



UNIVERSITY OF THE PHILIPPINES

Master of Arts in Nursing

Atenogenes Potito R. Asuncion

**Nurse Competency and Caring Efficacy Among Primary Health
Care Nurses of a Medical Services Department in Qatar**

Thesis/Dissertation Adviser:

Asst. Prof. Rita C. Ramos, MAN, RN

Faculty of Management and Development Studies

Thesis/Dissertation Critic:

Asst. Prof. Queenie R. Ridulme, MAN, RN

Faculty of Management and Development Studies

Date of Submission

02 June 2020

Permission is given for the following people to have access to this thesis/dissertation:

Available to the general public	Yes
Available only after consultation with author/thesis/dissertation adviser	Yes
Available only to those bound with confidentiality agreement	Yes

Student's Signature:

Signature of Thesis/Dissertation Adviser:

University Permission Page

"I hereby grant the University of the Philippines a non-exclusive, worldwide, royalty-free license to reproduce, publish, and publicly distribute copies of this thesis or dissertation in whatever form subject to the provisions of applicable laws, the provisions of the UP IPR policy and any contractual obligations, as well as more specific permission marking on the Title Page."

"Specifically, I grant the following rights to the University:

- a) To upload a copy of the work in the theses database of the college/school/institute/department and in any other databases available on the public internet;*
- b) To publish the work in the college/school/institute/department journal, both in print and electronic or digital format and online; and*
- c) To give open access to above-mentioned work, thus allowing "fair use" of the work in accordance with the provisions of the Intellectual Property Code of the Philippines (Republic Act No. 8293), especially for teaching, scholarly, and research purposes."*

Atenogenes Potito R. Asuncion, 02, June 2020
Student Name Over Signature and Date



UNIVERSITY OF THE PHILIPPINES
OPEN UNIVERSITY
FACULTY OF MANAGEMENT AND DEVELOPMENT STUDIES

CERTIFICATE OF ACCEPTANCE OF THESIS

The thesis attached hereto, entitled “**Nurse Competency and Caring Efficacy Among Primary Health Care Nurses of a Medical Services Department in Qatar,**” prepared and submitted by **MR. ATENOGENES POTITO R. ASUNCION**, in partial fulfillment of the requirement for the degree of **Master of Arts in Nursing** with specialization in **Adult Health Nursing** is accepted.

ASST. PROF. RITA C. RAMOS
Chair/Adviser

Accepted as partial fulfillment of the requirements for the degree of

MASTER OF ARTS IN NURSING

DR. PRIMO G. GARCIA

Dean

Faculty of Management and Development
Studies

UP Open University



UNIVERSITY OF THE PHILIPPINES
OPEN UNIVERSITY

FACULTY OF MANAGEMENT AND DEVELOPMENT STUDIES

APPROVAL SHEET

We, the members of the oral examination panel for **MR. ATENOGENES POTITO R. ASUNCION** unanimously approved the thesis entitled “**Nurse Competency and Caring Efficacy Among Primary Health Care Nurses of a Medical Services Department in Qatar.**” The thesis attached hereto was defended on June 02, 2020, at UPOU Learning Center in Manila for the degree of **Master of Arts in Nursing** is hereby accepted.

PANEL MEMBERS

SIGNATURE

ASST. PROF. RITA C. RAMOS
Chair/Adviser

ASST. PROF. QUEENIE R. RIDULME
Critic

MS. MA. ELMA L. MIRANDILLA
Member

MS. MARIA CECILIA E. PUNZALAN
Member

MS. GRACE RIEGO DE DIOS
Member

We therefore recommend that **MR. ATENOGENES POTITO R. ASUNCION** be awarded the degree of **Master of Arts in Nursing** from the **Faculty of Management and Development Studies**.

Very truly yours,

ASST. PROF. RITA C. RAMOS
Chair/Adviser

Endorsed:

ASST. PROF. QUEENIE R. RIDULME
Program Chair, MAN

DR. PRIMO G. GARCIA
Dean

TABLE OF CONTENTS

	Page
Title Page	i
University Permission Page	ii
Certificate of Acceptance of Thesis	iii
Approval Sheet	iv
Table of Contents	v
List of Tables	vii
List of Figures	viii
List of Appendices	ix
Acknowledgment	x
Abstract	xii
Chapter 1: The Research Problem	
Introduction	1
Background of the Study	3
Statement of the Problem	5
Research Objectives	9
Significance of the Study	10
Scope and Limitations	13
Chapter 2: Theoretical Background	
Review of Related Literature	15
Theoretical Framework	28
Conceptual Framework	32
Operational Definition of Terms	33
Hypothesis	35
Research Paradigm	36
Chapter 3: Research Methodology	

Research Design	37
Study Population	39
Research Variables	40
Research Setting	40
Sample Design	41
Research Instrument and Tools	43
Translation of Research Tools and Instruments	50
Method & Procedure of Data Collection	50
Plan for Data Analysis & Management	52
Ethical Considerations	54
Chapter 4: Results and Discussion	
Characteristics of Respondents	57
Level of Nurse Competency	59
Level of Caring Efficacy	69
Relationship between Socio-demographics and Nurse Competency	75
Relationship between Socio-demographics and Caring Efficacy	77
Correlation of Nurse Competency and Caring Efficacy	79
Chapter 5: Summary, Conclusion and Recommendations	
Summary	81
Conclusion	83
Recommendations	84
References	88
Appendices	96

LIST OF TABLES

Table 1.	Socio-demographic Profile of the Respondents	57
Table 2.	Means and Standard Deviation of Nurse Competency of the Respondents	59
Table 3.	Means and Standard Deviation of Caring Efficacy of the Respondents	69
Table 4.	Relationship Between Socio-demographic and Nurse Competency of the Respondents	75
Table 5.	Relationship Between Socio-demographic and Caring Efficacy of the Respondents	77
Table 6.	Correlation of Nurse Competency and Caring Efficacy of the Respondents	79

LIST OF FIGURES

Figure 1	Conceptual Framework	32
Figure 2	Research Paradigm	36
Figure 3	One Sample Kolmogorov-Smirnov Test	53

LIST OF APPENDICES

Appendix. A	UPOU Ethical Regulatory Board Action Form	96
Appendix. B	Permission to Conduct Research Study	97
Appendix. C	Request Letter for Permission to Use an Existing Questionnaire	98
Appendix. D	Granted Permission to Use the Instrument	102
Appendix. E	Individual Informed Consent	103
Appendix. F	Research Instruments	108
Appendix. G	Curriculum Vitae	118

ACKNOWLEDGEMENTS

Foremost, I would like to thank the supreme natural being our “ALMIGHTY GOD” for his guidance, and protection on the right path of my life. Becoming his instrument to help and touch other people’s lives.

I would like to acknowledge my previous college professors and mentors in University of the East Ramon Magsaysay Memorial Medical Center, College of Nursing. To Dr. Carmelita Divinagracia, Dr. Wilhelmina Atos, Prof. Belinda Capistrano and Prof. Mary Josephine Famorca for the guidance, learning and mentorship during my collegiate years. To my college close friends, Ma. Fatima Fundal, Debbie Sarausa- Evangelista, Kristine Sara Bunggay-Montilla, Ma. Victoria Felices-De Castro, Nino Angelo Allam Pardy, Aileen Balatucan-Lanipao, Mary Anne Ragojo, Valerie Co-Nismal and Joy Damian, they were the one who inspires me to become more resilient in my academic career.

I would like to thank my University of the Philippines-Philippine General Hospital Department of Emergency Medical Services, for paving an exemplary training ground as an emergency room nurse in the Philippines. To my previous colleagues (Doctors and Nurses) Ms. Myleene delos Angeles, Ms. Maricho Manlavi, Ms. Avegaile Amorao-Cantuba and Ms. Cristina Jesusa Oredina, you are my inspiration in my clinical practice and who keeps on believing and exuding my potentials to be the best of my abilities.

In addition, I would like to thank my colleagues from the Ministry of Interior, Medical Services Department specially Mr. Naini Ahajadi, Mrs. Rosemarie De Guzman-Pau, Ms. Rachel Galvan-Manauis, Mr. Khalid Mohammad Yakoob, Ms. Joyce Enriquez and Joanna Crystel Enriquez, for supporting my beliefs and ideals in my lifelong journey in clinical practice and education.

Lastly, To the technical panel during my final master thesis defense especially to my thesis adviser Prof. Rita Ramos, Prof. Queenie Roxas-Ridulme, and Ms. Riza Rosarito Pulpulaan, for your guidance and support during my research study.

Thank you all for your support.

DEDICATION

I would like to dedicate my master's thesis paper to my mother, Mrs. Edna R. Asuncion, who is my icon, strength and my constant companion in my life. I would like to honor Mrs. Dida R. Fernandez, for being the arms and wings of my mother in her life. You are my inspiration and you always believe in my potentials.

ABSTRACT

Caring is the fundamental core component in the nursing profession and nurse-patient interaction. Competency is the integration of skills, values, knowledge, and attitudes to specific, contextual practice situations.

In the Middle East, particularly in Qatar, the health care sector depends greatly on expatriates. The link between nurse competency and caring efficacy has not been directly investigated thoroughly in a different clinical setting. Professional nursing practice is the vital role of nurses towards patient-centered care, teamwork, and collaboration, evidence-based practice, quality improvement, safety, and informatics.

Professional caring behaviors include developing good relationships with patients and other staff; working in a self-directed manner; making clinical decisions and the management of practice. This descriptive correlational research design aims to examine the relationship between nurse competency and caring efficacy among primary health care nurses.

A total of 102 nurses of the medical services department from different health care facilities of the Ministry of Interior, Doha, Qatar were included in the final sample using purposive sampling. The average age of nurses was 37 years old, most were Filipino nurses, married and had a baccalaureate degree. The average of the length of nursing experience was 3 years and the mean average of the length of the nursing service was 2 years. Data were collected using Nurse Quality and Safety Inventory scale and Caring Efficacy Scale.

The study showed that there was a significant relationship between nurse competency and caring efficacy. Specifically, nurse competency had a significant, positive, and direct but weak relationship to caring efficacy.

Furthermore, this suggests that nurse competency increases with increasing caring efficacy. Nurse competency is a vital element in the provision of nursing care. It is a synthesis of skills, knowledge, attitudes, values, and abilities in providing safe, effective, and quality care to individuals, families, and communities. Thus, having professional nurse competency leads to professional caring behavior that directly affects safe and quality health care delivery. It also increases patient satisfaction, helps promote nursing as a profession, and improves nursing education and clinical nursing practice.

CHAPTER 1

THE RESEARCH PROBLEM

INTRODUCTION

Caring is the fundamental core component in the nursing profession and it is skilled in interpersonal interaction between the nurse and patient, based on both the nurse's and the patient's subjective experience and the nurse's commitment to maintaining the patient's dignity. The concept of caring is identified by caring behaviors to which are actions concerned with the well-being of a patient, such as sensitivity, comforting, attentive listening, honesty, and nonjudgmental acceptance.

As caring defined and stated by the International Council of Nurses (2010) "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Patient advocacy, promotion of safe environment, research, and participation in shaping health policy and in patients and health systems management, and education are also key nursing roles".

Nurses are the eminent illustrators of caring behaviors and they can better identify, understand, and address the unique requirements of individualized care for patients when they understand the concept and values of caring experience. Such an understanding allows nurses to efficiently interact with patients and respond to their needs and preferences. According to the Institute of Medicine in the United States (2013) patient-centered care is "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guided in all clinical decisions" (p.9).

As nurses persuade their caring abilities to patient care gauging towards the nursing practice environment.

Nurse competency is a vital element in the provision of nursing care. It is a synthesis of skills, knowledge, attitudes, values, and abilities in providing safe, effective, and quality care to individuals, families, and communities.

A nurse must be competently adapted to practice on caring abilities to execute a meaningful caring experience for each individualize care for patients. As evidence supports the competency theory of novice to expert is a simple and concise model which explains five steps through which a person gains required competency for performing special skills, the theory can be utilized as a guideline for determining various levels of nursing competency based on descriptive information provided by nurses themselves and observation of the actual performance of them (Hargreaves & Lane, 2001). Moreover, caring efficacy as defined by Coates (1997) “nurses’ beliefs in their abilities to express caring orientations, attitudes, and behaviors and to establish caring relationships with clients or patients”. This conceptualization of caring behaviors that reciprocates self-efficacy towards nurse-patient interaction, that encompasses once perceived confidence and ability to conduct the needed task to be done. As supported on the notion of self-efficacy by Bandura (1977) that perceived self-efficacy is influenced by four main factors: mastery experiences (having completed a task); vicarious experiences, such as seeing a peer achieve success; social persuasion through verbal encouragement, which can help develop skills and a sense of personal efficacy; and reducing anxiety about an event by encouraging a positive understanding of one’s physical and emotional states.

In Qatar, the health care sector depends greatly on expatriates. The link between nurse competency and nurses' abilities to exercise caring behaviors (caring efficacy) has not been directly investigated thoroughly in a different clinical setting. Professional nursing practice behaviors include developing good relationships with patients and other staff; working in a self-directed manner; making clinical decisions and the management of practice. This study investigates and analyzes the relationship between nurse competency and staff nurses' perceived ability to express caring behaviors (caring efficacy) towards individualized patient care and in their present working environment.

BACKGROUND OF THE STUDY

The concept of nurse competency and caring behaviors are the major key role in nursing practice. Competency is the creation of new rules and reasoning procedures for a chosen plan or perspective to determine which aspects of the current and contemplated future situation should be applied (Benner, 2001; Benner, Tanner, & Chesla, 2009). Caring is an innate hallmark in the nursing profession. Caring is a skilled, interpersonal interaction between the nurse and patient, based on both the nurse's and the patient's subjective experience and the nurse's commitment to maintaining the patient's dignity (Smith, Turkel, & Wolf, 2013). Spichiger, Wallhagen & Benner (2005) described caring practices from an ontological perspective. Perceived caring practices are determined by the concerns that define an individual's self (the nurse) and the world and what is required to restore a person (the patient) and lifeworld.

Caring is an integral component of the nursing profession. Nurses are distinguished exemplifications of caring behavior. As nurses impel caring behaviors efficiently in a different clinical practice environment. Nurses must be

equipped with knowledge, skills, and attitude in delivering safe, effective, and quality individualized patient care. Nurse competency is the benchmark in providing an effective nursing care intervention to patients and opts to provide a quality health care delivery following international standards.

As nurses persuade caring behavior efficiently towards patient care. Nurses must be competently addressing the needs and goals of individual patient care. Competency is the integration of skills, values, knowledge, and attitudes to specific, contextual practice situations. As nurses gain experience and knowledge in a specific clinical domain, they move along the continuum from novice to expert (Benner, 2001). Competency creates a sense of emotional involvement in the outcome and a greater sense of salience through experiential learning. Without competency, poor patient outcomes increased errors, and the inability to make sound decisions may occur.

As the demand for competent practitioners who deliver nursing care in a skilled, interpersonal manner continues to dominate the healthcare landscape, nurses must understand their perceptions, levels of confidence, and beliefs in their ability to develop caring relationships and express caring orientations. As nurses gain experience and knowledge in a specific clinical domain, they also must understand their perceptions of their competency. Nurses who use the process of reflection by way of self- assessment consider their caring practices within their practice setting; identify strengths and areas needed for further development, and focus on the attitudes and behavioral repertoire necessary for nurse competency and caring efficacy (Coates, 1997; Meretoja, Isoaho, & Leino-Kilpi, 2004).

When nurses assess their competence and caring practices, it is an important step in identifying professional and educational development programs in

academia and the workplace. As nurses continually grow to professional career advancement. Both competency and caring behaviors, works simultaneously in the nursing profession and nursing practice environment. As evidence on the recent study conducted by Moss (2018) in a US hospital in Texas, shows a moderate, positive relationship between nurse competency and caring efficacy was found in the veteran's affairs medical center.

Therefore, these models provide a framework for the nursing doctrine which makes the practitioners enable them to analyze various conditions in a more effective way and based on which organize their behaviors (Meleis, 2011). Regarding patient surveillance, nursing theories can be highly effective in improving surveillance standards, reducing healthcare costs, and enhancing patients' lives quality (Roy & Jones, 2006; Rafat, 2015). In context, the use of nursing theories in both research and clinical issues would expand the body of nursing science (Meleis, 2011).

This paper will determine the vital role of nurses on competency which directs on patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety and informatics, and its relationship to nursing practice behavior leading to caring efficacy towards individualizing patient care.

STATEMENT OF THE PROBLEM

Today, the healthcare industry pose different health care issues, demands, and problems. Nurses are the “backbone” of any healthcare system and their workload is multifaceted and very complex. Nurses are facing ever-increasing challenges in establishing nurse-patient relations in achieving value congruence in expressing direct patient care. The nursing profession, the individual nurse,

employers, the consumer, regulatory agencies share in the responsibility of ensuring nurse competency and the factors affecting caring efficacy creates a gap between the caring values of the nurse thinks that are important and this concept of caring existence could be found in the nursing practice environment.

Nurses must be professionally competent in establishing and support the caring relationship between the nurse and the patient. Nurses must be able to develop professional nursing competency and caring relationships with patients to express professional identity, find the real meaning of caring experience and core values in their caring efficacy to achieve optimal satisfaction on patient outcomes and nursing practice environment. Nurses must be competently present to be able to be attentive to the needs of patients to show compassion and empathy, to meet the expressed needs of patients, to monitor patients' complications, and to respond to subtle changes in patients' condition.

This paper will examine the relationship of nurse competency and caring efficacy that could aid nurses in developing the means and strategies to work effectively, prompt to give an optimal quality standard of care to patients, and managing a patient-centered goal geared towards the individualized concept of caring practice effectively. Nursing competency and caring efficacy correlate nurses' beliefs in the importance of delivering quality patient care.

Strategies need to be developed that will revitalize the nursing profession, change the conditions in which nurses must work in a competent caring environment, energize the profession to find a voice, to support change, while continually providing direct patient care and quality health care. These strategies must reinforce professional identity, recognize the value of caring, demonstrate the importance of nurses' participation in the caring environment effectively and

make sure that there will be a nurse at the bedside caring for the most vulnerable of society thus, fulfilling the nurse's commitment to caring for all persons in society under any condition and any circumstance.

This study aims to determine the relationship of nurse competency and caring efficacy alongside the socio-demographic factors that influence on both of these variables. Through this study professional nurses and organizational stakeholders, may have a greater awareness of their respective nursing competency and professional caring behaviors.

