursing (MSN) in Samar State University. The purpose of this study is to assess the provision of caring behaviors of nurses working in a military hospital. The result that could be gained from this study would provide essential and useful inputs to the institution to improve the quality of health service delivery.

In this connection, I would like to ask from your good office to allow me or my representative to distribute my questionnaires to nurses and patients at Fort Magsaysay Army Station Hospital, 7ID, PA. Attached herein is a copy of my proposal and questionnaire for your perusal.

I am hoping for your kind approval. May God bless you.

Respectfully yours,

(Sgd.) JHOANNA RAE T. RELI, RN
Researcher

Noted By:

(Sgd.) MARICEL M. TIZON, RN, MAN
Research Adviser

Recommending Approval:

(Sgd.) FELISA E. GOMBA, Ph.D
Acting Dean, College of Graduate Studies/
Vice President for Academic Affairs

APPROVED BY:

(Sgd) CPT KENNEDY N ALAURIN MC
OIC, Camp Lukban Station Hospital

APPENDIX D
Letter Request to Conduct Survey

SAMAR STATE UNIVERSITY
COLLEGE OF GRADUATE STUDIES
Catbalogan City

December 2017

LTC IGNACIO P TIMBOL JR MC PA
Commanding Officer
Camp Melchor F Dela Cruz Station Hospital
5TH Infantry Division, Philippine Army
Upi, Gamu, Isabela

Thru: MAJ ROMELIA E QUILO NC PA
Chief Nurse

Dear Sir/Madam:

Good day! The undersigned is a staff nurse of Camp Lukban Station Hospital, 8ID, PA, presently working on a research study entitled "**Caring Behaviors of Nurses in a Military Hospital**" as a final requirement for Thesis Writing in Master of Science in Nursing (MSN) in Samar State University. The purpose of this study is to assess the provision of caring behaviors of nurses working in a military hospital. The result that could be gained from this study would provide essential and useful inputs to the institution to improve the quality of health service delivery.

In this connection, I would like to ask from your good office to allow me or my representative to distribute my questionnaires to nurses and patients at. CMFDC SH, 5ID, PA Attached herein is a copy of my proposal and questionnaire for your perusal.

I am hoping for your kind approval. May God bless you.

Respectfully yours,

(Sgd.) JHOANNA RAE T. RELI, RN
Researcher

Noted By:

(Sgd.) MARICEL M. TIZON, RN, MAN
Research Adviser

Recommending Approval:

(Sgd.) FELISA E. GOMBA, Ph.D
Acting Dean, College of Graduate Studies/
Vice President for Academic Affairs

APPROVED BY:

(Sgd) CPT KENNEDY N ALAURIN MC
OIC, Camp Lukban Station Hospital

APPENDIX E

Cover Letter of the Questionnaire

SAMAR STATE UNIVERSITY
COLLEGE OF GRADUATE STUDIES
Catbalogan City, Samar

Dear Sir/madam:

The undersigned is a staff nurse of Camp Lukban Station Hospital, 8ID, PA, presently working on a research study entitled "**Caring Behaviors of Nurses in a Military Hospital**" as a final requirement for Thesis Writing in Master of Science in Nursing (MSN) in Samar State University. The purpose of this study is to assess the provision of caring behaviors of nurses working in a military hospital.

In this connection, I am giving you the questionnaire herein attached for the gathering of the data I need. You are requested to supply the information asked for Part I and to give your honest information in Part II and Part III. This questionnaire is completely anonymous and confidential. Your responses are critical part of my research.

Thank you for your time and cooperation.

Very truly yours,

(Sgd) JHOANNA RAE T. RELI, RN
Researcher

APPENDIX F

Letter Request to the Statistician

SAMAR STATE UNIVERSITY
COLLEGE OF GRADUATE STUDIES
Catbalogan City

December 2017

DR. MARIANNE AGNES T. MENDOZA
Head RDU-RSO and Managing Editor of JST
Naval State University
Naval, Biliran

Dear Madam:

Good day! The undersigned researcher is presently working on a research study entitled **"Caring Behaviors of Nurses in a Military Hospital"** as a final requirement for Thesis Writing in Master of Science in Nursing (MSN) in Samar State University. The purpose of this study is to assess the provision of caring behaviors of nurses working in a military hospital.

In this connection I would like to ask your expert service as statistician of this study.

I am hoping for your kind approval. May God bless you.

Very truly yours,

(Sgd.) JHOANNA RAE T. RELI, RN
Researcher

Noted By:

(Sgd.) MARICEL M. TIZON, RN, MAN
Research Adviser

APPENDIX G

Questionnaire for Nurses in a Military Hospital

Part I. Nurses Socio-Demographic Profile
Instructions: Please supply the information asked for. Check (/) parenthesis that represents your response.

