Spiritual Care Competency of Staff Nurses: Basis for an Enhancement Program

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Abstract

This research determined the spiritual care competency of staff nurses of tertiary hospitals in La Union as a basis in the formulation of the spiritual nursing care competency enhancement program. The study utilized the descriptive-developmental research design. To gather the needed data, a survey questionnaire was used. Frequency and percentage were used to identify the characteristics of the respondents and weighted mean was computed to analyze on the level of spiritual care competency of staff nurses based on the ratings of staff nurses themselves, patients and immediate nurse supervisors and the extent to which personal, psychological and socio-cultural factors affect the level of spiritual care competency of staff nurse. The Pearson r was used to determine whether or not there is a significant relationship between the two variables and the ANOVA was used to determine if the difference is significant.

The researcher found out that majority of the respondents were ages 20 – 39, male, single, Roman Catholic, graduated from non-sectarian schools, with 0-3 years length of service from different wards such as Medical, Surgical, Orthopedic and Ob-Gyne wards.

Based on the data gathered, the spiritual care competency of the staff nurses was moderate which means that they provide spiritual care to patients sometimes. Generally, there is no significant relationship between the demographic profile and the level of spiritual care competency of staff nurses. The levels of spiritual care competency of staff nurses between the ratings made by themselves, patients and immediate nurse supervisors show a significant difference. The extent of effect of the personal, psychological and socio-cultural factors on the spiritual care competency of staff nurses were high.

There is a significant relationship between the levels of spiritual care competency and the extent of effect of personal, psychological and socio-cultural factors on the spiritual care competency of staff nurses.

Background of the Study

The World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1992). A decade after the WHO Department of Mental Health recognized aspects related to spirituality, religion and personal beliefs as aspects of the quality of life as shown in its other program which focus on the spiritual facets of human being (WHO 2002). WHO emphasizes the importance of attention to human activities in the area of spirituality in its International Classification of Functioning and also states that palliative care encompasses the spiritual aspects of patient care (WHO 2001; 2007).

Spirituality is now accepted as one of the most essential factors that affect people in performing at work as it helps them build a good and harmonious relationship with the people they work with and work for. This is supported by studies regarding the relationships between spirituality, health and health care (Koenig 2002; Ross 2006). These research studies were done among different kinds of patient populations in physical, mental, chronic and palliative health care settings. They revealed comprehensively the significance of incorporating spiritual dimension to health and healthcare generally.

In the field of nursing, spirituality plays a vital role which led to the coining of a new nursing concept now known as spiritual care. This is described as the activities and ways of being that brings spiritual quality of life, well-being, and function – all of which are dimensions of health – to clients (McEwan 2005) and becomes an essential component in providing holistic care to patients (Meyer 2003).
Spiritual care is characterized as care that provides dignity and respect for each patient by honoring the person’s values and beliefs and encouraging practices that assisted the patient in finding meaning and hope in suffering and despair (Puchalski, Lunsford, Harris, and Miller 2006). Jochemsen et al. (2002) also describes spiritual care in nursing as the care nurses deliver relative to the religious and existential needs of patients, including their questions and experiences of meaning and purpose.

Spiritual care services include the availability of a chaplain or spiritual caregiver to offer advice and guidance, facilities in which to practice religion or faith such as a prayer room and the understanding of different healthcare practices required for different beliefs and faiths (Welsh Government 2010).

Supporting clients’ spirituality through spiritual care has the possibility to improve the health of clients in a number of ways including better adherence to a plan of care, encouraging health promoting behaviors, and buffering psychological distress and social isolation (Boland, 2005).

The field of nursing, Bukhart and Schmidt (2012), has long recognized the importance of spiritual care in nursing practice as promoting the integration of meaning and purpose in life. Moreover, nurses have a unique role during spiritual encounters with patients because nurses represent three different identities: professionals who promote physical and spiritual health and healing; citizens of a liberal society who must remain nonjudgmental concerning a patient’s spiritual beliefs and practices; and individuals who have personal beliefs and feelings concerning spirituality (Pesut& Thorne 2007).

In the Philippines, the Commission on Higher Education (CHED) recognizes the importance of spiritual care in the field of nursing, hence, the issuance of CHED Memorandum No. 14 Series of 2009 which include Spiritual Care Nursing as an elective subject to the new nursing curriculum. Spirituality has been a topic included in the Foundations of Nursing books but is not discussed lengthily.