Mainly, the purpose of this study is to provide answers to the following research questions:

1. To describe socio-demographic characteristics among nurses of the primary health care units of medical services department?
 - 1.1 Age
 - 1.2 Gender
 - 1.3 Marital Status
 - 1.4 Nationality
 - 1.5 Educational Attainment
 - 1.6 Length of Nursing Service
 - 1.7 Years of Nursing Experience
 - 1.8 Nursing Practice Area
2. What is the level of nurse competency among nurses of the primary health care unit of the medical services department?
 - 2.1 Patient-Centered Care
 - 2.2 Teamwork and Collaboration
 - 2.3 Evidence-Based Practice

2.4 Quality Improvement

2.5 Safety

2.6 Informatics

3. What is the level of caring efficacy among nurses of the primary health care unit of the medical services department?

3.1 Caring Efficacy

4. Is there a relationship between socio-demographics and the nurse competency among nurses of the primary health care unit of the medical services department?

4.1 Age and Nurse Competency

4.2 Gender and Nurse Competency

4.3 Marital Status and Nurse Competency

4.4 Nationality and Nurse Competency

4.5 Educational Attainment and Nurse Competency

4.6 Length of Nursing Service and Nurse Competency

4.7 Years of Nursing Experience and Nurse Competency

4.8 Nursing Practice Area and Nurse Competency

5. Is there a relationship between socio-demographics and the nurse's perception of the ability to express caring behavior (caring efficacy) among nurses of the primary health care unit of the medical services department?

5.1 Age and Caring Efficacy

5.2 Gender and Caring Efficacy

5.3 Marital Status and Caring Efficacy

5.4 Nationality and Caring Efficacy

5.5 Educational Attainment and Caring Efficacy

5.6 Length of Nursing Service and Caring Efficacy

5.7 Years of Nursing Experience and Caring Efficacy

5.8 Nursing Practice Area and Caring Efficacy

6. Is there a relationship between nurse competency and caring efficacy among nurses of the primary health care units of the medical services department?

6.1 Nurse Competency and Caring Efficacy

RESEARCH OBJECTIVES

The general objective of this research study is to examine the relationship between nurse competency and caring efficacy among nurses in primary health care units of the medical services department.

SPECIFIC OBJECTIVES:

1. To describe socio-demographic characteristics of primary health care nurses in terms of age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area in current practice.
2. To determine the level of nurse competency among nurses of the primary health care unit of the medical services department.
3. To determine the level of caring efficacy among nurses of the primary health care unit of the medical services department.
4. To determine the relationship of nurse competency and the socio-demographics among nurses in the primary health care units of the medical services department.
5. To determine the relationship of caring efficacy and the socio-demographics among nurses in the primary health care the units of medical services

department.

6. To correlate nurse competency and caring efficacy among nurses in the primary health care units of the medical services department.

SIGNIFICANCE OF THE STUDY

Health systems comprise all services whose main purpose is to promote, restore or maintain health, primary health care as defined by the World Health Organization, Declaration of Alma Ata (1978) as a state of complete physical, mental, and social well-being and not simply as the absence of any illness or infirmity. As the ultimate goal of primary health care is better health for all. Caring encompasses the essential primary care core principles that are directed to accessibility, health promotion, interdisciplinary collaboration, uses of appropriate skills and technology, and public participation.

To ensure safe, quality, and effective health care delivery one of the main pillars of the health care services are the professional nurses which are directed to nursing administration, education, nursing practice, and research.

This study will discover various answers that will provide professional nurses, nurse- leaders, and organizational stakeholders with information and research findings to formulate strategies that will contribute and enhance the value of nursing competency, the importance of caring efficacy to individualized patient care. It will help nurses feel more satisfied with their profession, and their ability to give quality, safe, and effective care to individualize patients. Defining the importance of the nurses in exercising caring behaviors competently and effectively and the influence on its significance that will encourage organizations to re-evaluate the nurses' work environment, the nurse patient-relationship, and the value of caring.

The findings of this study, will help professional nurses to determine their level of nurse competency and perceived caring abilities (caring efficacy) and thereby, empowering nurses professionally to certain changes and to enhance their competency levels in both respective manners. Besides, organizational stakeholders may have a better idea in constructive changes in terms of building and managing protocols, procedures, plans, restructuring organizational and professional plan of management, creating a positive and healthful environment to patient and nurses by which to give a quality health care services and delivery to the public.

Nursing Education

Caring is considered both process and outcome. As directed by means of our nursing education, transcribing theory into practice. Caritas nursing involves the integration of transpersonal caring and love within the context of the nurse-patient relationship and interaction, resulting in a healing and caring relationship. Competency is the unification of knowledge, skills, and attitude.

Nurses that asserts on quality patient outcomes are guided by caring behaviors and explaining the way through which practitioners acquire skill based on the five steps of the novice to the expert theory that find ways to which these steps can be passed in a faster and more efficient way, by modeling a nurse on how to be their best selves, creating a caring environment with living relationships between nurses and patients, creating a caring space for the patient to have an authentic dialogue with a transformation of consciousness, and confirming/affirming on their caring behaviors that will hold their ideal caring behavior to be the best or highest level on themselves and to promote reflective thinking, determination of nursing expertise, and creating a

system using which the performance of nurses can be evaluated and incentives can be applied based on the expertise and experience of them.

Competency and caring works simultaneously as directed to patient care by giving optimal quality safe, effective health care delivery and increased patient satisfaction.

Nursing Administration

A nurse leader that practices professionally that concern into nursing administration. Nurse leaders who are strong, goal-driven, and capable to have a desire to change towards positive patient outcomes and the practice environment. A competent nurse leader addressing health care problems, demands, and issues of individualized care to the patient. By providing access to structural empowerment factors for staff in delivering safe, effective, and quality care. A strong unit-level nursing leadership that influences nurses' competency, self-efficacy, and caring behaviors, which in turn leads to more professional practice behaviors.

As a professional nurse guided by theory turns into practice and mold by clinical experiences, enables transformation that can help to empower and aid nurses to influence health care improvements and policies effectively.

It provides nurses with the skills to contribute on the development of quality and safety of patient care while enhancing their career satisfaction.

Nursing Practice

The nursing practice environment is the pivotal element in exercising professional nurse competency and professional caring behaviors. An environment that allows professional competent nurses to spend more time in providing care to

patients and values their caring behaviors, that may enhance both patient and nurses' satisfaction and improve the quality of care. Thus, improving the quality of care in practice environments such as competency and efficacy could result in positive patient care outcomes. As nurses actuate the presence of professional caring behavior and competency should be given utmost importance in primary health care settings as these attributes are expected from nurses in addressing the needs of patients in a quality, safe and effective manner.

Nursing Research

In today's health care system, there is a huge impact on addressing quality patient care in nursing research. Quality patient care involves the nursing competency and caring behaviors of professional nurse. A competent nurse must possess knowledge, skills, and attitude while practicing caring behavior professionally. Competencies and caring behaviors must be based on evidence-based practice which can elevate nurses among multi-professional teams.

Quality care improvement strategies are focused on involving nurses in evidence-based practice and research which then help nurses to gain a sense of professionalism to their identity and self-esteem. These also directly improved patient outcomes and enhance clinical practiced based on international standards.

SCOPE AND LIMITATION

The scope of the study would be limited to primary health care nurses of the medical services department, under the ministry of interior, Doha, Qatar, and to those nurses who have employed satellite primary health care units governed by the said

institution. The study would examine the variable of nurse competency and caring efficacy.

Participants include bedside nurses working full-time for at least a year at the medical services department under the ministry of interior, Doha, Qatar. The study conducted for a period of 2 to 3 months after obtaining approval. Therefore, caution must be taken in applying the results outside of this population. The data collected based on self- reporting methods, which can be influenced by several uncontrollable factors in completing the questionnaires.

CHAPTER 2

THEORETICAL BACKGROUND

Review of Related Literature

NURSE COMPETENCY

Professional competency in nurses is defined as a combination of skills, knowledge, attitudes, values, and abilities that bring about effective or high performance in occupational and professional positions (Karami et.al, 2017). Integrating the principle concept of nurse competency, as directed to correct judgment and habits in terms of the use of knowledge, technical skills, clinical reasoning, communication, feelings, values, and rethinking daily activities aimed at providing services to individuals and the society.

Nurses play an important role in direct patient care. Meeting the needs and demands of patient care in a therapeutic milieu, nurses propels a vital and significant performance in direct patient care. Nurses must be equipped with knowledge, skills, and attitude, and to be able to provide safe and effective nursing care interventions.

Supporting the guidelines in professional competency, as recommended by WHO (2018), *Global strategic directions for strengthening nursing and midwifery 2016–2020*, provides a framework for WHO and key stakeholders to develop, implement and evaluate nursing and midwifery accomplishments to ensure accessible, acceptable, quality, and safe nursing and midwifery interventions.

These include ensuring an educated, competent and motivated workforce within effective and responsive health systems at all levels and in different settings; optimizing policy development, effective leadership, management, and governance; maximizing the capacities of potential nurses and midwives through professional

collaborative partnerships, education and continuing professional development; and mobilizing political will to invest in building effective evidence-based nursing and midwifery workforce development.

In order, to become proficient and effective in delivering quality patient care. The profession of nursing is operational and contains constant care measures. This care begins with simple affairs and gradually, moves towards complex care and ultimately, terminates with comprehensive decision-making in presenting care.

In nursing, nurses show clinical skills and additionally, their theoretical knowledge regularly according to an identified framework. In a nursing career, most research and study plans are concentrated on clinical affairs. Competency can be observed as a necessary requisite for nursing services with high quality in clinical environments.

The nurses' competency is an effective indicator and factor on the guarantee of care measures' quality presented for patients and their satisfaction. In a recent study, conducted by Elhami et. Al (2018), suggests that to increase the nursing skills and can be easily recognized, nurses must hold re-education courses that can help to improve and develop nursing clinical competency and patients' satisfaction as a whole and further supports in a study made by Bahreini et. Al (2013) reported an overall level of competency was good.

Evidence suggests in the recent findings that nursing competency is imperative in giving quality direct patient care. So, to facilitate an effective, safe, and quality delivery to patients and the public. A self-evaluation method, evaluating the clinical competency by nurses themselves helps them to pay attention to their clinical functions through raising their self-awareness and commitment to change, and to make efforts to improve it. By this method and using rethinking processes,

nurses will gain a deeper recognition of their functions, and they can identify their weaknesses and strong points, obstacles, and fields requiring improvement in their function, and in their constant training process, undertake more activities. Self-evaluation can be learned during nursing studying and career. In order, to validate and evaluate our nursing professional competencies.

In Lieu of the present study, based on the facts and premises of the professional nursing practice. Nurse competency is vital and significant as a professional nurse in providing a safe, effective, and quality patient care following the international standard.

The American Nurses Association (ANA) (2010) defined competency as “an expected level of performance that integrates knowledge, skills, abilities, and judgment” (p. 78). Therefore, it stands to reason that a competent person can perform successfully at an expected level (ANA, 2010). The American Nurses Association (2010) also defined each of the key attributes comprising their definitions of competency, nursing knowledge, skills, abilities, and judgment.

Knowledge, according to the ANA (2010) “encompasses thinking; understanding of science and humanities; professional standards of practice, and insights gained from practical experiences; personal capabilities, and leadership performance” (p. 78). Skills were defined as including the “psychomotor, communication, interpersonal, and diagnostic skills” (ANA, 2010, p. 78) of the nurse. Ability (attitude) is the “capacity to act effectively requiring listening, integrity, knowledge of one’s strengths and weaknesses, positive self-regard, emotional intelligence, and openness to feedback” (ANA, 2010, p. 78). Judgment, according to the ANA (2010), “includes critical thinking, problem-solving, ethical reasoning, and decision making” (p. 78).

Cronenwett et al. (2007) determined that the overall goal of the Quality and Safety Education for Nurses (QSEN) project was to “better prepare future nurses with the appropriate knowledge, skills, and attitudes (KSAs) necessary to continually improve the quality and safety of healthcare systems within which they work” (p. 122). Although the QSEN core competencies don’t include judgment as a separate sub-competency metric that would be developed during pre-licensure and continuing nursing education, it should be noted that it is reflected within the knowledge, skills, and attitude competencies of each QSEN domain.

QSEN adapted and expanded the initial five Institute of Medicine (IOM) (2003), health care competencies to six core competencies or domains for the nursing profession namely:

QUALITY AND SAFETY EDUCATION FOR NURSES

Patient-Centered Care (PCC): This pertains to how the nurse recognizes the patient or designee as the source of control and full partner in providing and coordinated care based on respect for the patient’s preference value and needs. Reports on demographic factors influences on patient-centered care found that higher quality of healthcare experience was associated with higher patient-centered provider communication. Thus, the race and ethnicity, age, and gender are significant factors that influence patient-centered provider communication, and specifically higher quality of healthcare experience (Singh, et. Al 2019). In addition, in a study of Suhonen et. Al (2011), stated that there is a significant influence as to age, gender, educational level, length of stay, and type of admission of patients to perceive individualize care and patient satisfaction.

Teamwork and Collaboration (T&C): This pertains to how the nurse functions effectively within nursing and interpersonal teams, fostering open communication,

mutual respect, and shared decision making to achieve a quality of care. An article posted on the factors that related to registered nurses' readiness for interprofessional learning in the context of continuing professional development Williams (2014), found that demographic factors such as age, gender, primary or secondary degree nurses, the highest level of nursing education, number of years practicing as a registered nurse, and nursing specialty related to readiness toward interprofessional learning and teamwork for registered nurses. Meanwhile, an investigation, on the relationship between nursing unit educational composition, teamwork, and missed nursing care (Sarver, 2019), concluded that the higher the educational attainment and the percentage of BSN graduates in an institution have linked to improved teamwork and collaboration.

Evidence-Based Practice (EBP): This pertains to how the nurse integrates best practice with clinical expertise and patient/family preferences and values for delivery of optimal health care. Reports from an assessment of nurses' knowledge and utilization of evidence-based practice and its associated factors Tadesse, Teshome & Eyoel (2018), found that demographic factors such as sex, marital status, and nursing experience were significantly associated with knowledge regarding evidence-based practice. Comparable findings reported on the study of Carlone & Igbirieh (2014) on measuring attitudes and knowledge of evidence-based practice in the Qatar workforce found that as high educational attainment sets an indication of increasing knowledge and awareness on EBP.

Quality Improvement (QI): This pertains to how the nurse uses data to monitor the outcomes of care processes and use improvement of methods to design and test changes to continuously improve the quality and safety of the health care system. As

disclosed in the study of Blegen, Vaughn & Goode (2001), which determines the relationship between nurses' education and years of experience are predictors of quality improvement for patient care. Thus, the more experienced nurse is believed to contribute to quality care improvements and patient outcomes. Consistent findings believed that experienced nurses with higher total nursing hours per patient, and a higher percentage of RNs deeply influence quality patient care outcomes (Dunton, 2007).

Safety (S): This pertains to how the nurse minimizes the risk of harm to patients and providers through both system effectiveness and individual performance. A recent study suggests that demographic factors such as age and years of training can affect organizational role and perception of organizational safety culture as reported by Abrahamson et. Al (2018).

A latter evidence on the study of Azimi & Bahadori (2012), shows on the effect of safety culture education on patient safety, found that educational attainment has a positive effect on the improvement of managers' attitudes towards safety culture.

Informatics (I): This pertains to how the nurse utilizes information and technology to communicate, manage knowledge, mitigate error, and support decision making. Recent reports on the impact of e-learning on nurses' professional knowledge and practice show that age and the level of education plays a significant role in the utilization of electronic courses for nurses. Thus, online electronic courses found to have a relatively high impact on the degree of academic and professional education (Dalhem & Saleh, 2014; Mungania, 2003). Latter findings to support on the evidence of demographic factors in the study of Alquraini et al., (2007); Brumini et al., (2005), found that nationality, the level of education, previous experience in computer use and

computer skills, as well as gender, age, education, and computer usage, were the statistically significant predictors of nurses' attitudes toward using electronic medical records. Furthermore, young, highly educated nurses with computer knowledge have more positive views towards the usage of electronic medical records than other nurses. Also, nurses with higher job positions had a more favorable perspective toward computerization and the usage of electronic medical records.

These core competencies were to act as a tool to bridge what was considered a disconnect between quality and safety education in the practice environment and the academic setting (Brown, Feller, & Benedict, 2010). These indications suggest that educational strategy should focus on learning, not the teaching if the nursing practice is to change (Regnier, Kopelow, Lane, & Alden, 2005). Each of the QSEN competencies is seen as working in unison with, and in many respects impacting each of the other QSEN competencies. These core competencies are expected to apply to pre-licensure, and as well as practicing registered nurses irrespective of their independent healthcare practice setting.

QSEN focuses on developing and implementing teaching strategies that address the knowledge, skills, and attitudes of each core competency of nurses. In review, the QSEN core competencies are patient-centered care (PCC), teamwork and collaboration, evidence-based practice (EBP), quality improvement (QI), safety, and informatics (I).

CARING EFFICACY

Caring is considered as the underlying principle of the nursing profession and it is through exhibiting caring behaviors and establishing caring relationships with patients that nurses find meaning in their work, have a sense of well-being

professionally as well as personally, and find satisfaction with their jobs and professions. Swanson (1991) noted caring is the practice of knowing, presence, providing for, enabling, and maintaining a belief. The philosophical underpinnings of caring include the responsibility of a person to care for and develop relationships with other people (Watson, 2005). Watson (2005) & Leininger (2002) regard caring as the foundation of nursing and from caring, nurses finding meaning in their work, and become engaged in their role.

As recommended by Watson Theory in Human Caring, to measure caring behavior efficiently, a measurement tool for caring behavior was created basing on Coates (1997), it is used as a measurement scale to assess nurses' belief about caring efficacy. An individual's belief of personal efficacy is strongly related to their ability to execute skills and, in nursing, it is directly linked to their ability to provide and exhibit caring behavior skills (Van der Bijl & Shortridge- Baggett, 2002). Caring efficacy is defined as "nurses' beliefs in their abilities to express caring orientations, attitudes, and behaviors and to establish caring relationships with clients or patients" (Coates, 1997, p. 54).

Watson (1988) describes the main force of transpersonal caring theory as directing people through caring interactions to harmony or health in the mind, body, and soul. This enables self-healing within the person.

The theoretical framework of caring efficacy underpinning this scale not only reflects Watson's transpersonal caring theory (Watson, 1985; Watson, 2005) but the equally important social learning theory of Bandura (1977) i.e., the perception one has of one's confidence and ability to provide care and develop caring relationships with patients (Coates, 1997).

Self-efficacy beliefs stem from a person's determinant of their performance in specific areas i.e., it is domain-specific. This is demonstrated in the caring efficacy scale (Coates, 1997), which captures nurses' perceptions of their caring orientation, attitude, and behavior along with the capacity to develop caring relationships with patients. This self-report scale ties human beliefs about caring and their caring practices in specific environmental nursing contexts (Coates, 1997).

Few researchers have identified if age, years of nursing experience, employment status, and years of employment as contributing factors influence the nurses' ability to express caring efficacy. Benner (2001) suggests that years of experience would increase the nurses' knowledge, competency, and confidence in providing caring actions.