Age: _____

Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married

[ ] Widow/er [ ] Separated

Monthly Income: [ ] Less than P 5,000

[ ] P 5,000 to less than P 15,000

[ ] P 15,000 to less than P 25,000

[ ] P 25,000 to less than P 35,000

[ ] P 35,000 to less than P 50,000

[ ] P 50, 000 and above

Years of

Hospital Experience: [ ] 0-5 [ ] 6-10 [ ] 11-15

[ ] 16-20 [ ] 21- 25 [ ] 26 years & above

Part II. CARING BEHAVIOR ASSESSMENT

Please check your rating of how the nurses in general in this military hospital cater the following care needs of the patients.

VS -VERY SATISFACTORY **S** - SATISFACTORY
MS- MODERATELY SATISFACTORY **F**- FAIR **P** -POOR

Caring Behavior Assessment	Caring Behavior in the Transaction				
	VS	S	MS	F	P
Humanism/Faith-Hope/Sensitivity					
1. I treat patients as individual.					
2. Tries to see things from the patient's point of view.					
3. Knows what I'm doing.					
4. Reassures the patient.					
5. Makes the patient feel someone is there if needed.					
6. Praises the patient's efforts.					
7. Understands the patient.					
8. Asks the patient how things should be done.					
9. Accepts the way the patient is.					
10. Sensitive to the patient's feelings and moods.					
11. Kind and considerate.					
12. Knows when the patient has "had enough" and acts accordingly (for example, limiting visitors).					
13. Maintains a calm manner.					
14. Treats the patient with respect.					
15. Praises the patient's efforts.					
Helping/Trust					
16. Really listens to the patient when he/she talks.					
17. Accepts the patient's feelings without judging them.					
18. Come into the room just to check on the patient.					
19. Talks to the patient about his/her life outside the hospital.					
20. Asks what the patient likes to be called.					
21. Introduces self to the patient.					
22. Answers quickly when the patient calls for me.					
23. Gives the patient my full attention when with me.					
24. Visits the patient when he/she moves to another hospital unit.					
25. Touches the patient when he/she needs it for comfort.					
26. Does what I say I will do.					
Expression of Positive/Negative Feelings					
27. Encourages patient to talk about how he/she feels.					
28. I don't become upset when the patient is angry.					

29. Helps the patient understand his/her feelings.					
30. I don't give up on the patient even when he/she is difficult to get along with.					
Teaching/Learning					
31. Encourages the patient to ask questions about his/her illness					
32. Answers the patient's questions clearly.					
33. Teaches the patient about his/her illness.					
34. I ask the patient questions to be sure he/she understands.					
35. Asks the patient what he/she wants to know about his/her illness					
36. Helps the patient set realistic goals for his or her health.					
37. Helps the patient plan ways to meet those goals.					
38. Helps the patient plan for his/her discharge from the hospital.					
Supportive/Protective/ Corrective Environment					
39. Tells the patient what to expect during the day.					
40. Understands when the patient needs to be alone.					
41. Offers things (position changes, blankets, back rub, lighting, etc.) to make the patient more comfortable.					
42. Leaves the patient's room neat after working with him/her.					
43. Explains safety precautions to the patient and family.					
44. Gives the patient pain medication when he/she needs it.					
45. Encourages the patient to do what he/she can for him/herself.					
46. Respects the patient's modesty (, keeping him/her covered).					
47. Checks with the patient before leaving the room to be sure he/she has everything needed within reach.					
48. Considers the patient's spiritual needs.					
49. Is gentle with the patient.					
50. Is cheerful.					
Human Needs Assistance					
51. Helps the patient with his/her care until able to do it for oneself.					
52. Knows how to give shots, IVs, etc.					
53. Knows how to handle equipment (for example, monitors).					
54. Gives the patient treatments and medications on time.					
55. Keeps the patient's family informed of the progress.					
56. Lets the patient's family visit as much as possible.					
57. Checks the patient's condition very closely.					
58. Helps the patient feel like he/she has some control.					
59. Knows when it's necessary to call the doctor.					
Existential/Phenomenological Spiritual forces					
60. Seems to know how the patient feels.					
61. Helps the patient see that his/her past experiences are important.					
62. Helps the patient feel good about oneself.					

APPENDIX H

Questionnaire for Military Patients

Part I. Patient Socio-Demographic Profile

Instructions: Please supply the information asked for. Check (/) parenthesis that represents your response.