Although the nurses acquire skills on spiritual care, the essence of providing spiritual care is still through the therapeutic use of self. Nurses must be willing to engage “self” in this activity while recognizing that spiritual care must be patient led, not nurse directed. Nurses need to clearly understand where their own spiritual needs start and stop and where their patients’ needs begin. Skills of listening, observing, and presence are inherent in nursing and support spiritual care (Rieg, Mason & Preston 2006). Nurses’ attitude towards a patient’s spirituality as a component of spiritual care is regarded as an important aspect of nursing competency (Baldacchino 2006; McSherry 2006).

Competencies in spiritual care refer to a complex set of skills employed in a professional context, that is, the clinical nursing process (Leeuwen&Cusveller 2004). A competence is defined as the ability to perform a task with desirable outcomes that integrates the cognitive, affective and psychomotor domains of nursing practice (Meretoja et al. 2004).

Based on the findings of an online survey of nurses’ perceptions of spirituality and spiritual care conducted by McSherry and Jamieson (2011), it was proven that nurses recognize that attending to the spiritual needs of patients enhances the overall quality of nursing care. However, despite all the attention given to the spiritual dimension, the majority of nurses still feel that they require more guidance and support from governing bodies to enable them to support and effectively meet their patients’ spiritual needs.

Locally, a Benguet-based study of Besaang (2012) on “Lived Experiences of Critical Care Nurses” also revealed that respondents agreed that it is necessary for a nurse to provide spiritual care and all nurses have the responsibility to be aware of and be sensitive to their patients’ spiritual needs as a dimension of holistic health care. However, it is difficult to respond to spiritual needs of others if they themselves are experiencing unresolved spiritual concerns or distress.

This reality on the increasing attention and researches on spirituality and spiritual care as it affect nursing and nursing care inspired and challenged the researcher to conduct a study to determine the level of spiritual care competency of staff nurses and to find out the extent to which the personal, psychological and socio-cultural factors affect the spiritual care competency of staff nurses, thus, spiritual-health care delivery system will be enhanced and uplifted. Conclusively, once spiritual care competency of staff nurses will be improved, patients’ spiritual health needs will then be edified as well.
Theoretical Framework

The theories that were considered most relevant and substantial on spiritual care are; Watson’s Theory of Human Caring, Edelman and Mandle’s Holistic Health Model, Reed’s Self-Transcendence Theory, and Benner’s Stages of Clinical Competence. These theories provided a strong springboard and served as the backbone of the study especially in determining the level of spiritual care competency of the staff nurses.

Watson’s Theory of Human Caring which cites the role of spiritual care in the nursing profession is a strong concept in which the study is based on. This explains the uniqueness of nursing as a caring-healing profession and that health modes are also connected to the factors involving or affecting the level of competency in giving spiritual care. Vincensi (2011) further quoted the theory as the standard to address some of the components of the interpersonal relationship found in spiritual care and the energy exchange occurs within the environment between nurse-client. The Transpersonal Human Caring process as one of its concepts describes how the nurses bring the mind-body-spirit dimension of their own existence into caring-healing relationship so that both the nurse and the patient will be able to explore and suffice their needs in spiritual aspect. In that way, the nurse becomes more aware of himself and becomes more competent in rendering the needed care for the patient.

Another theory that has equal significance in the study is the Holistic Health Model by Edelman and Mandle (2002) which explains that holism represents the interaction of a person’s mind, body and spirit within the environment and it is based on the belief that people (or their parts) cannot be fully understood if examined solely in pieces apart from their environment. This model could further describe the role of spirituality in the quality of services a staff nurse could render.

The theory of Self-Transcendence by Reed also confers that if a nurse entails a deeper understanding of self, as he will expand interpersonally, he will be able to relate to others especially to his patients. It will then be easier for the nurse to perform his duty for he knows himself well. The expansion of the four self-boundaries would then result to a more competent, efficient and effective nurse who can render holistic care to his patients.

The researcher also adopted the theory of Patricia Benner’s Stages of Clinical Competence (1996) to emphasize that experience is a strong factor in rendering services better than just what is required. The expert nurses develop skills and understanding of patient care over time through a sound educational base as well as a multitude of experience. From being a novice to an expert, one learns to develop expertise, particular changes in performance occur, including movement from abstract to concrete, from viewing a situation in bits to viewing it as a whole, and from detached observation to involved performer.