In a recent study conducted by Reid et. al (2018) examining the relationship of caring efficacy and sociodemographic in Australian registered nurses' population, concrete evidence shows that there is a relationship found between years of experience, marital status and caring efficacy expectations among Australian registered nurses who belonged to an industrial and professional organization. The number of years of experience of nurses who participated in this current study was related to their perceived confidence and ability to express care and develop caring relationships with their patients. Marital status (i.e., nurses who reported being married or had been previously married) was also found to be related to higher levels of perceived self-efficacy in nurses, however, this has not been previously reported.

Using targeted strategies of self-efficacy in nurses' professional development programs might assist in the development of perceived self-efficacy of nurses to provide care to and develop relationships with patients. The findings add to the current body of knowledge regarding relationships between the socio-demographic

variable, years of experience, and perceived self-efficacy in nurses in both the Australian and international contexts. It suggests that less experienced nurses are particularly more at risk of having poorer perceived self-efficacy expectations.

In the Study of Schofield, Tolson, Arthur, Davies & Nolan (2005) compared the caring attributes and perception of work change in the geriatric nursing population in England, Scotland, and Hong Kong. During this study, Schofield found that nurses in acute care units had lower caring attributes as measured by the caring attribute scale. Besides, age, qualifications, and length of experience working with geriatric patients demonstrated stronger caring attributes. Nurses between the ages of 25-29 years of age scored the lowest on the caring assessment scale.

As cited in the study Lee (2000), in a study of 770 nurses from Taiwan, identifies that older nurses, who had more nursing experience measured higher of the caring assessment report evaluation Q sort (than younger nurses with less nursing experience. Lee also compared the four levels of nursing education to the scores on the CARE-Q and reported a difference does exist between education level and CARE-Q scores. Diploma educated nurses reported the highest mean score on the CARE-Q and nurses with Bachelor's degrees scored the lowest on the CARE-Q. Also, Lee's research discovered a difference between specialty nurses and exhibiting caring behaviors, with nurses in emergency units demonstrated the fewer caring behaviors compared to pediatric units, surgical units, and psychiatric units (which scored the highest).

Patients value a caring relationship with nurses as evidence of the study (Davis, 2005; Larrabee & Bolden, 2001) states that the presence or availability of the nurses has been expressed significantly strong on expectation on patient satisfaction. Another study supports the negative ideation on the caring presence on the study of

(Clarke & Aiken, 2003; Vlarke, Sloane, Sochlaski & Silber, 2002), the inability of the nurse to exercise caring behaviors, decreases patient satisfaction.

A US study made by Manojlovich (2005a) established that a significant relationship exists between self-efficacy in nursing and professional practice behaviors, which in turn provides information about the determinants of practice behaviors and the sources of those determinants. Also, environmental, self-efficacy, and personal factors influenced the development of professional practice behaviors.

A lack of self-efficacy in nursing (i.e. nurses believing they cannot activate the required motivation, cognitive resources, and courses of action required to have control over their work) may have an effect on nurses choosing to stay away from patients, gather at the nurses' station and remove themselves from intense healthcare situations. While this is not functional professional practice, it is an option for reducing stress in extremely challenging work situations (Begat, Ellefsen & Severinsson, 2005; Manojlovich, 2005a).

Professional nursing practice behaviors have been described as the ability to establish and maintain patient relationships, autonomy, decision-making, and control over practice and collaborative relationships particularly with the physicians at a unit level. Other self-efficacy research in nursing has also shown that high levels of self-efficacy may be an indicator of improved professional nursing practice behaviors (Le Blanc et Al., 2010; Lee & Ko, 2010; Manojlovich, 2005a; Scott et al., 1999).

In a recent study made by Torres (2017), on the influence of work environment conditions on the ability of critical care nurses to provide efficacious nursing care in Puerto Rico, were identified the existing associations between the scale measuring

the empowering structures in the working environment, sociodemographic variables, and caring efficacy. A positive correlation between the relationships with patients and families and caring efficacy was established.

Valuing a caring relationship, entails responsibility not only to the patient, community, and hospital setting. The value of care from correctional nursing facilities is intricate, it implies autonomous independent nursing function and implied critical nursing judgment bound on custodial care.

Nursing practice to different set-up has gone far in terms of effective, safe, and quality individualized care such practices are immense and not noticeably known to the public, that nurses are practicing their congruent care same with other people.

In a study by Dhaliwal & Hirst, (2016). Caring in correctional nursing, found that correctional nurses must embrace boundaries to develop therapeutic relationships with offenders, minimize manipulation, and uphold correctional priorities while providing quality care, on this study recommends future implications that need to be studied furtherly in terms of quality care, nursing research and education.

On the other hand, to be able to commence a proper congruent and effective caring behavior, a recent study conveying recommendation was found based on the implication as a health care provider to have individualized care for the patient as evidence in the recent study of Johnson et. al, (2016), as emphasized healthcare providers should be culturally aware by having a basic comprehension of Muslim beliefs, values, and practices to provide culturally safe and informed care.

Healthcare providers must be culturally aware of their own beliefs both personally and professionally while unpacking any biases, time invested for the

development of relationships with Middle Eastern clients, families, and other health-care professionals are essential. Healthcare providers must have cultural knowledge, to individualize nursing care to meet healthcare needs within the unique context of culture, beliefs, values, and practices. Healthcare providers must attain cultural skills to be able to conduct cultural assessments that encompass a culturally-based physical assessment. Healthcare providers must have knowledge about cultural encounters in specific Muslim culture (i.e. awareness of the use of silence) and lastly, healthcare providers must engage in and learn about the particular middle eastern country and its culture before going overseas and immersing in the culture once they arrive.

In connection with the present study, nurses caring abilities are innate in the nursing profession. The eminent illustrators of caring behaviors are nurses. As nurses persuade their caring ability to direct patient care. Nurses must be aware of professional perceived caring behaviors as encompasses and recommended by the theory of Watsons' transpersonal caring and succeeded in further researches recommends caring efficacy scale which was developed by Coates (1997).

Therefore, examining both concept and scope of competency and caring abilities. The integration of these core concepts will help professional nurses to determine their level of nurse competency and perceived caring abilities (caring efficacy). Thereby, empowering nurses professionally to certain changes and enhance their competency levels in both respective manners.

THEORETICAL FRAMEWORK

BENNER'S NOVICE TO EXPERT THEORY

Both theory and practice work concomitantly in the nursing profession. As a scientific profession, nursing needs a scientific basis of theories.

Without theory there is no evidence nor guidelines in nursing practice. Theories provide a framework as well as goals for recognition and assessment of nursing practices (Mohammadi, 2015). The importance of nursing models and theories can be explained from a different point of view. Such models provide a framework for a nursing doctrine which makes the practitioners enable them to analyze various conditions in a more effective way and based on which organize their behaviors (Meleis, 2011).

Patricia Benner's from novice to expert is known as one of the most important theories in the field of nursing (Cash, 1995). Benner carried out extensive research on methods of achieving, consensus, assessment, and interprofessional evaluation during 1999 and explained that as well as practical applications, knowledge needs to be expanded constantly. Experience and proficiency are necessary for nursing practice. Intuitive experience would lead to moral reasoning and personal knowledge (Benner, 1996). Therefore, as a guideline of nursing practice, each nurse persuades the innate characteristics of knowledge, skills, and attitude towards direct patient care.

As evidence explained by Benner, expertise as a road with five sections that should be passed through by a practitioner to become clinically skilled. These sections are as follows; (1) novice, (2) advanced beginner, (3) competent, (4) proficient, (5) expert. As recommended to the ladder of nursing practice, parallel to the progressive movement of the practitioner from the novice level to the expert one,

his/her performance and mind would be changed in four main areas; (1) practitioners will tend to use empirical experiences in their practices instead of relying on abstract principles, (2) they will appeal to intuitions rather than analytical or rule-based thinking, (3) they will be able to obtain a comprehensive understanding of various situations, and (4) their position will be changed from an outside observer to an individual who is fully involved in the situation (Alligood, 2013).

WATSONS TRANSPERSONAL CARING THEORY

As stated in Watson's Theory "Caring is essential to the theory and practice" (Watson, Jackson & Borsabi, 2005 p. 114). The nursing profession places a high value on caring and it is the cornerstone of the nursing practice. Caring behavior by nurses can contribute to the satisfaction and well-being of patients and is more than only the performance of the healthcare organizations or a specific type of professional and human-to-human contact. The core attributes of caring behaviors are the 10 carative factors developed by Watson's transpersonal theory: Core Concepts of Jean Watson's Theory of Human Caring/Caring Science, (1979;1985) Formation of humanistic- altruistic system of values, Instillation of faith-hope, Cultivation of sensitivity to oneself and others, Development of a helping- trusting (human caring) relationship, Promotion, and acceptance of the expression of positive and negative feelings, Systematic use of the scientific problem-solving method of decision-making, Promotion of interpersonal teaching-learning, Provision for a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment, Assistance with the gratification of human needs and Allowance for existential-phenomenological forces.

As evidence by the middle range theorist in Nursing as Caring Theory by Boykin & Schoenhofer's (2001) nursing as caring theory, the authors defined the

profession as “nurturing persons living to care and growing in caring”. The authors assert that persons are whole, complete, and caring moment-to-moment under their humanness.

Humanness is a process of living grounded in caring, enhanced by participating in nurturing relationships with caring others by participating in nurturing relationships, nurses support the worth, dignity, and rights of the other. As supported by another middle range theorist Swanson (1991), Caring consists of five processes: knowing, being with, doing for, enabling, and maintaining.

It is through these activities and behaviors that nurses find meaning in their work as well as personally. Caring is about building relationships with those in need it is about being present, providing comfort, and skillfully and competently meeting the changing needs of the patients. These two middle-range theorists underpin the philosophy of human caring and the concept as a whole person and the presence of human caring are interrelationship to build a good and effective caring environment.

Caring is the essence and central focus of the nurse’s role to foster improved health and well-being for all clients (Hess et. Al, 2013). Caring is embedded in personal and cultural meanings and commitments that are both instrumental and expressive (Benner, 2001; Benner, Tanner, & Chesla, 2009). When describing various types of caring in various contexts, nurses comprehend the role of caring in health, healing, and recovery (Benner, 2001). Caring is based on what matters to an individual and the conscious or unconscious actions that follow that which matters (Edwards, 2001). The encounters between nurses and patients are guided by one’s value system and philosophy of care.

Caring is a skilled, interpersonal interaction between the nurse and patient, based on both the nurse’s and the patient’s subjective experience and the nurse’s

commitment to maintaining the patient's dignity (Smith, Turkel, & Wolf, 2013). Spichiger, Wallhagen, & Benner (2005) described caring practices from an ontological perspective. A caring attitude is not passed down via genes, from generation to generation.

Caring attitudes are developed and transmitted by the culture of the nursing profession as a means of coping with its environment (Smith et al. 2013).

Watson believes that caring relationships depend on the nurse's ability to embrace the patient's frame of reference and create a healing environment (Sitzman & Watson, 2014). Perceived caring practices are determined by the concerns that define an individual's self (the nurse) and the world and what is required to restore a person (the patient) and lifeworld.

Watson framed specific ontological/caring competencies that aim to deepen nurses' ways of cultivating having a healing presence. Some of these competencies include the ability to center, quiet down and pause before entering a client's room; ability to be present; maintain appropriate eye contact based on personal/cultural sensitivity; accurately detect other's feelings; and authentically listen/hear behind the words (Watson, 2008).

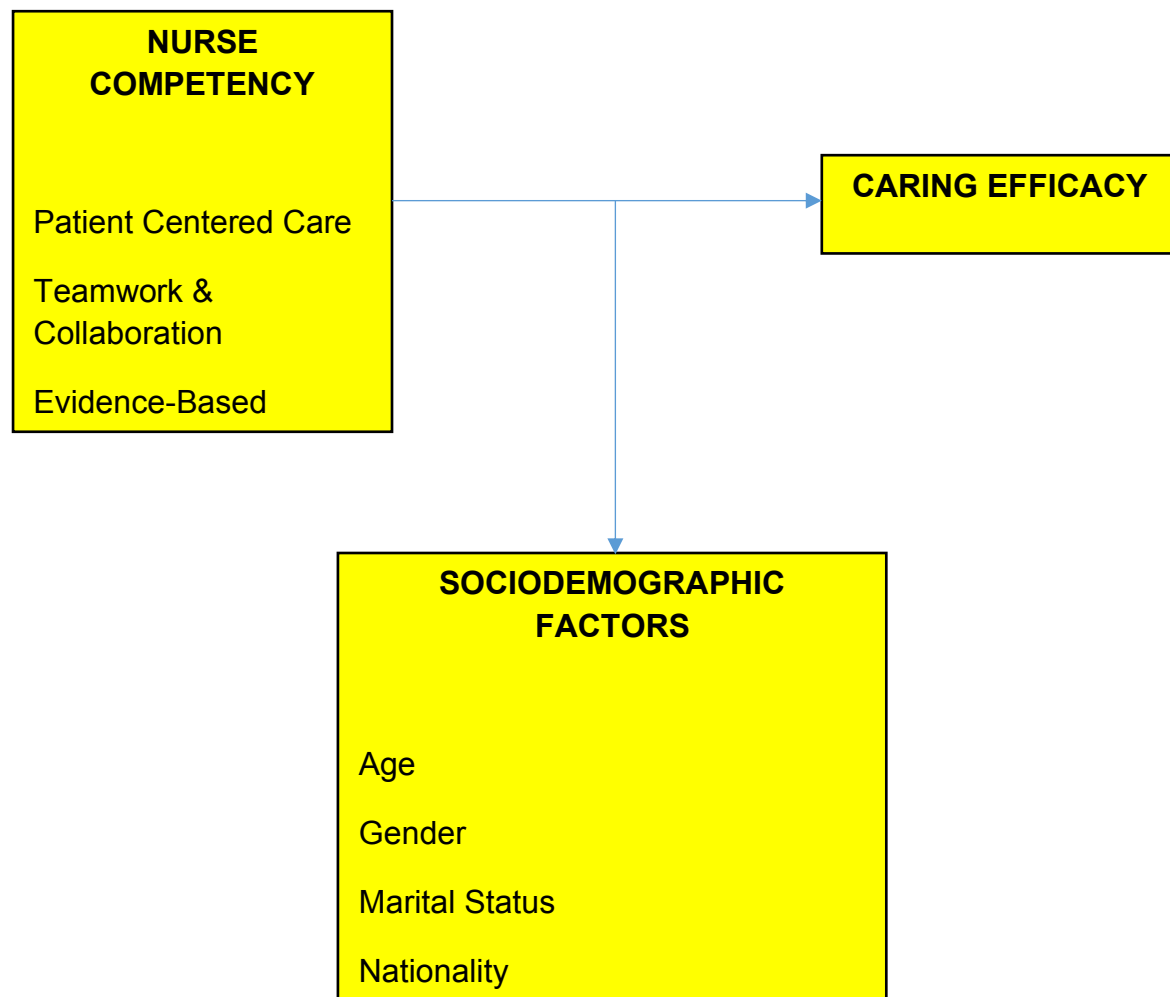
These competencies are not all-inclusive. Watson recommended that the nursing profession continue to explore models for ontological/caring competencies. Within this framework of competencies, nurses should remember they are not just in the environment. They are the environment (Watson, 2008).

Thus, as professional nurses, both theory and practice work simultaneously. The inherent characteristics of the nursing profession are nurse competency and caring abilities. To become more effective and proficient, professional nurses must

adopt the principles and guidelines in nursing practice, to provide safe, effective, and quality direct patient care delivery and services to all.

CONCEPTUAL FRAMEWORK

Figure 1: Conceptual Framework



The above figure shows the interdependence of the variables to be covered in this research study wherein, the independent variable (nurse competency) would correspond the caring behavior (efficacy) the dependent variable and part of the intervening variables to the demographic factors: age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service and nursing practice area.

The conceptual framework above outlines the selected factors to be examined concerning nurse competency and caring efficacy among nurses. There are two major variables in this research study: (1) nurse competency as an independent variable and (2) caring efficacy as the dependent variable.

The socio-demographic characteristics such as age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area are demonstrated using a straight line to convey how may affect the relationship between the independent variable and the dependent variable.

OPERATIONAL DEFINITION

1.1 Demographic variables are described as “characteristics or attributes of subjects that are collected to describe the sample which commonly includes age, educational attainment, gender, ethnicity, marital status, income, job classification, work experience, years of experience, etc.” (Grove, Gray, & Burns, 2014).

1.1.1 Age refers to the number of years lived from the time of birth.

1.1.2 Gender refers to the state of being male or female.

1.1.3 Marital status refers to use to describe a person with a significant relationship to others.

1.1.4 Nationality refers to the status of belonging to a particular nation.

1.1.5 Educational attainment refers to the highest level of education completed.

1.1.6 Years of nursing experience refer to the number of years working as an experienced nurse.

1.1.7 Length of service refers to the number of years working of working

experience as a nurse in the current institution

1.1.8 The nursing practice area refers to a place of current nursing place to practice the nursing profession.

1.2 Nurse competency was conceptually defined as a nurse's experience on the job in the same or similar situations for two to three years, has more focus on clinical issues than completing tasks, views actions in terms of long-range goals or plans anticipate certain typical progressions in patients' recovery, and is more discriminating about the performance of others on the healthcare team (Benner, 2001; Benner et al., 2009). Nurse competency was operationally defined as a weighted, self-report score derived using the Nurse Quality and Safety Self-Inventory scale (NQSSI) based on Quality Safety and Education for Nurses (QSEN), an 18-item self-reported scale design to allow nurses to consider their practice within their practice setting, gain insight into them practice to identify strengths and opportunities, and improve practice through self- assessment.

1.3 Caring efficacy was conceptually defined as "the underlying cognitions, attitudes, and behavioral repertoire one has to express caring orientation and develop caring relationships with clients or patients" (Coates, 1997). Caring efficacy was operationally defined as a weighted, self- report score derived using the Caring Efficacy Scale (CES), a 30-item Likert- type instrument designed to identify a nurse's confidence in his or her ability to develop caring relationships and express a caring orientation with clients (Coates, 1997).

HYPOTHESIS

HA1: There is a difference in the level of nurse competency in terms of age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area in the current work field among primary health care nurses of medical services department.

H01: There is no difference in the level of nurse competency in terms of age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service and nursing practice area in the current work field among primary health care nurses of medical services department.

HA2: There is a difference in the level of caring efficacy in terms of age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area in the current work field among primary health care nurses of medical services department.

H02: There is no difference in the level of caring efficacy in terms of age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area in the current work field among primary health care nurses of medical services department.