Age: _____

Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married

[ ] Widow/er [ ] Separated

Educational Attainment: [ ] Elementary Grad [ ] High school Undergrad

[ ] High school Graduate [ ] College Undergraduate

[ ] College Graduate [ ] Masters

Monthly Income:

[ ] P 25,000 to less than P 35,000

[ ] P 35,000 to less than P 45,000

[ ] P 45,000 to less than P 55,000

[ ] P 55,000 and above

Part II. CARING BEHAVIOR ASSESSMENT

Please check your rating of how the nurses in general in this military hospital cater the following care needs.

VS -VERY SATISFACTORY **S** - SATISFACTORY
MS- MODERATELY SATISFACTORY **F**- FAIR **P** -POOR

Caring Behavior Assessment	Caring Behavior in the Transaction				
	VS	S	MS	F	P
Humanism/Faith-Hope/Sensitivity					
1. Treat me as individual.					
2. Try to see things from my point of view.					
3. Know what they're doing.					
4. Reassure me.					
5. Make me feel someone is there if I need them.					
6. Encourage me to believe in myself.					
7. Points out positive things about my condition.					
8. Praise my efforts.					
9. Understand me.					
10. Ask me how I like things done.					
11. Accept me the way I am.					
12. Sensitive to my feelings and moods.					
13. Kind and considerate.					
14. Know when I've "had enough" and act accordingly (for example, limiting visitors).					
15. Maintain a calm manner.					
16. Treat me with respect.					
Helping/Trust					
17. Really listen to me when I talk.					
18. Accept my feelings without judging them.					
19. Come into my room just to check on me.					
20. Talk to me about my life outside the hospital.					
21. Ask me what I like to be called.					
22. Introduce themselves to me.					
23. Answer quickly when I call for them.					
24. Give me their full attention when with me.					
25. Visit me when I move to another hospital unit.					
26. Touch me when I need it for comfort.					
27. Do what they say they will do.					
Expression of Positive/Negative Feelings					
28. Encourage me to talk about how I feel.					

29. Don't become upset when I'm angry.					
30. Help me understand my feelings.					
31. Don't give up on me when I'm difficult to get along with.					
Teaching/Learning					
32. Encourage me to ask questions about my illness and treatment.					
33. Answer my questions clearly.					
34. Teach me about my illness.					
35. Ask me questions to be sure I understand.					
36. Ask me what I want to know about my illness/health.					
37. Help me set realistic goals for my health.					
38. Help me plan ways to meet those goals.					
39. Help me plan for my discharge from the hospital.					
Supportive/Protective/Corrective Environment					
40. Tell me what to expect during the day.					
41. Understand when I need to be alone.					
42. Offer things (position changes, blankets, back rub, lighting, etc.) to make more comfortable.					
43. Leave my room neat after working with me.					
44. Explain safety precautions to me and my family.					
45. Give me pain medication when I need it.					
46. Encourage me to do what I can for myself.					
47. Respect my modesty (for example, keeping me covered).					
48. Check with me before leaving the room to be sure I have everything I need within reach.					
49. Consider my spiritual needs.					
50. Are gentle with me.					
51. Are cheerful.					
Human Needs Assistance					
52. Help me with my care until I'm able to do it for myself.					
53. Know how to give shots, IVs, etc					
54. Know how to handle equipment (for example, monitors).					
55. Give me treatments and medications on time.					
56. Keep my family informed of my progress.					
57. Let my family visit as much as possible.					
58. Check my condition very closely.					
59. Help me feel like I have some control.					
60. Know when it's necessary to call the doctor.					
Existential/Phenomenological Spiritual forces					
61. Seem to know how I feel.					
62. Help me see that my past experiences are important.					
63. Help me feel good about myself.					

APPENDIX I

FOCUSED GROUP DISCUSSION (FGD)

1. Can you tell me something about yourself?
2. Please describe to me your day to day routine in Camp Lukban Station Hospital.
3. How do you think your job as military nurse is similar to nurses in general hospitals?
4. How do you think your job as military nurse is different to nurses in general hospitals?
5. How are your patients different from patients in general hospitals?
6. What are the top competencies you think nursing students should learn to be able to work effectively as military nurse?
7. What are that advantages of working as military nurses?
8. What are that disadvantages of working as military nurses?