Hypotheses

To guide the researcher, the following hypotheses were formulated:

1. There is no significant relationship between the demographic profile and spiritual care competency of staff nurses.
2. There is no significant difference between the levels of spiritual care competency of staff nurses as rated by themselves, patients and immediate nurse supervisors.
3. There is no significant relationship between the levels of spiritual care competency of staff nurses and the extent to which the personal, psychological, and spiritual factors affect spiritual care competency.

Methodology

This section is devoted to the discussions of the methods and procedures used in this study, specifically the research design, population and locale of the study, data gathering tools, data gathering procedures and treatment of data.

Research Design

The study utilized the descriptive-developmental research design which aims to develop a certain output based on the data gathered.
Basically, the descriptive research design was used. Polit (2008) explained that descriptive research collects detailed descriptions of existing variables and use the data to justify and assess current conditions and practices. It describes what exists in terms of frequency of occurrence. The purpose of descriptive studies is to observe, describe and document aspects of a situation as it naturally occurs and sometimes to serve as a starting point for hypothesis generation or theory development.

A developmental research has been defined as the systematic study of designing, developing, and evaluating instructional programs, processes, and products that must meet criteria of internal consistency and effectiveness. The most common types of developmental research involve situations in which the product-development process is analyzed and described, and the final product is evaluated (Richey 1994).

**Population and Locale of the Study**

The study was conducted in two tertiary hospitals in La Union in the months of January and February 2014. Since the study aimed to determine the spiritual care competency of staff nurses employed in tertiary hospitals, a total enumeration was used wherein all the employed regular staff nurses and immediate nurse supervisors assigned in the Medical, Surgical, Orthopedic, and Obstetrical-Gynecological Wards in the two hospitals were taken as respondents in the study. A ratio of 1:2 of staff nurse to patient was used to determine the number of patients who were taken to participate in the study.

The total number of respondents was 36 staff nurses, 8 immediate nurse supervisors and 72 patients. There were 18 staff nurses, 4 immediate nurse supervisors and 36 patients from the private tertiary hospital and 18 staff nurses, 4 immediate nurse supervisors and 36 patients from the government tertiary hospital. The other tertiary hospitals in La Union opted not to join the study because of their institutional policy to safeguard their staff nurses’ confidentiality.

**Data Gathering Tools**

A questionnaire developed by the researcher based on spiritual care books and nursing books on theoretical foundations of nursing was used in gathering the needed data. The questionnaire was designed into three (3) parts: the first part comprised the demographic profile of the staff nurses in terms of age, sex, marital status, religious affiliation, school graduated, length of service, and area of assignment. The second part contained four (4) subparts, equivalent to the respondents’ levels of spiritual care competency in Assessment, Planning, Implementation, and Evaluation. The third part has three (3) subparts, corresponding to the Personal, Psychological, and Socio-cultural factors affecting the spiritual care competency of the staff nurses.

All the item-indicators in the second part were stated positively. The third part contains both negative and positive statements. The 5-Point Likert Scale of Point Values was used in which 5 is the highest and 1 is the lowest (See Treatment of Data).

The questionnaire was validated by a pool of experts in the field of Spiritual Nursing and Research (See Appendix C). Pretesting of the instrument was done at the Benguet General Hospital, La Trinidad, Benguet which yielded a rating of 0.7948, interpreted as very reliable in the Cronbach’s Alpha Reliability Test (See Appendix E).

**Data Gathering Procedures**

After the questionnaire was finally approved for administration having passed the validity and reliability tests and letter request endorsed by the researcher’s adviser and the Dean of College of Nursing, Midwifery and Allied Health Program of Union Christian College (UCC), the researcher arranged with the Tertiary Hospitals in La Union to seek permission to conduct the study in their respective hospitals.

Before the actual administration of the questionnaires, the researcher explained briefly the purpose, significance of the study and direction/instruction for answering the questionnaire with the supervision of one of his advisers and the head-nurse-in-charge. The filled out questionnaire was retrieved after 1 month.

**Treatment of Data**

The data gathered were tallied, tabulated, organized and analyzed accordingly. Frequency count, percentage were used to treat the data for problem 1 on the demographic profile of the

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respondents. Weighted means were used to answer problems 2 and 5 to establish the level of spiritual care competency of staff nurses as rated by themselves, patients and immediate nurse supervisors in terms of Assessment, Planning, Implementation and Evaluation; and, the extent to which the personal, psychological, and socio-cultural factors affect spiritual care competency.