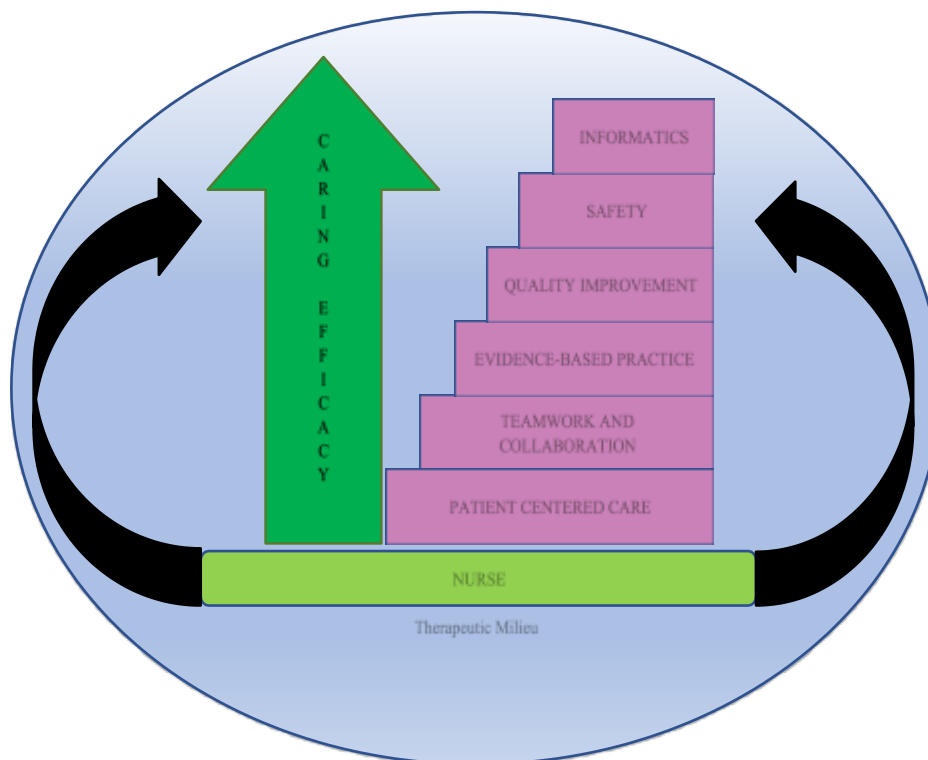
HA3: There is a significant relationship between nurse competency and the nurses' ability to express caring behaviors (caring efficacy) among primary health care nurses of the medical services department.

H03: There is no significant relationship between nurse competency and the ability to express caring behaviors (caring efficacy) among primary health care nurses of the medical services department.

RESEARCH PARADIGM

The research paradigm is based on Watson's transpersonal caring theory using the caring efficacy scale as constructed on 12 carative factors and Benner's theory of novice to expert theory using subscales of nurse quality and safety self-report based as constructed on quality and safety education for nurses.

Figure 2: Research Paradigm



The above figure shows the research paradigm which asserts the assumption of the nurse at the beginning of the professional nursing career. The nurse has a ladder to achieve from the beginning of the professional nursing career and congruently, in the same manner, the caring ability of the nurses ascends and increases as the nurse persuade towards patient and therapeutic milieu. As the nurse interacts and continues to grow professionally in terms of competency level and adapting the carative factors ultimately to become more effective, proficient, and adapting caring behaviors professionally (caring efficacy).

CHAPTER 3

RESEARCH METHODOLOGY

RESEARCH DESIGN

A quantitative methodology was used as a descriptive correlational design, for its aims were to describe the variables and the relationships that exist naturally between and among them. The primary purpose of the study was to address the research hypothesis and its relationship between nurse competency and on the expression of caring behaviors (caring efficacy) alongside with the socio-demographic variables. The research methodology was to determine the sociodemographic variables among primary health care nurses of the medical services department as to age, gender, marital status, nationality, years of nursing experience, length of service in current practice, and nursing practice area. Nurse Quality and Safety Self-Inventory Scale (Piscotty, 2013) was used to determine the level of nurse competency and the nurses' perceived ability to express caring behaviors using the Caring Efficacy Scale (Coates, 1997; Watson, 2002) was used to determine the level of caring behaviors (caring efficacy) and investigated the relationship nurse competency and caring efficacy.

A quantitative descriptive correlational design was appropriate to use in this study. Since the variables of interest were studied from representatives of different areas of primary health care units of the medical services department under the ministry of interior, within a subset of a target population and would be determined for correlations at a single point in time. Moreover, given that knowledge, skills, attitudes, demographic factors, and practice of nurses had taken place even before the conduction of the study, it is understood that such variables cannot be

controlled or manipulated. This type of non-experimental research design is enough to correspond to or answer the purpose of the study.

The first research question was to address sociodemographic information among primary health care nurses of the medical services department as to age, gender, marital status, nationality, years of nursing experience, length of service in current practice, and nursing practice area.

The second research question was to address the level of nurse competency among primary health care nurses in the medical services department.

The third research question was to address the level of caring efficacy among primary health care nurses of the medical services department.

The fourth research question was to investigate that there is a relationship in nurse competency (independent variable) in terms of socio-demographic information (to age, gender, marital status, nationality, years of nursing experience, length of service in current practice and nursing practice area)

The fifth research question was to investigate that there is a relationship in caring efficacy (dependent variable) in terms of socio-demographic information (to age, gender, marital status, nationality, years of nursing experience, length of service in current practice, and nursing practice area).

The sixth research question was to investigate that there is a correlation between nurse competency (independent variable) and the nurses' ability to express caring behaviors (caring efficacy) (dependent variable) among primary health care nurses of the medical services department.

To ensure the validity and reliability of this research study, by determining the extraneous variables that impact the outcome variable such as the proper selection of target population, validity, and reliability of chosen research questionnaire

Nurse Quality and Safety Self-Inventory Scale by Piscotty (2013) and Caring Efficacy Scale by Coates (1997).

STUDY POPULATION

The target population was primary health care nurses of the medical services department under the ministry of interior, Doha, Qatar. The total population of the nurses in primary health care units of the medical services department under the ministry of interior, Doha, Qatar, comprises of N=165. The population of the nurses comprising of N=165, (ER/Ambulatory Clinic N=42, Out-Patient Clinic N= 51, Dental Clinic N=15, Prison Facility Clinic N=52). Since, it is unnecessary to collect responses from the entire population to derive a conclusion for this study, determining a representative sample of the total population that is adequate.

Subsequently, the accessible population that mainly makes up bedside nurses is N=165. The total population was drawn from licensed, registered nurses, in Doha, Qatar assigned in different areas of primary health care units covered by the medical services department, under the ministry of interior.

This population was chosen for the purposive convenience and proximity of the researcher. Inclusion criteria were nurses directly providing care to patients and working full-time for at least a year within primary health care nursing facility. Bedside nurses who sometimes act, as charge nurses in satellite extension departments were also be recruited. However, the study excludes nurses permanently assigned to the role of charge nurse, nurses who refuse to participate in the study, and those who are on leave during the period of data gathering.

RESEARCH VARIABLES

Two main variables were central to the study: (1) independent variable (nurse competency) (2) dependent variable (caring efficacy) and (3) socio-demographics (intervening variable). Both main variables were measured along with the inherent characteristics of the participants. This study takes into consideration the sociodemographic information of nurses such as to age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service and nursing practice area in the current work field as to nurse competency as an independent variable and its relationship to caring efficacy as the dependent variable.

On the other hand, extraneous variables that impact the dependent or outcome variable in the study, are believed to include the environment, the procedure, the researcher, and the participant himself or herself. Such variables alter the condition or behavior of the participants during data collection and therefore alone, would bring real effects into the dependent variable. Helpful ways to control for threats to validity and reliability in this study design had required the elimination of extraneous variables by consistently approaching the participants, by conducting the study in a constant and natural setting, by ensuring standardized procedure in the data collection process, and by setting inclusion criteria to minimize differences between participant variables.

RESEARCH SETTING

The research study takes place in primary health care units of medical services department situated in Doha, Qatar operates under the ministry of interior and caters its health care services to both dental and medical services, to employees who are working under ministry of the interior such as military personnel

(police force, air-force, navy, special security forces, general guards, jail-guards, emir-guards), immigration staffs, central evidence, and investigation division personnel, families of the emir and to both locals and expatriates working in the said institution.

The said institution extends its extension to satellite health care units and services in a prison facility and drug facility. Given the wide range of nursing care activities that nurses in this specialty perform, the medical-surgical nurses, dental nurses, and jail nurses are a suitable population for studying the relationship between nurse competency and caring efficacy.

SAMPLE DESIGN

A master list of all nurses was obtained from the chief nurse with the permission of the immediate nurse supervisor of the involved facility was used to ensure the total number of staff nurses. With purposive sampling, eligible nurses who are encountered by the researcher and who happens to be available during working hours were asked to participate in the study.

Purposive sampling is a type of nonprobability sampling that does not entail randomization. It is somewhat similar to convenience sampling except, that it requires inclusion criteria. This technique is advantageous if there are limited time and resources as it is easily accessible and only aims to get many responses that would satisfy the required sample size.

Using G power V. 3.1 software, a priori power analysis for correlations was based on correlation: point biserial model revealed a computed required sample size of 82 given the following parameters:

- Two-tailed test
- A medium effect size of 0.3

- Alpha of 0.05
- Power at 80% (minimum power level considered to be adequate)

The sample size was determined by using G Power software, where a confidence level was set at 95%, a power level of 80% was set with moderate effect size, similar to the study of Moss (2018). Eighty-two participants were statistically calculated to represent the population. The population of the nurses comprising of N=82, (ER/Ambulatory Clinic N=20, Out-Patient Clinic N= 20, Dental Clinic N=20, Prison Facility Clinic N=22).

However, to avoid a low response rate, that affects the sample size, thus a larger sample was recruited which was more than that calculated in the assumption that not every individual in the sample would respond to the study. A final sample of 102 nurses was recruited using purposive sampling.

In relevance to the current research study, As recommended by Polit & Beck (2004), With power equal to .80, there is a 20 % risk of committing type II error, with alpha and power that is set and specified, between the relationship of variables it can detect and estimate the population size effect. Although this risk may seem high, a stricter criterion requires sample sizes much larger than most researchers could afford, therefore, when the relationship (effects) are strong, they can detect at significant levels even small samples and when relationships are modest, large sample sizes are needed to avoid type II errors.

Others recommend as stated by Nieswiadomy (2002), It is always wise to set the sample size a little bit larger than what is desired (to allow for nonresponse or subject dropout). Also, an absolute minimum sample size should be declared at the beginning of a study.

RESEARCH INSTRUMENT AND TOOLS

A quantitative correlational study was used for this methodology, to study the relationship of nurse competency and among nurses' ability to express caring efficacy, alongside with the socio-demographic data for nurses who are working in the primary health care units of medical services department under Ministry of Interior, Doha, Qatar. A socio-demographic questionnaire (intervening variable) was used to describe the characteristics of the nurses including age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area in current work field were supplemented to the adapted instruments for this study.

The nurse quality and safety self- inventory scale (independent variable) by Piscotty (2013) and the caring efficacy scale (dependent variable) by Coates (1997) measures the nurses' ability to express caring behaviors. The questionnaire for data collection was divided into three sections: (1) socio-demographic information (2) nurse competency (independent variable) by Piscotty (2013) (3) caring efficacy scale (dependent variable) by Coates (1997).

SOCIODEMOGRAPHIC QUESTIONNAIRE

A socio-demographic questionnaire was used to assess intervening variables (socio-demographic) attributes that affect the relationship between the independent variable (nurse competency) and the dependent variable (caring efficacy). This study takes into consideration the demographic information of nurses such as age, gender, marital status, nationality, educational attainment, years of nursing experience, length of service, and nursing practice area in the current work field as the independent variables. Both main variables would be

measured along with the inherent characteristics of the participants classified as modifying variables.

NURSE QUALITY AND SAFETY SELF-INVENTORY SCALE

The nurse quality and safety self-inventory scale developed by Piscotty (2013) was assessed as an independent variable. The NQSSI is an 18-item, self-rated inventory developed to measure nurse's self-rated knowledge, skills, and attitudes regarding the six quality and safety education for nurses (QSEN) competency areas namely; patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety and informatics. Each item was constructed to correspond with the knowledge, skills, and attitudes area of each of the six competencies. Three questions are included under each competency to address the three areas of knowledge, skills, and attitudes.

A self-report rating scale containing 18 items was chosen for measuring self-rated attributes of the quality and safety competency. The inventory is rated on a 7-point Likert-type scale with 7 = strongly agree, 1 = strongly disagree, and a neutral choice. Scores are totaled for the entire inventory by calculating a mean score. Also, a mean score can be calculated for knowledge, skills, or attitudes, as well as for each of the six quality and safety education for nurse's competency areas. Higher mean scores indicate greater confidence regarding quality and safety competencies. On a scale of 1.00 to 2.50 indicates very low confidence, 2.51 to 4.00 indicates low confidence, 4.51 to 5.50 indicates high confidence, and 5.51 to 7.00 indicates very high-level confidence.

The total scale means score may be used to garner a global understanding of the student's self-rated competency, or the two subscales may be used to

examine knowledge or attitudes. All 18 items on the NQSSI are worded positively, which increases the ease of scoring.

Reliability of Nurse Quality and Safety Self-Inventory Scale

The initial testing for NQSSI reliability was performed using a convenience sample of all the students enrolled in two leadership and management courses in the baccalaureate nursing program at a public Midwestern university was used. The students were enrolled during the fall 2009 semester. The two groups consisted of traditional (n = 132) and accelerated second-degree (n = 44) students enrolled in the Bachelor of Science in Nursing program. The internal consistency coefficient (Cronbach's alpha) of the NQSSI was 0.93, which indicates satisfactory reliability. The NQSSI had strong item-total correlations that indicate the ability to discriminate between high and low scores. The reliabilities of the new subscales are satisfactory and ranged from 0.88 to 0.92. The study findings support that NQSSI is an effective measure for assessing nursing students' self-rated quality and safety competencies. Researchers who attempt to design effective interventions to improve nursing quality and safety in nursing students can use the NQSSI to measure effectiveness.

In the study of Lusk (2016), Comparing the Knowledge, Skills, and Attitudes of Newly Hired Nursing Staff Before and After Implementation of a Quality and Safety Competency-Based Nursing Orientation Program under Denver VA Medical Center and VA Eastern Colorado Health Care System.

Significance was found for those with 0-3 years of experience having scored lower on the NQSSI than those with greater than 20 years of experience or those with 4-7 years of experience in the following KSAs: Attitudes for Evidence-

Based Practice ($p=.005$); Knowledge and Skills for Quality Improvement ($p=.012$ and $p=.007$); Knowledge and Skills for Safety ($p=.004$ and $p=.013$; and Knowledge and Skills for Informatics ($p=.008$ and $p=.037$).

The validity of Nurse Quality and Safety Self-Inventory Scale

The initial results from the study Initial Psychometric Evaluation of the Nursing Quality and Safety Self-Inventory (Piscotty, et. Al 2013), Provides support for the reliability and validity of the NQSSI as an instrument to measure self-rated quality and safety competencies of nursing students. The NQSSI assesses nursing students' self-rated quality and safety knowledge and attitudes related to the six QSEN competencies. The reliability of the NQSSI is much stronger in contrast to that reported on the Patient Safety Attitudes, Skills, and Knowledge Scale (Schnall et al., 2008). The Patient Safety Attitudes, Skills, and Knowledge Scale was developed based on the six aims from the IOM, but it had poor reliability (Schnall et al., 2008).

The NQSSI has two subscales that are conceptually congruent with the knowledge and attitudes of the QSEN competencies. Although either subscale could be used independently, it is recommended that the total scale be used to garner a holistic assessment of nursing students' self-rated quality and safety competencies. The NQSSI also showed good internal consistency, with evidence of contrast validity.

CARING EFFICACY SCALE

The Caring Efficacy was measured as the belief or self-confidence in the nurses' ability to express caring behaviors and establish caring relations with patients. The caring efficacy scale developed by Coates (1997) assessed as a

dependent variable. The Caring Efficacy Scale is a self-report questionnaire containing 30 test items on a 6-point Likert scale labeled with three negative numbers and three positive numbers ranging from strongly disagree (-3) to strongly agree (+3). This scale is at the ordinal level of data. The ordinal scale assumed that the distance between the responses categories is valued equally.

The higher the mean the more nurses perceive that they establish and express caring behaviors. There is no neutral category within the scale. On a scale of 1.00 to 2.25 indicates a very low caring efficacy, 2.26 to 3.50 indicates low caring efficacy, 3.51 to 4.75 indicates high caring efficacy, and 4.76 to 6.00 indicates a very high level of caring efficacy.

Each statement was designed to measure the participant's perspective toward clients/patients. There is an equal division between the number of negative and positive statements. The statements are mutually exclusive. The negatively worded items were recoded to reflect so that *strongly disagree* = 6 (-3 on the Likert scale) and *strongly agree* = 1 (+3 on the Likert scale). The positively worded items were recoded to reflect so that *strongly disagree* = 1 (-3 on the Likert scale) and *strongly agree* = 6 (+3 on the Likert scale). The means for the negatively worded statements have conceptually expressed the belief in one's inability or lack of confidence in establishing or expressing caring behaviors (questions 1, 8, 12, 13, 15, 16, 17, 20, 21, 23, 24, 26, 27, 29, 30). The positively worded questions were measured on how nurses believe they can express and establish caring behaviors (questions 2,3,4,5,6,7, 9,10,11, 14,18,19,22,25,28).

The participants were instructed to select the number that represents how they feel about the statement as it relates to their recent work with patients in their

clinical setting. The total score of the CES is calculated by using the average score between the 15 positive and 15 negative test items. The scale requires that the participant choose a particular answer. Individuals refused to respond to an item contributing to missing data, this lack of response was considered a disadvantage.

Reliability of the Caring Efficacy Scale

The initial testing for CES reliability was performed using a convenience sample of graduating student nurses, the student nurses' preceptors, alumni, and subjects employed from three academic programs, Baccalaureate, Master's program, and Doctorate (Coates, 1997). Coates sent the survey to 144 subjects (83 graduating BS student nurses, 51 master students, and 10 nursing doctoral students) achieving a 61% to 90% response. Coates again sent the survey to another sample to 850 alumni subjects from the three programs that had graduated at least 1 year before the data collection of this study. The response rate varied according to program with overall 189 alumni subjects, all of which were included in the analysis. Besides, voluntary employees were added to the subject list. During the initial testing the CES, Coates compared the initial Form A with Form B and found that no significant difference between the two forms. Coates reported Cronbach's alpha of 0.85 for Form A and a Cronbach's alpha reliability of 0.88 for Form B. Meretoja & Leino-Kilpi (2001) in reviewing the literature for instruments that measure nursing performance, found the instrument to have a reliability of equivalence, assessed by using inter-judge reliability and reported Cronbach's alpha of 0.83–0.96 for the CES (Meretoja & Leino-Kilpi, 2001). Watson (2002) inciting an unpublished study by Coates (1997) describes a study that assessed the effects of training based on empowerment and Watson's caring theory.