APPENDIX J

Demographic Profile of Nurses-Respondents

NURSES NUMBER	AGE	SEX	MARITAL STATUS	MONTHLY INCOME	HOSPITAL EXPERIENCE
1	29	2	1	5	2
2	32	2	2	4	1
3	26	2	1	5	1
4	31	2	2	5	2
5	32	1	2	6	3
6	60	2	3	3	6
7	28	2	2	3	3
8	29	1	2	3	2
9	53	2	2	4	6
10	29	2	1	3	2
11	29	2	2	3	2
12	34	2	3	3	4
13	27	1	1	4	1
14	31	2	2	4	6
15	27	2	2	4	6
16	25	2	1	6	3
17	31	2	2	5	6
18	30	2	2	3	4
19	29	2	2	1	1
20	27	2	1	3	1
21	25	2	1	3	1
22	32	2	1	6	3
23	23	2	1	1	1
24	41	2	2	3	3
25	44	2	2	3	3
26	27	1	1	5	2
27	58	2	2	4	6
28	28	1	2	3	1
29	33	1	2	5	3
30	50	2	2	3	5
31	58	2	1	2	6
32	51	2	2	3	3
33	43	2	1	3	5
34	38	1	2	2	2
35	32	2	1	2	4

36	28	2	2	6	2
37	32	2	2	6	3
38	50	2	2	3	3
39	26	2	1	3	1
40	28	1	2	6	3
41	29	2	1	3	2
42	30	2	2	4	6
43	31	2	1	3	1
44	32	2	2	3	3
45	27	2	2	3	5
MEAN	**34**	**2**	**2**	**4**	**3**

APPENDIX K

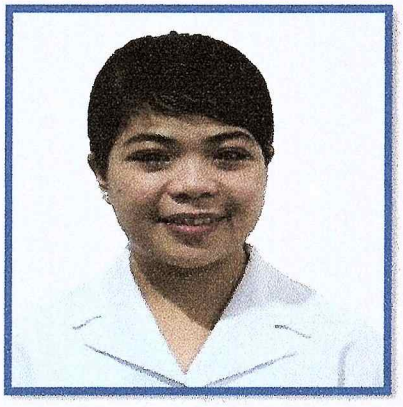
Demographic Profile of Military Patients Respondents

RESPONDENT NUMBER	AGE	SEX	EDUCATIONAL ATTAINMENT	MARITAL STATUS	MONTHLY INCOME
1	19	1	3	1	3
2	26	1	5	1	3
3	20	1	4	1	3
4	20	1	4	1	3
5	19	1	3	1	3
6	18	1	3	1	3
7	24	1	4	1	3
8	19	1	4	1	4
9	27	1	3	2	3
10	25	1	5	1	3
11	26	1	5	1	2
12	33	1	4	1	5
13	28	1	4	1	4
14	27	1	5	2	4
15	25	1	3	1	3
16	20	1	3	1	3
17	22	1	4	1	3
18	23	1	4	1	3
19	38	1	3	2	5
20	35	1	4	4	4
21	48	1	4	2	6
22	41	1	3	3	3
23	30	1	4	1	3
24	45	1	4	2	6
25	30	1	3	4	6
26	24	1	4	1	3
27	25	1	4	1	3
28	23	1	5	1	4
29	29	1	4	2	4
30	22	1	5	1	2
31	18	1	2	1	1
32	20	1	3	1	2
33	36	1	4	2	5
34	27	2	3	2	3
35	30	2	4	2	2

36	40	2	5	2	3
37	47	2	5	2	5
38	25	1	5	1	5
39	31	1	4	2	3
40	42	2	5	2	3
41	36	1	4	4	4
42	25	1	5	1	4
43	31	1	4	2	3
44	52	1	4	2	4
45	29	2	4	1	2
MEAN	**29**	**1**	**4**	**2**	**3**

C U R R I C U L U M V I T A E

CURRICULUM VITAE



PERSONAL BACKGROUND

NAME:	RELI, JHOANNA RAE T.
AGE:	27 years old
SEX:	Female
ADDRESS:	Brgy. Mudboron, Alangalang, Leyte
PLACE OF BIRTH:	Catbalogan, Samar
DATE OF BIRTH:	August 23, 1990
EMAIL ADD:	raejhoanna1990@gmail.com
POSITION:	Nurse I
OFFICE:	Camp Lukban Station Hospital, 8ID, PA
OFFICE ADDRESS:	Camp Lukban, Brgy. Maulong, Catbalogan City
FATHER:	Jovencio A. Reli
MOTHER:	Rebecca T. Reli

EDUCATIONAL BACKGROUND

GRADUATE:	Master of Science in Nursing Samar State University Catbalogan City March 2018
TERTIARY:	Bachelor of Science in Nursing Colegio de Sta. Lourdes of Leyte Foundation Inc., Tabontabon, Leyte April 2010
SECONDARY:	Alangalang National High School Alangalang, Leyte March 2006
ELEMENTARY:	Alangalang I Central School Alangalang, Leyte March 2002

ELIGIBILITIES

Career Service Eligible: Professional Level
CSC: October 2012

Registered Nurse
NLE: December 2010

EXPERIENCES

Nurse 1
Camp Lukban Station Hospital
8th Infantry Division, Philippine Army
Catbalogan City

LIST OF TABLES

LIST OF TABLES

LIST OF FIGURE

LIST OF FIGURES