The formula used for weighted mean calculation was:

$$\bar{x} = \frac{I(1) + 2(2) + 3(3) + 4(4)}{13}$$

The 5-Point Likert Scale of Point Values was used to classify the weighted, average weighted and grand means.

The mean scores on the variables of spiritual care competency of staff nurses were interpreted as follows:

<table>
<thead>
<tr>
<th>Scale of Values</th>
<th>Statistical Range</th>
<th>Descriptive Equivalent Rating</th>
<th>Descriptive Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4.20 – 5.00</td>
<td>Always</td>
<td>Very Highly Competent</td>
</tr>
<tr>
<td>4</td>
<td>3.40 – 4.19</td>
<td>Often</td>
<td>Highly Competent</td>
</tr>
<tr>
<td>3</td>
<td>2.60 – 3.39</td>
<td>Sometimes</td>
<td>Moderately Competent</td>
</tr>
<tr>
<td>2</td>
<td>1.80 – 2.59</td>
<td>Seldom</td>
<td>Fairly Competent</td>
</tr>
<tr>
<td>1</td>
<td>1.00 – 1.79</td>
<td>Never</td>
<td>Not Competent</td>
</tr>
</tbody>
</table>

The mean scores on the variables that affect the spiritual care competency of staff nurses were interpreted as follows:

<table>
<thead>
<tr>
<th>Scale of Values</th>
<th>Statistical Range</th>
<th>Descriptive Equivalent Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4.20 – 5.00</td>
<td>Very High Effect</td>
</tr>
<tr>
<td>4</td>
<td>3.40 – 4.19</td>
<td>High Effect</td>
</tr>
<tr>
<td>3</td>
<td>2.60 – 3.39</td>
<td>Moderately Effect</td>
</tr>
<tr>
<td>2</td>
<td>1.80 – 2.59</td>
<td>Low Effect</td>
</tr>
<tr>
<td>1</td>
<td>1.00 – 1.79</td>
<td>Least Effect</td>
</tr>
</tbody>
</table>

To answer problems 3 and 6, the Pearson Product Moment Correlation Test or Pearson r was used to determine whether or not there is a significant relationship between the levels of spiritual care competency of staff nurses to: a) demographic profile, and b) extent to which the personal, psychological, and socio-cultural factors affect spiritual care competency. This was calculated by the formula for Pearson r:

$$r = \frac{\sum(xy) - \frac{1}{n} \sum x \sum y}{\sqrt{\left[ \sum(x^2) - \frac{1}{n} \left( \sum x \right)^2 \right] \left[ \sum(y^2) - \frac{1}{n} \left( \sum y \right)^2 \right]}}$$

Where: $x = Observed\ data\ for\ the\ independent\ variable$

$y = Observed\ data\ for\ the\ dependent\ variable$

$n = Sample\ size$

$r = degree\ of\ relationship\ between\ x\ and\ y$

The following scale was used in determining whether or not there is a significant relationship between the two variables:

<table>
<thead>
<tr>
<th>Range of Values</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>± 1.0</td>
<td>Perfect ± Correlation</td>
</tr>
<tr>
<td>± 0.91 to 0.99</td>
<td>Very High ± Correlation</td>
</tr>
<tr>
<td>± 0.71 to 0.90</td>
<td>High ± Correlation</td>
</tr>
<tr>
<td>± 0.51 to 0.70</td>
<td>Substantial ± Correlation</td>
</tr>
</tbody>
</table>
Problem 4 was treated and measured using Analysis of Variance (ANOVA) to determine the significant difference between the levels of spiritual care competency of staff nurses as rated by themselves, their patients, and head nurses. It has a formula of:

\[
F = \frac{\frac{\sum(x - \bar{x})^2}{k - 1}}{\frac{\sum(y - \bar{y})^2}{k (n - 1)}}
\]

Where:

- \( \sum(x - \bar{x})^2 \) = Sum of square between
- \( \sum(y - \bar{y})^2 \) = Sum of squares within

The 5 percent level of significance was the reference point of the interpretations of the results of the statistical tests to answer problems 3, 4 and 6 along with their subparts.

Results and Discussion

This section presents the findings of the study and their interpretations.

Demographic Profile of the Staff Nurses

This segment presents the frequency count and percentage of the demographic profile used in this study.