A sample of 118 healthcare workers was given the CES and Maslach Burnout Inventory. Watson reported a Cronbach's alpha of 0.91 on the pretest and 0.84 on the posttest in this study. Manojlovich (2005b) used the CES in a descriptive comparative survey type study investigating a link between empowerment and nurses' self-efficacy to professional nursing practice behaviors. Using a homogeneous randomly selected sample of 500 medical-surgical nurses (308 usable surveys were returned and used for analysis) the researcher measured structural empowerment and self-efficacy.

In this study the researcher reported a Cronbach's alpha of 0.89 for the CES. Sadler (2003) conducted a study to measure caring efficacy of 193 baccalaureate nursing students in their last semester was asked to participate that completed Form B, Salder reported a Cronbach's alpha of 0.90.

The validity of the Caring Efficacy Scale

The original study by Coates was contained 46-items was reviewed by nursing faculty members in the United States and Canada. Faculty members of the University of Colorado Center assessed the current CES Form B self-reporting instrument for content validity for Human Caring. The faculty members found that the CES appropriately represented Watson's carative factors and reported that three of the items presented one of the carative factors, 11 items represented two factors, and 13 represented three of the carative factors. The actual factors that were represented were not reported (Coates, 1997). Concurrent validity was investigated by comparing the two measures of caring: CES and clinical competency (CET), a known measure of caring performance. Using a two-tailed test, examined in graduate nurses and their preceptors, alumni of various

programs, and employers of those subject's concurrent validity, Coates (1997) reports limited correlation between the CES and CET instruments with the graduate nurses but a greater correlation between CES and CET was found with the alumni sample.

TRANSLATION OF RESEARCH TOOLS AND INSTRUMENTS

Both of the intended tools for the study were nurse quality, and safety self-inventory scale, Biscotti (2013) and caring efficacy scale, Coates (1997): Since one of the main goal of this study were to gain a multi-cultural perspective regarding nurse competency and caring efficacy in culturally-diverse setting such as here in Doha, Qatar, where professional nurses were composed of local national (Qatar) and mostly, professional nurses came from south Asia (India) and southeast Asia (Philippines) as well as neighboring Middle East countries like Jordan, Tunisia, Pakistan, Morocco, and Sudan. The researcher believed that the translation of the research tool to other languages such as Arabic is considered. Upon approval of the author regarding the translation of the tool to another language, the researcher sought expert assistance in translating the said tools to encourage participation from professional nurses such as local national and expatriate, to facilitate for easier data collection. Translation of the 3-part questionnaire as well as the research invitation was facilitated and validated by the affiliated and accredited legal translating agencies.

METHOD AND PROCEDURE OF DATA COLLECTION

Data collection commenced following from the approval of the research study from the chief nurse of the medical services department under the ministry of interior, and the IRB of the academic institution at the University of the Philippines Open

University. Once the necessary approval was secured from both university and the participating institution, the eligible and potential respondents were approached and contacted by the researcher personally. A master list of all nurses that were obtained from the chief nurse with the permission of the immediate nurse supervisor of the involved facility was used to ensure the total number of staff nurses. The nature and purpose of the study were then disclosed to the respondents and they were given a questionnaire packet, written either in English or Arabic as per their preference, containing the survey packet questionnaire contained a cover letter that includes a description of the study, approximate length of time needed to complete the instruments, the voluntary nature of participants and the methods of confidentiality.

Also, the survey packet questionnaires, consisting of a socio-demographic survey, nurse quality and safety self-inventory scale, and a caring efficacy scale questionnaire. was distributed to a purposively selected sample of nurses within all the primary health care units of the medical services department (main facility and external facility) during working hours by the researcher.

The aim of the study its risks and benefits, and the instructions before answering were all be briefly explained by the researcher. Additionally, further questions regarding the study or its content were clarified. Informed consent was sought as proof of voluntary participation.

Participants were advised to strictly not to use any resources related to the current research study when answering the questionnaire. Answering of questionnaires should take no more than 30 minutes; however, collection of accomplished forms (during working hours as well) by the researcher was extended for a week to allow maximum time for the sampled nurses to decide and respond and for gathering answered forms. Questionnaires are screened for

missing data while the researcher is in contact with the participants. Missing data are recovered if possible or managed appropriately before encoding and analysis to maintain the statistical power of the study. If missing data are hardly retrievable, questionnaires with missing data were not analyzed and deducted from the total response rate. Information of the respondents was kept confidential at all times.

As per the instructions indicated in the research questionnaire packet they received, completed questionnaires were kept in the sealed envelope and submitted to the bin located on the designated nursing reception area. All the research questionnaires were then collected by the researcher and temporarily stored in a safe place with a key while awaiting data collation and analysis. Data collection lasts for 3 months. After data collection and analysis, managing the answered packet questionnaires were kept by the researcher for safekeeping for a maximum of five years as per UPOU ERB Guidelines and post-study data and findings collected were not be utilized for any other purposes for compliance on strict confidentiality of data aside from what is stated in the study and participants were not be revealed in case of public presentation or publication.

PLAN FOR DATA ANALYSIS AND MANAGEMENT

Data gathering was entered into IBM Statistical Package for the Social Sciences (SPSS) Statistics 20.0 software. Descriptive statistics were used to summarize the collected data. Frequency and univariate statistics (mean, standard deviation, percentage) were run for all continuous variables nurse competency (NQSSI scale), caring efficacy (caring efficacy scale), and demographic data.

Accordingly, a level of 0.05 was used for all inferential statistics. To compare differences in socio-demographics to nurse competency and caring efficacy in the primary health care unit of the medical services department.

ONE-SAMPLE KOLMOGOROV SMIRNOV TEST was used to determine if the data is normally distributed. If it is, then we use Parametric tests like T-test, One-way ANOVA. Hence, if it is not, we use Non-Parametric tests like (ANOVA).

Figure 3: One-Sample Kolmogorov-Smirnov Test

One-Sample Kolmogorov-Smirnov Test								
	Gender	Age	Nationality	Marital Status	Ed Status	Length of Nursing Experience	Length of Nursing Service	Practice Area
N	102	102	102	102	102	102	102	102
Normal Mean	1.6078	2.1765	1.1961	1.7843	3.0098	2.7941	1.7353	2.7549
Parame Std. Deviation ^b	.49064	.51534	.44587	.45874	.29835	.88260	.81964	1.17259
Most Absolute	.396	.399	.493	.446	.464	.208	.266	.228
Extrem Positive	.284	.399	.493	.300	.464	.208	.266	.148
Differen Negative	-.396	-.307	-.330	-.446	-.448	-.200	-.185	-.228
Kolmogorov-Smirnov Z	3.997	4.027	4.984	4.500	4.687	2.101	2.688	2.307
Asymp. Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000

a. Test distribution is Normal.

b. Calculated from data.

Since p-values are less than .05 alpha-level of significance, we reject the null hypothesis for each variable that the distribution is normal. This implies that the distribution of all independent variables is not normal and hence, non-parametric tests

are used. Therefore, Kruskal Wallis and Mann-Whitney U were used for non-parametric data.

Kruskal Wallis Test was used as a nonparametric test that determines if there are statistically significant differences between two or more groups of an independent variable on a continuous or ordinal dependent variable. It is then, considered the nonparametric alternative to the one-way ANOVA and an extension of the Mann-Whitney U Test to allow the comparison of more than two independent groups. Meanwhile, the Mann-Whitney U test was used to compare the differences between two independent groups when the dependent variable, which is either ordinal or continuous.

On the other hand, Correlational analysis (Spearman's rho) was used to determine the relationship between the mean score of the nurse competency (NQSSI) and caring efficacy (CES) alongside with the socio-demographics. Nurse Competency for nurses would be measured using the Quality and Safety Self-Report Scale developed by Piscotty (2013) and Self-efficacy in nurses would be measured using the Caring Efficacy Scale previously developed by Coates (1997).

ETHICAL CONSIDERATIONS

Before the start of data collection, the researcher sought guidance from the involved academic institution (University of the Philippines, Open University) and the chief nurse of the medical services department under the ministry of interior, Doha, Qatar as the participating facility. The researcher sought approval from the research committee as well as the Ethics committee of the academic institution and the participating institution to ensure that ethical considerations were strictly observed throughout the study.

A master list of all nurses was obtained from the chief nurse with the permission of the immediate nurse supervisor of the involved facility was used to ensure the total number of staff nurses. Upon approval of the Institutional Review Board (IRB) at the University of the Philippines, Open University and the participating facility at the Ministry of Interior, Medical Services Department, Doha, Qatar.

The researcher then communicates a formal letter of cooperation, to proper channels and addressed to immediate supervisors of the nursing department in different areas of primary health care units. Staff Nurses in the ministry of interior, medical services department in Doha, Qatar (main facility and external facility) were eligible to participate in the study securing a verbal consent before data collection and to ensure that the participant is well aware of the purpose of the study and the nature of their participation.

Questionnaires were concise and respondents are oriented about the study before securing informed consent. As per the instructions indicated in the research questionnaire packet they received, completed questionnaires were kept in the sealed envelope and submitted to the bin located on the designated nursing reception area.

As per agreement with the chief nurse of the ministry of interior, medical services department in Doha, Qatar, completion of the three-part questionnaire serves as consent to respondents to participate in the study, hence, a written letter of approval of the research study and informed consent is necessary.

The participant's response was assured that anonymity and confidentiality were exercised throughout the study and that their responses are not affected by their nursing practice and job performance. To ensure anonymity and confidentiality,

the questionnaires were distributed to those who are eligible to participate following the inclusion criteria of the research study and the answers does not bear any identifiable information.

It is only indicated the respondent number is utilized for data collation and analysis. They were given ample time, not more than 30 minutes, and to ask the researcher regarding any concerns about their participation in the study as well as to answer the three-part questionnaire to the best of their knowledge. With follow-up, questionnaire turn-over time usually ranges from 1 day to 4 weeks. Once finished answering the questionnaire, they were asked to seal the packet containing the research packet questionnaires and submit it to the designated bin located in the nursing reception area. Only the researcher was allowed to open it for data collation. Participants were reassured that their responses to the questions would not be divulged to other personnel outside the study and participants were not be revealed in case of public presentation or publication.

CHAPTER 4

RESULTS AND DISCUSSIONS

This study primarily aims to investigate the level of nurse competency and perceived level of caring efficacy among nurses in the primary health care units of the medical services department of the ministry of interior, Doha, Qatar. The analysis is presented and arranged according to the objectives of the study. This chapter discusses findings and interpret the results of the study as to sociodemographic profile, level of nurse competency, level of caring efficacy, and provides evidence to accept or reject the null hypothesis.

Table 1. Socio-demographic Profile of the Respondents

Characteristics	Frequency (<i>N</i>)	Percentage (%)	Mean (<i>M</i>)	Standard Deviation (<i>SD</i>)
Sex				
Male	40	39.2		
Female	62	60.8		
Age			36.98	5.72
20 – 30 years old	6	5.9		
31 – 40 years old	72	70.6		
More than 40 years old	24	23.5		
Nationality				
Filipino	84	82.4		
Indian	16	15.7		
Others (Morocco, Lebanese)	2	2.0		
Marital Status				
Single	24	23.5		
Married	76	74.5		
Separated	2	2.0		
Educational Status				
Associate	4	3.9		
Baccalaureate	93	91.2		
Masters	5	4.9		

Practice Area				
Emergency	22	21.6		
Dental	19	18.6		
Out-Patient	23	22.5		
Outside Clinic	38	37.3		
Length of Nursing Experience			2.94	1.20
0 to 5yrs	6	5.9		
6 to 10yrs	34	33.3		
11 to 15yrs	37	36.3		
More than 15yrs	25	24.5		
Length of Nursing Service			1.74	0.82
0 to 5yrs	46	45.1		
6 to 10yrs	42	41.2		
11 to 15yrs	9	8.8		
More than 15yrs	5	4.9		

Table 1 shows the sociodemographic of the respondents. There was a preponderance of female nurses (60.8%) than male nurses (39.2%) out of 102 respondents. The mean age of nurses was 36.98 years old ($SD = 5.72$), and the majority of them were 31 – 40 years old (70.6%). Most of the nurses were Filipino (82.4%), married (74.5%), graduated with a Baccalaureate degree (91.2%). The three most popular areas of practice were emergency room (21.6 %), out-patient clinic (22.5 %), and dental clinic (18.6%). Other areas of practice such as outside clinics were prison facilities, police colleges, and police training institutes. Most held respondents who participated in the study were from the outside clinic (37.3%).

The average of the length of nursing experience was 2.94 years ($SD 1.20$). Many of the nurses had either 6 to10 years of nursing experience (33.3%) or 11 to 15 years of nursing experience (36.3%). Almost a quarter of the participants had more than 15years of nursing experience (24.5 %), and few of them had less than 6 years of nursing experience (5.9%).

However, the mean average of the length of the nursing service was 1.74 years ($SD=0.82$). Most of the nurses had 10 years or less of nursing service (86.3%), while nurses with more than 15 years of nursing service were only a few (4.9%).

Table 2. Means and Standard Deviation of Nurse Competency of the Respondents

Item	Patient-Centered Care	Mean (M)	Standard Deviation (SD)
1	I feel confident I have the necessary knowledge to practice patient- centered care	6.33	0.65
2	I feel confident I have the necessary skills to practice patient-centered care.	6.35	0.64
3	I feel confident I have the necessary attitudes to practice patient-centered care	6.38	0.63
	Overall Mean (PCC)	6.36	0.60
Item	Teamwork and Collaboration	Mean (M)	Standard Deviation (SD)
4	I feel confident I have the necessary knowledge to ensure an effective nursing practice based on teamwork and collaboration.	6.25	0.79
5	I feel confident I have the necessary skills to ensure an effective nursing practice based on teamwork and collaboration.	6.29	0.74
6	I feel confident I have the necessary attitudes to ensure an effective nursing practice based on teamwork and collaboration.	6.27	0.76
	Overall Mean (TC)	6.27	0.72
Item	Evidence-based Practice	Mean (M)	Standard Deviation (SD)
7	I feel confident I have the necessary knowledge to achieve an evidence- based nursing practice.	6.09	0.78
8	I feel confident I have the necessary skills to achieve an evidence-based nursing practice	6.07	0.82
9	I feel confident I have the necessary attitudes to achieve an evidence- based nursing practice	6.83	7.06
	Overall Mean (EBP)	6.33	2.51

Item	Quality Improvement	Mean (M)	Standard Deviation (SD)
10	I feel confident I have the necessary knowledge to participate in quality-improvement in nursing practice	6.76	7.07
11	I feel confident I have the necessary skills to participate in quality-improvement in nursing practice.	6.07	0.85
12	I feel confident I have the necessary attitudes to participate in quality-improvement in nursing practice	6.13	0.77
	Overall Mean (QI)	6.32	2.52
Item	Safety	Mean (M)	Standard Deviation (SD)
13	I feel confident I have the necessary knowledge to deliver safe nursing care	6.42	0.71
14	I feel confident I have the necessary skills to deliver safe nursing care.	6.37	0.73
15	I feel confident I have the necessary attitudes to deliver safe nursing care.	6.41	0.71
	Overall Mean (S)	6.40	0.68
Item	Informatics	Mean (M)	Standard Deviation (SD)
16	I feel confident I have the necessary knowledge to deliver safe nursing care	5.88	0.97
17	I feel confident I have the necessary skills to deliver safe nursing care.	5.83	0.97
18	I feel confident I have the necessary attitudes to deliver safe nursing care.	5.87	0.92
	Overall Mean (I)	5.86	0.92
	Total Overall Means of Nurse Competency	6.26	0.90

Table 2 shows the mean and standard deviation of the nurse competency of the respondents (n=102). The overall mean for the level of nurse competency among primary health care units of the medical services department was reported very high confidence for nurse competency in primary health care nurses under the department

of the Ministry of Interior was reported ($M= 6.26$, $SD =0 .90$). Thus, the higher mean scores the greater confidence in self-reported competency areas. A similar study in the United States conducted by Davila (2019) found a very high level of nurse competency on nurse quality and safety self-inventory and its sub-scales in two groups of registered nurses with an overall mean of $M=5.89$ and $N= 68$.

The first nurse competency subscale is **patient-centered care** including items #1 to #3, which pertains to how the nurse recognizes the patient or designee as the source of control and full partner in providing and coordinated care based on respect for patient's preference value and needs. Results on the area of patient-centered care found that levels of attitude ($M= 6.38$, $SD= 0.63$), followed by skills ($M=6.35$, $SD=0.64$), and lastly by knowledge ($M= 6.33$, $SD=0.65$) were very high as reported by the respondents. Overall, scores on the subscale of patient-centered care were considered very high ($M=6.36$, $SD= 0.60$). This signified an increase in confidence in attitude and skills base on patient-centered care involves utilizing the nursing process and effective communication skills to patients and family, keeping patient's rights, and respecting individual differences in a culturally competent manner. Denoting these key elements are central to quality patientcare is establishing a nurse-patient relationship.

Respondents of the study were mostly expatriate nurses particularly Filipino (82.4 %), baccalaureate degree holders (91.2 %), married (74.5 %), had an experienced nurse from 11 to 15 years of nursing experience (36.3%) and competent.

In a study of Albougami (2016) on the relationship between cultural competency levels and perceptions of patient-centered care among Filipino and Indian expatriate nurses working in the Saudi Arabian healthcare sector, found that demographic

variables such as age, educational attainment, marital status and years of nursing experience had a significant impact in delivering quality patient care.

Evidence from a recent study on Filipino nurses' attitudes and cultural competency in caring believed that Filipino nurses, who were born, raised, and educated in the Philippines. Filipino nurses were known to be skilled, efficient, caring, compassionate, and making them highly remarkable and valued among nurses around the world and further disclose that Filipino nurses in terms of delivering quality health care services as to patient-centered were caring and compassionate that are indicative of positive attitudes towards patients (Rubio, 2019; Sentosa Recruitment Agency, 2016).

Thus, the findings that nurses perceive that they are highly aware of individual needs and provide care based on those needs, are consistent with the globally expressed values regarding patient-centered care. The fore-mentioned results from the study and supported the subscale nurse competency on quality and safety education for nurses' competencies evidenced that building rapport includes listening, confidence, therapeutic communication, family and culture/culturally differences (Moule et al., 2008; Cronenwett et al., 2007; Alinier et al., 2006; Bremner et al., 2006; Watson, 1985).

The second competency subscale is **teamwork and collaboration** including items #4 to #6 which pertains to how the nurse functions effectively within nursing and interpersonal teams, fostering open communication, mutual respect, and shared decision making to achieve a quality of care. Results on the area of teamwork and collaboration found that levels of skills ($M=6.29$, $SD=0.74$), followed by attitude ($M=6.27$, $SD=0.76$), and lastly by knowledge ($M=6.25$, $SD=0.79$) were very high as

reported by the respondents. Overall, scores on the subscale of teamwork and collaboration were considered very high ($M=6.27$, $SD=0.72$).