Table 1 illustrates the demographic profile of the 36 respondents of the study. With regards to age, 94.44 percent were ages 20 – 39 while 5.56 percent were on the 40-65 age group. This implies that staff nurses employed in the Medical, Surgical, Orthopedic, and Ob-Gyne wards of the tertiary hospitals in La Union are young. It is this group which is expected to be more equipped with the latest trends in nursing. This expectation is supported by the studies of Domrose (2001) that the younger breed of nurses are technologically oriented, thus, they can do the work better in the area of their assignment because units in the hospital, nowadays, are basically technologically laden. Lastly,
younger generation possessed greater stamina or endurance and tend to work efficiently or effectively even under pressure.

In terms of sex, 58.33% were males while 41.67% were females. This is in contrast to latest studies which resulted that male nurses represent just a small fraction or still the minority in the nursing profession in the United States (Scrubs 2012; http://www.highbeam.com/), the popular notion that nursing is not for men and admission capacity constraints of Nursing Schools seem to be major obstacles towards bringing more men to the profession but they are rapidly becoming a force to be reckoned with (Scrubs 2012). The trend of men in nursing profession shows a change in number. In 2008, there were 3,063,163 licensed registered nurses in the United States, only 6.6% of those were men (Pham 2014); in 2003, male RNs increased to 9.5% (Scrub 2012); in 2010, approximately 11% of the students in baccalaureate programs were men (Pham 2014); and, in 2011 the number of male RNs increased to 12.2% (Scrub 2012).

Table 1
Demographic Profile of the Staff Nurses

<table>
<thead>
<tr>
<th>Profile</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 – 39</td>
<td>34</td>
<td>94.44</td>
</tr>
<tr>
<td>40 – 65</td>
<td>2</td>
<td>5.56</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>58.33</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>41.67</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>30</td>
<td>83.33</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>16.67</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>30</td>
<td>83.33</td>
</tr>
<tr>
<td>Iglesiani Cristo</td>
<td>2</td>
<td>5.56</td>
</tr>
<tr>
<td>Protestant</td>
<td>2</td>
<td>5.56</td>
</tr>
<tr>
<td>Others (Mormon, Baptist)</td>
<td>2</td>
<td>5.56</td>
</tr>
<tr>
<td>School Graduated From</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sectarian</td>
<td>9</td>
<td>25.00</td>
</tr>
<tr>
<td>Non-Sectarian</td>
<td>27</td>
<td>75.00</td>
</tr>
<tr>
<td>Length of Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 – 3 years</td>
<td>32</td>
<td>88.89</td>
</tr>
<tr>
<td>4 – 6 years</td>
<td>3</td>
<td>8.33</td>
</tr>
<tr>
<td>7 – 9 years</td>
<td>1</td>
<td>2.78</td>
</tr>
<tr>
<td>Area of Assignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>11</td>
<td>30.56</td>
</tr>
<tr>
<td>Surgery</td>
<td>11</td>
<td>30.56</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>8</td>
<td>22.22</td>
</tr>
<tr>
<td>OB-Gyne</td>
<td>6</td>
<td>16.67</td>
</tr>
</tbody>
</table>

Although male nurses often face the challenges of gender discrimination, especially in expertise like obstetrics and gynecology, where, women often prefer to have female nurses, male nurses often end up in leadership roles and in specialties like intensive care, emergency and operating room nursing (http://www.jscms.com/).

According to Quan (2014), nursing is not gender-based, and if it was, most nurses might still be males. Most of the very first nurses were men, often in religious orders. In 250 BC, the first nursing
school was in India, and only men were thought to be “pure” enough to be nurses. Today, male nurses are a growing and valued aspect of the nursing profession. The art of caring is not just for women.

On the marital status, majority of the respondents were single (83.33%) and only 16.67% were married. Thus, these staff nurses are assumed to be more attentive to the needs of their patients and always available because they are not encumbered with family nuisances.

On the religious affiliation, most of the respondents (83.33%) were Roman Catholics and the rest were equally distributed to Iglesiani Cristo, Protestant and Others (Mormons and Baptist). Religion in the Philippines is heavily influenced by its history as a part of the Spanish Empire. Today around 80% of the country’s citizens are Roman Catholic Christians. Of the remaining people, 10% are from other Christian denominations and around 5% are Muslim, mainly based in the South West in the country (http://worldpopulationreview.com).