Results implied that nurses possess confidently and effectively in open communications. Denoting the result from the study was mostly a baccalaureate degree (91.2%) and experienced nurses from 11-15 years of nursing experience (36.3%) from the different nursing areas.

Findings of Moreno et Al., (2013), the longer practice in the area and graduate degrees in nursing possess a better foundation of quality nursing care, efficient relationship between medical and nursing staff with managers support, proper adequacy of manpower and health care resources are the key elements in a healthy nursing environment.

Nurses (as professional employees) activities were noticed such as the use of inter-professional cooperation with other health care team members. Coordinating and escalating pertinent and relevant health information of patients to respective key personnel. Defining the roles and activities of nurses was recognized in a clinically competent manner. Effective and open communication were noted fervently by the nurses through health care team members. These essential factors are evident in the study of Barton et. Al., (2009), who assert the competency development on quality and safety education for nurses.

Also, mutual respect and trust to health care team members are essential in teamwork and collaboration as these foster avenues and opportunities of shared governance through its team members leading to quality safe and effective health care services to patients. Kholed et Al., (2017), suggested that these are elements in building a framework in inter-professional teamwork and collaboration in healthcare

The third competency subscale is **evidence-based practice** including items #7 to #9, which pertains to how the nurse integrates best practice with clinical expertise and patient/family preferences and values for delivery of optimal health care. Results on the area of evidence-based practice found that levels of attitude ($M=6.83$, $SD=7.06$), followed by knowledge ($M=6.09$, $SD=0.78$), and lastly by skills ($M=6.07$, $SD=0.82$) were very high as reported by the respondents. Overall, scores on the subscale of evidence-based practice were considered very high ($M=6.33$, $SD=2.51$). This reflected a positive attitude followed by knowledge and skills in self-reports of evidence-based practice in the study.

Respondents of the study predominantly had a baccalaureate degree (91.2%), master's degree (4.9%), and 11 to 15 years of nursing experience (36.3%). These characteristics perhaps contributed to the positive attitude in this competency area. Education and experience may be a vital element in the implementation of evidence-based practice. Valuing the concept of evidence-based practice is integral in determining the best clinical practice and the need for quality improvement to patients. Thus, reading relevant professional journals, and adhering to strict protocols and policies must be valued. Al Busaidi et Al., (2019) on their study of nurses' knowledge, attitudes, and implementation of EBP in multi-institutional and a cross-sectional study, suggested the implementation of strategies to promote EBP utilization among nurses.

Cronewett & Sherwood (2011) supported that nurses are expected to practice the spirit of inquiry, basing on the care standards on evidence and applying technology to search for evidence of best care approaches and clarifying clinical decision makings.

The fourth competency subscale is **quality improvement** including items #10 to #12, which pertains to how the nurse uses data to monitor the outcomes of care processes and use improvement of methods to design and test changes to continuously improve the quality and safety of health care system. Results on the area of quality improvement found that levels of knowledge ($M=6.76$ $SD= 7.07$), followed by attitude ($M=6.13$, $SD= 0.77$), and lastly by skills ($M=6.07$, $SD=0.85$) were very high as reported by the respondents. Overall, scores on the subscale of quality improvement were considered very high ($M=6.32$, $SD= 2.52$).

Respondents had a baccalaureate degree (91.2%), master's degree (4.9%), 11 to 15 years of nursing experience (36.3%,) and an average length of nursing service is 10 years or less (86.3%). These attributes are essential in building and supporting quality improvement such as recognizing that nursing and other health professionals are parts of the system care process that affect outcomes for patient and family, appreciate the rigorous process of quality improvement of health care delivery to patients and values own and others contribution of care in the respective unit.

Years of nursing experience and educational qualification are important contributing factors in addressing quality improvement in nursing support expertise and have a positive impact on the quality of care provided (Hill, 2010). Results in this competency area could be attributed to the foundations of learnings and education of the respondents through training and conferences for continuing education programs for nurses, skills acquisition on new development and trends in the nursing profession, and application of values and attitudes towards direct patient care.

Synthesizing the core qualities that highlight the fundamental purpose of quality improvement that provides quality, safe and effective health care services as suggested in the draft of plans in quality improvement for health care professionals (Health Foundation, 2012).

The fifth competency subscale is **safety** including #13 to #15, which pertains to how the nurse minimizes the risk of harm to patients and providers through both system effectiveness and individual performance. The reported result on this subscale on safety based on knowledge ($M=6.42$, $SD=0.71$), attitudes ($M=6.41$, $SD=0.71$), and skills ($M=6.37$, $SD=0.73$) with overall result ($M=6.40$, $SD=0.68$) indicate a very high level of confidence on safety. This indicates the principle of quality of safety on patient care is practice confidently and effectively.

Results of the study were mostly baccalaureate degree holders (91.2%), master's degree (4.9%), 11 to 15 years of nursing experience (36.3%), and an average length of nursing service is 10 years or less (86.3%). Subsequent findings in the study of Khater, Akhu-Zaheya & Alkhater (2015), affirms that degree holders and the higher number of total years of experience, the better perception of the patient safety culture will be.

Parallel to nurses' professional activities was observed, as they persuade their positive health care behavior towards patient care by utilizing the nursing process such as assessment, applying the guidelines in addressing of giving medications by minimizing and reducing medication errors, to practice the proper nursing skills properly such as handwashing, and to collaborate effectively towards other health care team members. Thus, augmenting the principles in quality and safety guidelines that are direct to patient care. Nurses who are both well-educated and experienced are in

the position to give the highest quality of care. It shows that retaining experienced nurses are essential in improving quality and patient care and safety. Thus, the fundamental component of an experienced nurse is experiential knowledge which is characterized by skillful execution of nursing procedures as well as the ability to perform complex multidisciplinary assessments and can early recognize signs of deterioration in the condition of the patient (Hill,2010).

Furthermore, as the study supports the evidence on quality in safety outcomes an integrative review on simulation and safety by Shearer (2012), as the study suggests basing on their positive personal behavior and system factors were related to components on knowledge, skills, and attitudes on the proper administration of medications, adhering to appropriate nursing skills and effective communication process to other health care team members.

The sixth and final competency subscale is **informatics** including items #16 to #18, which pertains to how the nurse utilizes the use of information and technology to communicate, manage knowledge, mitigate error, and support in decision making. Results on the area of informatics found that levels of knowledge ($M= 5.88$, $SD=0.97$), followed by attitude ($M=5.83$, $SD=0.97$), and lastly by skills ($M=5.87$, $SD=0.92$) were very high as reported by the respondents. Overall, scores on the subscale of informatics were considered very high ($M=5.86$, $SD=0.92$).

Results from the study were mostly baccalaureate degree holders (91.2%), master's degree holders (4.9%), and 11 to 15 years of nursing experience (36.3%) which are indispensable factors in the application and utilization of informatics. Recent findings reveal that nurses' educational levels have positive associations with nursing informatics utilization (Sleutel & Guinn, 1999; Marasovic, Kenney, Elliot & Sindhusake,

1997; Kahouei, Zadeh & Roghani, 2015) and years of nursing experience positively influences attitude toward nursing informatics (Kipturgo, Kivuti-Bitok, Karani & Muiva, 2014; Kahouei, Zadeh & Roghani, 2015).

Nurses recognize the time, effort, and skills require for computers such as patients' information databases and pertinent information relevant to specific treatment plans and management of patients. Nurses seek education about on patient database using a computer on the information in the different nursing areas before providing care and values the usefulness of information technology. Affirms in the study of Ilfenido (2016), on moderating effects of demographic and individual characteristics on nurse's acceptance of information system.

Moreover, Nurses are expected to provide safe care in a complex health care system in an increasingly technical environment by utilizing information and technology (Institute of Medicine, 2003). Institute of Medicine (2003) further identified one's capacity to understand the value and the use of informatics as one of the core healthcare competencies to reduce errors, manage knowledge and information, and make decisions and communicate with other health care team members.

The primary health care nurses of medical services department reported a very high level of nurse competency both in overall ($M=6.26$, $SD = 0.90$) and subscale scores of nurse quality and safety self-reported inventory, namely; Patient Centered-Care ($M=6.36$, $SD=0.60$), Teamwork and Collaboration ($M=6.27$, $SD=0.72$), Evidence-Based Practice ($M=6.33$, $SD=2.51$), Quality Improvement ($M=6.32$, $SD=2.52$), Safety ($M=6.40$, $SD= 0.68$) and Informatics ($M=5.86$, $SD=0.92$).

The result from these competencies, means that nurses increase their professional nurse competency and confidence, in core competencies of nurse quality and safety self-inventory. It would aid nurses to improve quality patient care outcomes and support the goal of quality safety education for nurses. Cronenwett et al. (2007) stated, “better prepare future nurses with the appropriate knowledge, skills, and attitudes (KSAs) necessary to continually improve the quality and safety of healthcare systems within which they work” (p. 122).

Table 3. Means and Standard Deviation of Caring Efficacy of the Respondents

Item	Caring Efficacy	Mean (<i>M</i>)	Standard Deviation (<i>SD</i>)
1	I do not feel confident in my ability to express a sense of caring to my clients/patients	5.17	1.34
2	If I am not relating well to a client/patient, I try to analyze what I can do to reach him /her	4.62	1.70
3	I feel comfortable in touching my clients/ patients in the course of caregiving	4.96	1.16
4	I convey a sense of personal strength to my clients/ patients	5.06	0.88
5	Clients/ patients can tell me most anything and I won't be shocked.	4.43	1.20
6	I have the ability to introduce a sense of normalcy in stressful conditions	5.09	0.74
7	It is easy for me to consider the multifaced of a client's / patient's care, at the same time as I am listening to them	4.96	0.93
8	I have difficulty in suspending my personal beliefs and biases to hear and accept a client/ patient as a person	3.96	1.57
9	I can walk into a room with a presence of serenity and energy that makes clients/patients feel better.	5.20	1.02
10	I am able to tune into a particular client/patient and forget my personal concerns	5.15	1.09
11	I can usually create some way to relate to most any client/ patient.	4.66	1.13

12	I lack confidence in my ability to talk to clients/patients from backgrounds different from my own	4.71	1.39
13	I feel if I talk to clients/ patients on an individual, personal basis, thing might get out of control	4.47	1.57
14	I use what I learn in conversations with clients/ patients to provide more individualized care	5.20	1.04
15	I don't feel strong enough to listen to the fears and concerns of my clients/ patients	5.01	1.37
16	Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients/patients	4.31	1.55
17	I seem to have trouble relating to clients/ patients	4.97	1.34
18	I can usually establish a close relationship with my clients/ patients.	4.00	1.42
19	I can usually get patients/ clients to like me	4.22	1.29
20	I often find it hard to get my point of view across to patients/ clients when I need to	4.10	1.28
21	When trying to resolve a conflict with a client/ patient, I usually make it worse	5.32	0.98
22	If I think a client/ patient is uneasy or may need some help, I approach that person	4.97	1.19
23	If I find it hard to relate to a client/ patient, I'll stop trying to work with that person	4.95	1.12
24	I often find it hard to relate to clients/ patients from a different culture than mine	4.59	1.36
25	I have helped many clients/ patients through my ability to develop close, meaningful relationships.	4.56	1.19
26	I often find it difficult to express empathy with clients/ patients	4.75	1.26
27	I often become overwhelmed by the nature of the problem's clients/patients are experiencing	4.29	1.14
28	When a client/ patient is having difficulty communicating with me, I can able to adjust to his/her level.	5.15	0.89
29	Even when I try, I can't get through to difficult clients/ patient	4.20	1.55
30	I don't use creative or unusual ways to express caring to my clients/patients	4.41	1.56
Total Overall Means of Caring Efficacy		4.71	0.55
Total Overall Means of Negative Questions		4.61	0.55
Total Overall Means of Positive Questions		4.81	0.57

Table 3 shows the means and standard deviation of the caring efficacy of the respondents (n=102). Caring efficacy assesses belief in one's ability to express a caring orientation and to develop caring relationships with clients or patients. The level of caring efficacy of primary health care nurses of the medical services department reveals high caring efficacy ($M=4.71$, $SD=0.55$). Thus, the higher the mean scores the more nurses perceive that they can establish and express caring behaviors.

As evidence to support a recent study conducted by Lukmanulhakim, Arifyani & Haryani (2019), highly suggested that nurses who have confidence in their ability to perform caring behavior are urgently required and it is important for nurses to build and apply caring efficacy into their selves. Furthermore, in a more recent study of caring efficacy in Italy, Gonzales, et.al (2019), on nurses' perceptions and its work-related factors. The results of participants $N=77$ scored high confidence to care for 55%.

The mean for the negatively worded statements (items 1, 8, 12-13, 15-17, 20-21, 23-24, 26-27, 29-30) which conceptually expresses the belief in one's inability or lack of confidence in establishing or expressing caring behaviors was ($M= 4.61$, $SD= 0.55$). On the other hand, the positively worded statements (items 2-7, 9-11, 14,18-19,22,25,28) which measures how nurses believe they can express and establish caring behaviors had a mean of ($M= 4.81$ $SD= 0.57$).

The three highest scores were derived from positive statements, question 9 *"I can walk into a room with a presence of serenity and energy that makes clients/patients feel better"* ($M= 5.20$, $SD=1.02$), question #14 *"I use what I learn in conversations with clients/ patients to provide more individualized care"* ($M=5.20$, $SD=1.04$) and question #28 *"When a client/ patient is having difficulty communicating*

with me, I can adjust to his/her level" ($M=5.15$, $SD=0.89$). Denoting the three positive responses from the respondents indicates they are confident to care for patients such as building and sustaining rapport with patients. They can easily grasp the organizational environment and culture of the institution; they have positive assertiveness to help their patients and eagerness to learn and cope with specific tasks.

Subsequently, Results from the data were mostly expatriate nurse's Filipino (82.4 %), baccalaureate degree (91.2 %), married (74.5 %), 11 to 15 years of nursing experience (36.3%) and competent. Evidence from a recent study on Filipino nurses' attitudes and cultural competency in caring, depicts Filipino nurses' positive traits who are sincere, patient-centered, caring and compassionate that are indicative of positive attitudes towards patients and came from a caring culture where families take care of sick and aging relatives (Rubio, 2019; Cal, 2018).

Moreover, addressing culturally competent care of Filipino nurses as evidence on the study of AISulaimani (2014) on self-efficacy of Filipino nurses in Taif, City Hospitals in Saudi Arabia, which further proves the notion that Filipino nurses as stated, even if they do not have formal education on transcultural nursing or did not attend seminars on transcultural competency, felt very confident in identifying through an interview the specific cultural factors that could influence their client behaviors in accepting or rejecting the care services to be given to them. They felt very confident that they can discuss different topics regarding culture-specific health care.

However, The three lowest means were derived from negative statements, question 8 *"I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/ patient as a person"* ($M= 3.96$, $SD=1.57$), question 20 *I often*

find it hard to get my point of view across to patients/ clients when I need to ($M=4.10$, $SD=1.28$), and question 29 *“even when I really try, I can’t get through to difficult clients/ patients”* ($M=4.20$, $SD=1.55$). Interestingly, the perceived lack of confidence in one’s ability to establish caring behaviors, doubts, and concerns to care evident in these responses was also depicted from previous research studies, possibly due to cultural practices and beliefs of an individual in a nurse-patient interaction geared towards multi-cultural therapeutic milieu.

Evidence to support as Al Sulaimani (2014), on practical competency of Filipino nurses working in Taif City, Kingdom of Saudi Arabia, stated that nurses were not certain concerning their abilities to discuss related issues openly because they were not well informed yet about the Arab culture and haven't been acculturated yet. As acculturation results when a group of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups where there is progressive adoption of ideas, words, values, norms, behavior, institutions by persons or groups of a given culture.

Moreover, the language barrier, might have contributed to the difficulty the Filipino nurses were facing in expressing themselves to determine the cultural factors that might have influenced a patient's behavior. This is consistent with the findings of Alshammari, Duff & Guilhermino (2019), integrative review on barriers to nurse-patient communication in the Arab context.

In assessing responses for individual questions, the positively worded statements had a slightly higher mean ($M= 4.81$, $SD= 0.57$) compared to the negative statements ($M= 4.61$, $SD=0.55$). Meanwhile, the overall mean ($M=4.71$, $SD=0.55$) and indicated a very high level of professional caring behavior (caring efficacy). It indicates

that nurses with higher caring efficacy, the more confident they can perform care, attention, and interventions suited for patient's needs. Nurses' professional caring behavior can give benefits to service as it increases quality care and achieves optimal health care services to patients.

Corresponding to the result of the study, age 31 to 40 years old (70.6 %), married (74.5 %) and 11 to 15 years of nursing experience (36.3%), possess higher caring efficacy and congruent to the study of Reid, Jones, Hurst, & Anderson (2018) on examining the relationship of socio-demographic and self-efficacy among registered nurses in Australia, the socio-demographic variable such as years of experience, is a predictor of enhanced care provision resulting from nurses being more knowledgeable, and having the ability and confidence to provide care to their patients and in a more recent study by Amendolair (2012), reported that age and years of nursing experience were related to nurses' perceived self-efficacy.

Previous research had comparable findings of high scores of caring efficacies. In the United States, Amendolair (2007) found a mean of ($M= 5.41$, $SD= 0.50$) in her analysis of registered nurses $N=1091$ in medical-surgical units, while Moss (2018) found a mean of ($M=5.28$, $SD =0.51$) in her study of direct patient care nurses $N=413$ in different clinical settings.

Also, Reid (2012) conducted a study on Australian registered nurses $N= 639$ across the region ($M= 5.07$, $SD= 0.49$) and discovered that all sampled nurses study results showed that one hundred percent (100 %) of nurses sampled shows high caring efficacy scores on average (> 3.0).

Table 4: Relationship Between Socio-Demographics and Nurse Competency of the Respondents

Variables	Kruskal-Wallis H test	
	χ^2	<i>p-value</i>
Age	0.52	0.77
Nationality	0.30	0.86
Marital Status	1.50	0.47
Educational Attainment	9.86	.007
Years of Nursing Experience	2.10	0.55
Length of service in current practice	4.22	0.24
Nursing Practice Area	2.470	.481
Variable	Mann-Whitney U test	
	U	<i>p-value</i>
Gender	1511	.063

****level of significance $p < .05$**

As shown in Table 4, the study explores the relationship between socio-demographic variables and nurse competency among nurses of the primary health care unit of the medical services department. Mann-Whitney U test was used to compare the two groups on sociodemographic variables of gender and nurse competency, and it revealed that there is no significant difference between gender and professional nurse competency ($U=1511$, $p < .05$).

This supports the analysis of the study assessing the clinical competency and quality of life from the perspective of nurses. It is believed that professional nurse competency (along with knowledge and attitude) is a skill that all nurses should have regardless of gender (Hajbaghery, Eshraghi & Arani, 2019; Habibzadeh, Mohamadpor, Khalkhali & Ghorbanzade, 2018). Relatively, aligning with empirical evidence from a systematic review of literature on the factors that affect nurse competence found that professional nurse competency is a self-driven quest on once confidence (physical and mental) and that self-efficacy is geared towards the

therapeutic environment which was proven respectively to enhance and increase the competency of nurses in the workplace (Rizany, Hariyati & Handayani, 2018).

Moreover, the results from Kruskal-Wallis test revealed that only educational attainment ($\chi^2 = 9.86$, $p < .05$) among other sociodemographic variables of nationality, marital status, nursing practice area, age, years of nursing experience and length of service in the current practice area was significantly correlated with nurse competency. This further disclosed from the result of the study that nurses with a baccalaureate (91.2%) and master's degree (4.9%) significantly possess a higher level of nurse competency compared to those with associate degrees only.

This proves the notion of the factors that affect nurse competency as evidenced in a recent systematic review of the literature. Rizany, Hariyati, & Handayani (2017), found in their review that nurses with diplomas had lower competencies compared to nurses with a bachelor's degree and nurses with a master's degrees. Nurses with high levels of education are believed to be well equipped for patients, thus, the vital role of education in developing nurses' competencies is emphasized.

However, personal factors such as age and length of nursing experience can positively affect the development of nurses' competencies Rizany, Hariyati, & Handayani (2017).

Aqtash et Al., (2017) in his analysis of self-assessed competence of experiences expatriate nurses in rural and remote areas in UAE, also found that professional nurse competence coexists with a total length of nursing experience. with professional competencies of expatriate nurses.

Furthermore, Karami, Farokhzadian, and Foroughameri (2017), asserted that based on professional competency and organizational commitment, the level of professional competency in married individuals was higher compared to unmarried individuals.

Table 5: Relationship Between Socio-Demographics and Caring Efficacy of the Respondents

Variables	Kruskal-Wallis H test	
	χ^2	<i>p-value</i>
Age	4.77	0.31
Nationality	0.50	0.97
Marital Status	2.94	0.59
Educational Attainment	16.54	.002
Years of Nursing Experience	6.13	0.41
Length of service in current practice	6.83	0.34
Nursing Practice Area	4.97	0.55
Variable	Mann-Whitney U test	
	U	<i>p-value</i>
Gender	888	0.45

****level of significance $p < .05$**

Table 5 as shown that the study explores the relationship between socio-demographic variables of age, gender, nationality, marital status, educational attainment, years of nursing experience, length of nursing experience in the current practice area, nursing practice area, and caring efficacy of nurse respondents. Mann-Whitney U test was used to compare the two groups on sociodemographic variables of gender and caring efficacy, and it revealed that there is no significant difference between gender and caring efficacy ($U=888$, $p < .05$).

A recent, comparable study finding on caring efficacy to improve nurse caring behaviors in two hospitals in Indonesia showed that there were no significant differences between gender, age, educational level, work experience, and length of

work and caring behavior of nurses. The study revealed that organizational and cultural backgrounds including motivations and knowledge such as training on professional caring behavior could influence the underlying attitude of a particular behavior or actions and that entails once caring behavior that is built on caring attitude, compassion, skills, empathy, responsibility, sensitivity, and support (Surbakti, Novieastari & Nuraini, 2019).

Moreover, the Kruskal-Wallis test revealed that only educational attainment ($\chi^2=16.54$, $p<.05$) among sociodemographic variables of age, gender, nationality, marital status, educational attainment, years of nursing experience, length of nursing experience in the current practice area, nursing practice area and caring efficacy. It shows that there is a significant relationship on educational attainment, among all these sociodemographic variables. The statistically significant relationship found between the educational attainment and caring efficacy in this study concludes that nurses with a higher level of education are more compelling in delivering quality patient care. Subsequently, the results from the study were mostly baccalaureate degree holders (91.2%), master's degree (4.9%). Thus, the role of education is critical in developing professional caring behaviors.

This is supported by an investigation on the effects of self-efficacy, affectivity, and collectively caring efficacy in Taiwan wherein, higher education levels showed higher caring scores Lee and Ko (2010). Further, more caring attributes were also noted among gerontological nurses with higher levels of education (Schofield et Al., 2005).

The findings of this study negate the evidence that age and years of experience coincide in providing care effectively on other relevant studies in the United States and

Australia (Amedolair,2012; Reid, 2018). Further, age and length of time working in the specialty area of geriatric nursing were also associated with higher levels of caring attributes (Schofield et al., 2005). Relatively as reported, being married significantly showed a higher level of perceived caring efficacy among nurses (Reid, 2018).

Table 6. Correlation of Nurse Competency and Caring Efficacy of Respondents

Variable		Nurse Competency	Caring Efficacy
Nurse Competency	Correlation Coefficient	.298**	1.00
	p-value	.002	.
	N	102	102
Caring Efficacy	Correlation Coefficient	1.00	.298**
	p-value	.	.002
	N	102	102

****.** Correlation is significant at the 0.05 level (2-tailed).

Moreover, as shown in TABLE 6 displays the relationship between nurse competency and caring efficacy. Spearman's rho (r_s) test revealed that the correlation coefficient is ($r_s = 0.298$) which can be interpreted as a weak relationship. Furthermore, since the p-value of .002 is less than .05 alpha-level of significance.

The study showed that there was a significant relationship between nurse competency and caring efficacy. Specifically, nurse competency had a significant, positive, and direct but weak relationship to caring efficacy. This suggests that nurse competency increases with increasing caring efficacy.

Nurse competency is a vital element in the provision of nursing care. It is a synthesis of skills, knowledge, attitudes, values, and abilities in providing safe, effective, and quality care to individuals, family, and communities

Thus, having professional nurse competency leads to professional caring behavior that directly affects safe and quality health care delivery. It also increases

patient satisfaction, helps promote nursing as a profession, and improves nursing education and clinical nursing practice. For instance, as nurse competency increases caring efficacy is likely to increase.

Similar to a recent US study conducted by Moss (2018), found moderate relationships between overall nurse competence and caring efficacy.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

The study analyzed significant findings on the nurse competency and caring efficacy among primary health care nurses of the medical services department under the Ministry of Interior, in Doha, Qatar. The study involved nurses from a government entity in the gulf region. For a period of three months which lasted from October to December 2019. Data collection was facilitated through the use of a three-part questionnaire, which was written both in English and Arabic, and was distributed via a purposive sampling method to the eligible subjects who met the pre-determined inclusion criteria. The total sample of all nurse participants was $N=165$. A total of 102 respondents who met the criteria, were successfully enrolled in the study, and were able to answer the questionnaires. The average length of time spent in completing the survey was 30 minutes. Particularly, this study determined (1) the level of nurse competency on self- reported scale (NQSSI), (2) the level of caring efficacy (CES), (3) the relationship between sociodemographic variables such as age, gender, nationality, marital status, educational attainment, years of nursing experience, length of service in the current practice, nursing practice area and nurse competency, (4) the relationship between sociodemographic variables such as age, gender, nationality, marital status, educational attainment, years of nursing experience, length of service in the current practice, nursing practice area and caring efficacy and (5) the relationship of nurse competency and caring efficacy and provides evidence to accept or reject the null hypothesis.

Descriptive statistics indicated more than half of all nurses had a minimum of BSN degree (91.2%). The mean average age of nurses was 36.98 years old ($SD = 5.72$), and the majority of them were 31-40 years old (70.6%). There was a predominance of female nurses (60.8%) than male nurses (39.2%) who participated in the study. Most of the nurse respondents were Filipino ex-pats (82.4%), married (74.5%), from the outside clinic (37.3 %). The mean average length of nursing experience was 2.94 years ($SD 1.20$). Most of the nurses had either 6 to 10 year of nursing experience (33.3%) or 11 to 15 years of nursing experience (36.3%). Almost a quarter of the participants had more than 15years of nursing experience (24.5%), and few of them had less than 6 years of nursing experience (5.9%). The mean average of the length of the nursing service was 1.74 years ($SD= 0.82$) wherein most of the nurses had 10 years or less of a nursing service (86.3%). Nurses with more than 10 years of nursing service are only a few (13.7%).

Data was gathered and analyzed to provide answers to the specific research questions as well as to provide evidence to prove or disprove the research hypotheses. The nurse competency self-reported scale scored a very high level of nurse competency both in overall ($M=6.26$, $SD =0.90$) and subscale scores on Patient-Centered Care ($M=6.36$, $SD= 0.60$), Teamwork and Collaboration ($M=6.27$, $SD=0.72$), Evidence-Based Practice ($M=6.33$, $SD=2.51$), Quality Improvement ($M=6.32$, $SD=2.52$), Safety ($M=6.40$, $SD=0.68$) and Informatics ($M=5.86$, $SD=0.92$). The correlation of sociodemographic variables to nurse competency found that there was a significant relationship on educational attainment among all the variables on the Kruskal-Wallis test ($\chi^2 = 9.86$, $p<.05$).

Moreover, the overall caring efficacy score with a mean ($M=4.71$, $SD=0.55$) and $N=102$ indicated a very high level of professional caring behavior (caring efficacy). Also, while assessing individual responses to the questions, the positively worded statements had a slightly higher mean ($M= 4.81$, $SD=0.57$) compared to the negative statements ($M= 4.61$, $SD= 0.55$). The correlation of sociodemographic variables to caring efficacy revealed that there was a significant relationship on educational attainment among all the variables on the Kruskal-Wallis test (χ^2 16.54, $p<.05$).

Furthermore, the relationship between nurse competency and caring efficacy reveals that there was a significant relationship between nurse competency and caring efficacy. Specifically, nurse competency and caring efficacy had a significant positive but weak relationship. Spearman's rho (r_s) test revealed that the correlation coefficient was ($r_s =0.298$, $p<.05$).

The results from this study showed that nurses reported a high nurse competency and caring efficacy based only on educational qualification. The correlation of nurse competency and caring efficacy shows a positively significant but weak relationship.

Conclusion

Several studies aimed to explore the levels of nurse competency and professional caring behavior (caring efficacy) across sociodemographic. There are factors to consider in relevance to the socio-demographic profiles of nurses. Some factors to consider are professional competency which involves the knowledge, skills, and attitudes of the nurse. Besides, other covariates might consider includes age, gender, nationality, marital status, educational qualification, length of service in the

nursing, years of nursing experience, and nursing area of practice. Interestingly, the educational qualification appears to be the dominating factor in the result of the study.

The study showed that there was a significant relationship between nurse competency and caring efficacy. Specifically, nurse competency had a significant, positive, and direct but weak relationship to caring efficacy. This suggests that nurse competency increases with increasing caring efficacy. Nurse competency is a vital element in the provision of nursing care. It is a synthesis of skills, knowledge, attitudes, values, and abilities in providing safe, effective, and quality care to individuals, families, and communities. Thus, having professional nurse competency leads to professional caring behavior that directly affects safe and quality health care delivery. It also increases patient satisfaction, helps promote nursing as a profession, and improves nursing education and clinical nursing practice. For instance, as nurse competency increases caring efficacy is likely to increase.

Recommendations

With the foreknown results, this study requires implications and recommendations as suggested to strengthen both nurse competency and professional caring behavior (caring efficacy). To increase knowledge and cognizance of nurse competency towards professional development. It creates an avenue of opportunities that can impact both nurse competency and caring efficacy for practicing nurses. The use of performance evaluations that allow nurses to assess the practice gaps and focus on competencies that need to be developed.

Nursing Practice and Research

There is a need to address the gap in both nurse competency and professional caring behavior by giving a quality, safe and effective health care delivery to patients; (1.) it is essential to exercise strategic plans and management to direct patient-care such as protocols, policies and procedures as mandated by international standard of nursing practice, (2.) the application of critical thinking and shared governance to promote evidence-based practice is needed in clinical decision making within multicultural milieu, (3.) drawing on knowledge and skills in working in information system, utilizing nursing informatics to aid nurses in the intricate and technicalities in healthcare system, (4.) creating and supporting research committees, to enhance the knowledge and skills of nurses and to support the ever-changing needs of health care delivery and (5.) applying the competencies of quality and safety education for nurses which is eminently publicized its core competencies and to strengthen each subscale on patient-centered care, teamwork and collaboration, evidence-based practice, safety and informatics.

Nursing Administration

Achieving quality health care delivery is vital to organizational stakeholders, to fervently hear the voices of the nurses in terms of structural empowerment of the staff; (1) building a framework of health care programs and creating a system of health care process to coordinate properly through different respective channels, (2) realigning the plans and management of particular unit to address areas requiring for improvement and choosing the right key personnel who is appropriate and eligible to mandate a particular unit, (3) formulation of educational training for new staff in Arabic culture to abide the complexity and diversity in a multicultural milieu and to meet the

standard of culturally competent nurse (4) improving nursing staff in establishing unit-based council to address the health care issues and reforms to give value in providing patient care and nurse satisfaction, (5) instituting an in-service education, training and seminars for staff nurses to improve professional competency and caring behavior that opt to quality safe and effective health care delivery, (6) establishing an adequate manpower to each particular unit and to ensure that there would be enough and available nurses to attend to patients needs and demands that is essential to direct patient care (7) adequate compensation for nurses should address the present health care demands and growing needs of patients to provide a satisfaction for both nurses and organizational stakeholders and (8) allocation of resources such as medical equipment that aides nurses in quality health care delivery for patients.

Nursing Education

To strengthen both professional nurse competency and caring behavior (caring efficacy). It is essential in health care delivery for the transformation of nurses in acquiring professional education and to concede on channels of nursing core competencies and opportunities; (1) building a continuous education program for nurses to learn and apply the up-to-date scale in present clinical practice (2) establishing a nurse educator to enhance nurses on their professional competency and remodeling a transformative leadership on individual nurses, (3) providing a patient educator to help the patient to establish and achieve optimal health care outcome as directed by the nurse, physician and patient, (4) implementing a nurse preceptorship role in every unit to acquire the necessary attributes such as protocols, procedures and plans of management in the institution and (5) creating a framework of the performance appraisal for core nursing competencies congruent to the performance evaluation scale which was set by the organizational stakeholders.

To further disclose, to bridge the gap in research regarding nurse competence and caring efficacy for nurses who perform in the proficient and expert levels of practice. Several recommendations for future research arise from this study, including:

1. Replication of the study using a larger, heterogeneous sample.
2. An examination of the relationship between practicing nurses' self-reported caring behaviors and patient perceptions of nurse's caring.
3. An exploration of additional factors that may impact the connection between competence and caring.
4. Further exploration of the relationship on other sociodemographic variables and other levels of competencies with the frequency of use of those competencies.

REFERENCES

- American Association of Colleges of Nursing [AACN]. (2008). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC:Author.
- Abrahamson, K., Fu, R., Pressler, K., Fulton, B. R., Morgan, K. H., & Anderson, J. G. (2018). Organizational Role and Perception of Organizational Safety Culture: A Survey of Registered Nurses, Physicians, and Managers. *OJIN: The Online Journal of Issues in Nursing*, 23(3).
- Aldosari, B., Al-Mansour, S., Aldosari, H., & Alanazi, A. (2018). Assessment of factors influencing nurses' acceptance of electronic medical records in a Saudi Arabia hospital. *Informatics in Medicine Unlocked*, 10, 82-88.
- Alquraini, H., Alhashem, A. M., Shah, M. A., & Chowdhury, R. I. (2007). Factors influencing nurses' attitudes towards the use of computerized health information systems in Kuwaiti hospitals. *Journal of Advanced Nursing*, 57(4), 375-381.
- Albougami, A. (2016). The relationship between cultural competency levels and perceptions of patient-centered care among Filipino and Indian expatriate nurses working in the Saudi Arabian healthcare sector (Order No. 10189576). Available from ProQuest Dissertations & Theses Global. (1880540913).
- Alligood M.R. (2013). Nursing theory: utilization & application. *Elsevier Health Sciences*.
- Azimi, L., & Bahadori, M. (2012). The Effect of Safety Culture Education on the improvement of Managers' Attitudes towards Patients' Safety. *International Journal of Collaborative Research on Internal Medicine & Public Health*, 4(3), 0-0.
- Bahreini, M., Moattari, M., Shahamat, S., Dobaradaran, S., & Ravanipour, M. (2013). Improvement of Iranian nurses' competence through professional portfolio: A quasi-experimental study. *Nursing & health sciences*, 15(1), 51-57.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191-215.
- Barton, A. J., Armstrong, G., Preheim, G., Gelmon, S. B., & Andrus, L. C. (2009). A national Delphi to determine the developmental progression of quality and safety competencies in nursing education. *Nursing Outlook*, 57(6), 313-322.