In terms of the schools they attended during college, 75% graduated from non-sectarian schools and 25% are from sectarian school. Sectarian schools are non-stock, non-profit educational corporations usually owned by religious organizations particularly by the Catholic and Protestant religions (wikipilipinas.org). Meanwhile, private non-sectarian schools are operated by private individuals or corporations (wikipilipinas.org) and not affiliated with or restricted to any particular religious group (wikipedia.org; http://www.ask.com) wherein students of these schools are free to join any religion they may desire to follow and these schools operate on a curriculum free and independent from any religious influence (http://www.ask.com). Non-sectarian schools usually follow the CHED-prescribed curriculum, which before 2009 gave no emphasis on Spiritual Care in Nursing. These include memorial or foundation schools, language schools and international schools. There are about 300 sectarian higher education schools and over 830 private non-sectarian schools in the country (wikipilipinas.org).

On the length of service of the respondents; most of them have 0 – 3 years length of service with a percentage of 88.89 while 8.33% have 4 – 6 and 2.78% have 7 – 9 years length of service respectively. In relation with the respondents’ age which shows that most of them are newly employed as staff and are recently graduated from their BSN course.

Statistics shows that 9 out of 10 registered nurse in the country, had already plan to go abroad after they reach the minimum experience to be qualified in the position offered outside the country (http://www.nursing.ph). Some of the agencies abroad prefer a minimum clinical experience of 2 – 3 years for a registered nurse to be qualified.

With regards to area of assignment, most of the respondents were assigned in Medical and Surgical Wards which both got 30.56 percent, 22.22 percent were in the Orthopedic and 16.67 percent were in Ob-Gyne Wards. The number of staff nurses is based on the number of approximated and/or expected number of patients in the area. Hence, the result portrays that most of the patients’ admissions are in the Medical and Surgical Wards which means that more demands of staff nurses are needed in these areas, providing general service and not specialized areas.

As cited by Coffman, Seago and Spetz (2002) on their article entitled “Minimum Nurse-To-Patient Ratios In Acute Care Hospitals In California” that A.B. 394 directs the California Department of Health Services (DHS) to establish “minimum, specific, and numerical licensed nurse-to-patient ratios by license nurse classification and by hospital unit” for inpatient units in acute care hospitals.

The minimum nurse-to-patient ratios proposed by the California DHS range from one nurse per patient in operating rooms to one nurse per eight infants in newborn nurseries. The DHS proposes that the minimum ratios for medical-surgical and rehabilitation units be phased in. Minimum ratios for these units would be set initially at one nurse (RN or LVN) per six patients and then shift to one nurse per five patients within twelve to eighteen months of enactment. Proposed ratios for other types of inpatient units would not be phased in (Coffman, Seago & Spetz 2002).

Level of Spiritual Care Competency of Staff Nurses as Rated by Three Groups in Terms of Assessment, Planning, Implementation and Evaluation

This section shows the staff nurses’ level of spiritual care competency as rated by themselves, patients and immediate nurse supervisors in terms of the facets of the nursing process (i.e. Assessment, Planning, Implementation and Evaluation).
Level of Spiritual Care Competency of Staff Nurses as Rated by Themselves, Patients and Immediate Nurse Supervisors in Terms of Assessment

Table 2 presents the data on the level of spiritual care competency of staff nurses as rated by themselves, patients and immediate nurse supervisors in terms of assessment. Staff nurses were rated based on their competency on how they collect information about patients’ spiritual needs through proficient asking/observation.

On collecting information regarding patients’ spiritual needs on the “affect and attitude” and based on the consolidated ratings of the three sets of respondents, the indicator “depressed”

Conclusions

Based on the salient findings of the study, this conclusion was drawn; the staff nurses are moderately competent in providing spiritual care, which is highly affected by personal, psychological and socio-cultural factors.

Recommendations

The researcher recommends the adoption of the proposed Spiritual Nursing Care Enhancement Program of the staff nurses, hospital nursing administration, schools and students affiliates and of the clerical/pastoral care department.

References

3. Chotkevys, Debra L. (2009). A Grounded Theory Study to Explore How Nurses Overcome Barriers to Spiritual Care. (Published Dissertation: Copyright 2011 by ProQuest LLC.)


23. RCN spirituality survey 2010. *A Report by the Royal College of Nursing on Members’ Views on Spirituality and Spiritual Care in Nursing Practice.* Published by the Royal College of Nursing 20 Cavendish SquareLondonW1G 0RN


27. Vincensi, Barbara (2011). *Spiritual Care in Advanced Practice Nursing.* (Published Dissertation: Copyright 2011 by ProQuest LLC.)