- Benner, P. (2001). From novice to expert: Excellence and power in clinical nursing practice (Commemorative edition ed.). Upper Saddle River, NJ: Prentice-Hall Health.
- Benner P, A Response by P Benner to K. Cash, Benner and expertise in nursing: a critique". *International journal of nursing studies*, 33, 1996, 669-674.
- Benner PE, Tanner CA & Chesla CA, Expertise in nursing practice: caring, clinical judgment, and ethics, springer publishing company, 2009.
- Bergquist-Beringer, S., Davidson, J., Agosto, C., Linde, N. K., Abel, M., Spurling, K., Dunton, N., & Christopher, A. (2009). Evaluation of the National Database of Nursing Quality Indicators (NDNQI) training program on pressure ulcers. *The Journal of Continuing Education in Nursing*, 40(6), 252-258.
- Bertch, D. A. (2012). Quality and safety education in newly hired RNs and RNs in staff leadership roles.
- Blegen, M. A., Vaughn, T. E., & Goode, C. J. (2001). Nurse experience and education: effect on the quality of care. *JONA: The Journal of Nursing Administration*, 31(1), 33-39.
- Berghout, M., van Exel, J., Leensvaart, L., & Cramm, J. M. (2015). *Healthcare professionals' views on patient-centered care in hospitals*.
- Brown, R., Feller, L., & Benedict, L. (2010). Reframing nursing education: The Quality and Safety Education for Nurses initiative. *Teaching and Learning in Nursing*, 5(3), 115-118.
- Brumini, G., Ković, I., Zombori, D., Lulić, I., & Petrovečki, M. (2005). Nurses' attitudes towards computers: a cross-sectional questionnaire study. *Croatian medical journal*, 46(1).
- Boykin, A., & Schoenhofer, S. (2001). *Nursing as caring: A model for transforming practice*. Sudbury, CT: NLN.
- Burns, N., Grove, S. K., & Gray, J. (2015). *Understanding nursing research: building an evidence-based practice*. 6th edition. St. Louis, Missouri: Elsevier.
- Carnegie Foundation Report. (2010). *Educating nurses: A call for radical transformation*.
- Cash K., and Benner (1995). Expertise in nursing: a critique. *International journal of nursing studies*, 32, 527-534.
- Carlone, J. B., & Igbirieh, O. (2014). Measuring attitudes and knowledge of evidence-based practice in the Qatar nursing workforce: A quantitative

- cross-sectional analysis of barriers to empowerment. *Avicenna*, 2014(1), 5.
- Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., ... & Warren, J. (2007). Quality and safety education for nurses. *Nursing outlook*, 55(3), 122-131.
- Coates, C. (1997). The caring efficacy scale: Nurses' self-reports of caring in the practice setting, *Advanced Practice Nursing Quarterly*, 3(1), 53-59. Retrieved May 23, 05 from ILL (5552181).
- Dalhem, W. A., & Saleh, N. (2014). The impact of eLearning on nurses' professional knowledge and practice in HMC. *Canadian Journal of Nursing Informatics*, 9(3-4), 1-14.
- Dolansky, M.A., Moore, S.M., (September 30, 2013) "Quality and Safety Education for Nurses (QSEN): The Key is Systems Thin: *The Online Journal of Issues in Nursing*, Vol. 18, No. 3, Making" OJINnuscrypt 1.
- Dossey, B. M., & Hess, D. (2013). Professional nurse coaching: advances in national and global healthcare transformation.
- Edwards, Steven (2001). *Philosophy of Nursing: An introduction*. Palgrave, Hampshire
- Elhami, S., Ban, M., Mousaviasl, S., & Zahedi, A. (2018). Self-Evaluation of Nurses Clinical Competency based on Benner Theory. *Middle East Journal of Family Medicine*, 7(10), 191-7.
- Encourage, I. I. D. (2012). **Quality improvement training for healthcare professionals.**
- Esslin, P. (2016). *Psychometric Evaluation of the Knowledge, Skills, and Attitudes-Part I: Patient-Centered Care Scale (KSAI-PCCS): A Pilot Study* (Doctoral dissertation, [Honolulu]:[the University of Hawaii at Manoa],[December 2016]).
- Finkelman, A. & Kenner, C. (2013). *Professional nursing concepts: Competencies for quality leadership*. Burlington, MA: Jones & Bartlett Learning.
- Gonzalez, C. I. A., Galletta, M., Melis, P., Contu, P., Watson, J., Finco, G., & Herrera, M. F. J. (2019). *Cultural adaptation and psychometric validation of the Caring Efficacy Scale in a sample of Italian nurses*. PloS one, 14(5).
- Hargreaves, J., & Lane, D. (2001). Delya's story: from expert to novice, a critique of Benner's concept of context in the development of expert nursing practice. *International journal of nursing studies*, 38(4), 389-394.

- Hess, D., & American Nurses Association. (2013). *The Art & Science of Nurse Coaching: The Provider's Guide to Coaching Scope and Competencies*. Silver Spring, Md: American Nurses Association.
- Ifinedo, P. (2016). The moderating effects of demographic and individual characteristics on nurses' acceptance of information systems: a Canadian study. *International journal of medical informatics*, 87, 27-35.
- Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academies Press.
- International Council of Nurses. (2010). *Definition of Nursing*.
- Keating, S. B. (2017), *Curriculum Development and Evaluation of Nursing. Fourth Edition*
- Karami, A., Farokhzadian, J., & Foroughameri, G. (2017). Nurses' professional competency and organizational commitment: Is it important for human resource management? *PLoS One*, 12(11), e0187863.
- Kholed, S. N. S., Hassan, N. M., Ma'on, S. N., & Hamid, N. Z. A. (2017). Teamwork and Collaboration in Healthcare: Elements of Inter-Professional Teamwork. *Advanced Science Letters*, 23(11), 10834-10837.
- Lukmanulhakim, L., Afriyani, A., & Haryani, A. (2019). Caring Efficacy and Nurse Caring Behavior in Taking Care of Critical Patients. *Jurnal Ners*, 13(2), 55-61.
- Lusk, D. (2016) "*Comparing the Knowledge, Skills, and Attitudes of Newly Hired Nursing Staff Before and After Implementation of a Quality and Safety Competency-Based Nursing Orientation Program*". All Regis University Theses. 840.
- MAN, R. R. M. A. R. (2019). Filipino Nurses' Attitudes and Cultural Competency in Caring for Mentally Ill Patients: A Scoping Review. *International Journal of Caring Sciences*, 12(2), 1-12.
- Mungania, P. (2003). *Seven e-learning barriers facing employees*: Executive summary of the dissertation. Academia.edu
- Meleis A.I. (2001). *Theoretical nursing: development and progress*. Lippincott Williams & Wilkins.
- Meretoja, R., & Leino-Kilpi, H. (2001). Instruments for evaluating nurse competency. *Journal of Nursing Administration*, 31(7/8), 346-352.

- Meretoja, R., Isoaho, H., & Leino-Kilpi, H. (2004). Nurse competency scale: development and psychometric testing. *Journal of advanced nursing*, 47(2), 124-133.
- Moatary, M., Akaberian, S., & Mirzaie, K. (2008). Determining nurses' clinical competency in hospitals of Bushehr University of Medical Sciences by self-assessment method. *ISMJ*, 11(1), 69-75.
- Mohammadi E, Abbasi K, Saadati M, Barriers to implementation of nursing theories in clinical practice from the perspective of nurses. *Iranian journal of nursing research*, 10, 2015, 13-24.
- Morrow, M. (2013). *Caring in Nursing Classics: An Essential Resource* (2013).
- Marlaine C. Smith, Marian Turkel, & Zane Robinson Wolf (Eds.). New York: Springer Publishing Company and Watson Caring Science Institute. *Nursing science quarterly*, 26(4), 380-382.
- Moss, E. (2018). *Examining the relationship between self-reported competency and caring efficacy in registered nurses* (Order No. 13804280). Available from ProQuest Dissertations & Theses Global. (2160649580).
- National League for Nursing. (2003). *Position statement: Innovation in nursing education: A call to reform*.
- Neal-Boylan, L. (2010). Book review: Benner P, Tanner C, Chesla C, Expertise in nursing practice: caring, clinical judgment, and ethics, second edition, Springer Publishing: New York, 2009, 497 pp.: 9780826125446. *Nursing Ethics*, 17(5), 675– 675.
- Nieswiadomy, R.M. (2002). *Foundations of nursing research* (4th ed.). Upper Saddle River, NJ: Pearson Education.
- Oshvandi, K., Moghadam, A. S., Khatiban, M., Cheraghi, F., Borzu, R., & Moradi, Y. (2016). On the application of novice to expert theory in nursing; a systematic review. *Journal of Chemical and Pharmaceutical Sciences*, 9(4), 3014-3020.
- Quality and Safety Education in Nursing [QSEN]. (2014). *AACN launches free QSEN learning module series*.
- Polit, D., & Beck, C. (2004). *Nursing research: Principle and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Polit, D., & Hungler, B. (1999). *Nursing research: Principles and methods* (5th ed.). London: Lippincott.

- Piscotty, R., Grobbel, C., & Abele, C. (2013). Psychometric evaluation of the Nursing Quality and Safety Self-Inventory: A self-report measure of quality and safety knowledge, skills, and attitudes. *Journal of Nursing Education*, 52(5), 269- 274.
- Rafat S, Gharib A, Rafat S & Rahimi F (2015). Related factors in medication error based on nurses' self-report in Sanandaj, Iran. *Der Pharmacia Lettre*, 7, 2015, 198- 201.
- Reid, C., Jones, L., Hurst, C., & Anderson, D. (2018). Examining relationships between socio-demographics and self-efficacy among registered nurses in Australia. *Collegian*, 25(1), 57-63.
- Regnier, K., Kopelow, M., Lane, D., & Alden, E. (2005). Accreditation for learning and change: quality and improvement as the outcome. *Journal of Continuing Education in the Health Professions*, 25(3), 174-182.
- Roy, S.C. & Jones, D.A. (2006). *Nursing knowledge development and clinical practice: opportunities and directions*. Springer publishing company.
- Sarver, W. L. (2019). *Investigating the Relationship Between Nursing Unit Educational Composition, Teamwork, and Missed Nursing Care* (Doctoral dissertation, Kent State University).
- Schnall, R., Stone, P., Currie, L., Desjardins, K., John, R. M., & Bakken, S. (2008). Development of a self-report instrument to measure patient safety attitudes, skills, and knowledge. *Journal of Nursing Scholarship*, 40(4), 391-394.
- Singh, S., Evans, N., Williams, M., Sezginis, N., & Baryeh, N. (2018). Influences of Socio-Demographic Factors and Health Utilization Factors on Patient-Centered Provider Communication. *Health communication*, 33(7), 917–923.
- Sitzman, K., & Watson, J. (2014). *Caring science, mindful practice: Implementing Watson's Human Caring Theory*. New York, NY: Springer Publishing.
- Smith, M.C., Turkel, M.C. & Wolf, Z.R. (2013). *Caring in nursing classics: an essentials resource*. New York: Springer Publishing Company, LLC.
- Spichiger, E., Wallhagen, M. I., & Benner, P. (2005). Nursing as a caring practice from a phenomenological perspective. *Scandinavian journal of caring sciences*, 19(4), 303-309.
- Suhonen, R., Papastavrou, E., Efstathiou, G., Tsangari, H., Jarosova, D., Leino-Kilpi, H., ... & Merkouris, A. (2012). Patient satisfaction as an outcome of individualized nursing care. *Scandinavian journal of caring sciences*, 26(2), 372-380.

- Swanson, K. (1991). Empirical development of a middle-range theory of caring. *Nursing Research*, 40(3), 161-166. Retrieved November 15, 2005, from ILL (14382520).
- Tadesse B, Teshome HW, Eyoel AD (2018). Assessment of Nurses Knowledge and Utilization of Evidence-based Practice and its Associated Factors in Selected Hospitals of Southern Ethiopia. *Adv Practice Nurs* 3: 150. doi:10.4172/2573-0347.1000150
- Toqan, D., Khalaf, I. and Ayed, A. (2019) The Impact of Concept Mapping on Caring Efficacy of Palestinian Nursing Students at Clinical Setting. *Open Journal of Nursing*, 9, 59-67. doi: 10.4236/ojn.2019.91006.
- Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston, MA: Little, Brown, and Company.
- Watson, J. (1985). *Nursing human science and human care*. NJ: Appleton-Century.
- Watson, J. (1988). *New dimensions of human caring theory*. *Nursing Science Quarterly*, 1, 175–181.
- Watson, J. (1996). Watson's theory of transpersonal caring. In P. H. Walker & B. Neuman (Eds.), *Blueprint for use of nursing models: Education, research, practice, and administration* (pp. 141–184). New York: National League for Nursing.
- Watson, J. (1999). *Nursing: Human science and human care: A theory of nursing* (Vol. 15, No. 2236). Jones & Bartlett Learning.
- Watson, J. (2002). *Assessing and measuring caring in nursing and health science*. New York: Springer Publishing Company.
- Watson, J. (2008). Nursing: The philosophy and science of caring (revised edition). *Caring in nursing classics: An essential resource*, 243-264.
- Watson, J. (2009). Caring as the essence and science of nursing and health care. *Mundo saúde (Impr.)*, 33(2), 143-149.
- Watson, J., Jackson, D., & Borbasi, S. (2005). Tracing nurse caring: Issues, concerns, debates. In J. Daly, S. Speedy, D. Jackson, V. Lambert, & C. Lambert (Eds.), *Professional nursing: Concepts, issues, and challenges* (p. 113-131). New York: Springer Publishing.
- Williams, C. (2014). *Factors that Relate to Registered Nurses' Readiness for Interprofessional Learning in the Context of Continuing Professional Development*.

World Health Organization. (2005). Declaration of Alma-Ata. 1978. In *Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*.

WHO (2018). *Global strategic directions for strengthening nursing and midwifery*. 2016–2020.

Appendix A

ETHICS REVIEW BOARD ACTION FORM



UNIVERSITY OF THE PHILIPPINES OPEN UNIVERSITY

Office of the Vice Chancellor for Academic Affairs

30 August 2019

ASST. PROF. QUEENIE RIDULME
Program Chair
Master of Arts in Nursing
Faculty of Management and Development Studies
UP Open University
Los Baños, Laguna

Dear Asst. Prof. Ridulme:

The UPOU Research and Publications Committee as per the endorsement of Ms. Maria Cecilia E. Punzalan and Dr. Josephine Agapito who served as Ethical Reviewers for the thesis proposal of one UPOU Master of Arts in Nursing student whose name is indicated below is recommending the following action:

Atenogenes Potito Asuncion: "Nurse Competency and Caring Efficacy among Primary Health Care Nurses of Medical Services Department in Qatar"

ACTION: Passed the ethical review and can proceed with her research but have to revise according to the comments made by the reviewers.

May we request you to disseminate the said information to the concerned student.

Thank you.

Truly yours,

MELINDA F. LUMANTA
Vice Chancellor and Chair
Research and Publications Committee

OVCAA, Los Baños, Laguna – Tel. No. (049)536-6001 to 06 local 300-301; Telfax No. 536-6014
ovcaa@upou.edu.ph - www.upou.edu.ph

Appendix B

PERMISSION TO CONDUCT RESEARCH

NURSE COMPETENCY AND CARING EFFICACY

Permission to Conduct Research Study

 University of the Philippines
Open University
Faculty of Management and Development Studies

September 01, 2019

TO: Huwaida Al Hulani
Chief Nurse Officer
Ministry of Interior
Medical Services Department
Doha, Qatar

THRU: PROPER CHANNELS

Dear Sir/Madam;

Greetings in Peace!

I, Atenogenes Potito Rasing Asuncion, a registered general nurse, and is presently having my graduate study program on Master of Arts in Nursing, at the *University of the Philippines Open University, Major in Adult Health Nursing*. I would like to ask for permission to conduct survey among staff nurses in the Ministry of Interior Medical Services Department, Doha, Qatar, as part of my academic requirement before graduation. This is in view of my thesis, entitled *"Nurse Competency and Caring Efficacy among primary health care nurses of medical services department in Qatar"*. The purpose of the study is to identify the professional nurse competency and caring efficacy of primary health care nurses. Through this study, professional nurses and organizational stakeholders, may have a greater awareness on their respective nursing competency and professional caring behaviors that may contribute towards improvements of work productivity and performance in caring management to our patient that opt to give safe, effective and quality health care delivery to our patients.

The survey would last not more than 30 minutes, and would be arranged conveniently to the staff nurses schedule. Participation in the survey is entirely voluntary and there are no known or anticipated risks to respondents on this study. All information provided will be kept in utmost strict confidentiality and would be used only for academic purposes. The names of the respondents and the participating institution will not appear on any publications resulting from this study.

In lieu to this letter, I have attached for a full proposal of the study, ethical regulatory board from academic institution and attached permitted questionnaire. After the data has been analyzed, if you wish to have a full executive copy of the thesis study (PDF format) and can be readily made available for quality improvement of the participating facility.

Your approval to conduct this study will be greatly appreciated. Thank you in advance for your interest and assistance with this current research study.

Sincerely Yours,

Atenogenes Potito R. Asuncion
Master of Arts in Nursing (Candidate)
Major in Adult Health Nursing
QCHP License Number 3359
Civilian Staff ID Number: 314016
Contact Number: +97477938614

2/10/2019

Appendix C

REQUEST LETTER FOR PERMISISON TO USE AN EXISTING QUESTIONNAIRE

From: Atenogenes Potito Asuncion <genepotit@gmail.com>,
atenogenespotito.asuncion@upou.edu.ph
Subject: Permission to use NQSSI
Date: April 28, 2019 at 11:19:45 AM GMT+3
To: piscotty@umaryland.edu

April 28, 2019

Dear Dr. Piscotty,

Greetings in Peace!

My name is Atenogenes Potito R. Asuncion, a registered nurse in the Philippines and a registered general nurse in Qatar. I am currently working in Doha, Qatar as a primary health care nurse and a graduate student taking up Master of Arts in Nursing, Major in Adult Health Nursing at the University of the Philippines Open University.

I would like to ask for your permission to use NQSSI as part of my questionnaire in my thesis study ***“Nurse competency and caring efficacy among primary health care nurses of the medical services department in Qatar”***. My proposed date of study will be conducted in July 2019

General Objective: To examine the relationship between nurse competency and caring efficacy among nurses in primary health care units of the medical services department.

Specific Objectives:

1. To describe the socio-demographic characteristics of primary health care nurses in terms of age, gender, educational attainment, years of nursing experience, and length of service in current practice.
2. To determine the level of nurse competency among nurses of the primary health care unit of the medical services department.
3. To determine the level of caring efficacy among nurses of the primary health care unit of the medical services department.
4. To determine the relationship between socio-demographics and nurse competency among nurses in the primary health care unit of the medical services department.
5. To determine the relationship between socio-demographics and caring efficacy among nurses in the primary health care unit of the medical services department.
6. To correlate nurse competency and caring efficacy among nurses in the primary health care units of the medical services department.

Research Questions:

1. What is the level of nurse competency among nurses of primary health care units of the medical services department?
2. What is the level of caring efficacy among nurses of primary health care units of the medical services department?

3. Is there a relationship between socio-demographics and the nurse competency among nurses of the primary health care unit of the medical services department?
4. Is there between socio-demographics and the nurse's perception to express caring behavior (caring efficacy) among nurses of the primary health care unit of the medical services department?
5. Is there a correlation between nurse competency and caring efficacy among nurses of the primary health care unit of the medical services department?

A quantitative methodology using a descriptive correlational design, for it aims to describe, the variables and the relationships that exist naturally between and among them. The primary purpose of the study is to address the research questions and its relations between nurse competency and the nurse's expression of caring behaviors (caring efficacy), alongside with socio-demographic variables. The research methodology determines the nurse's competency and the nurses' perceived ability to express caring behaviors (caring efficacy). A cross-sectional, correlation design would be appropriate to use in this study since the variables of interest will be studied from representatives from different areas of primary health care units of medical services department, within a subset of a target population and will be determined for correlations at a single point in time. Moreover, given that knowledge, skills, attitudes, demographic factors, and practice of nurses have taken place even before the conduction of the study, it can be understood that such variables cannot be controlled or manipulated. This type of non- experimental research design would be enough to correspond to or answer the purpose of the study.

The target population will be primary health care nurses of the medical services department, Doha, Qatar. The total population N= 165 will be drawn from licensed registered general nurses, in Doha, Qatar assigned in different areas of primary health care units covered by the medical services department in Doha, Qatar. The questionnaire for data collection will be divided into three sections: (1) demographic survey (2) NQSSI Scale (3) Caring Efficacy Scale.

Data gathering will be entered into IBM Statistical Package for the Social Sciences (SPSS) Statistics 20.0 software. Descriptive statistics will be used to summarize the collected data. Frequency and univariate statistics will run for all continuous variables on NQSSI, caring efficacy scale, and socio-demographic data. Accordingly, a level of 0.05 will be used for all inferential statistics to compare differences in socio-demographics to nurse competency and caring efficacy in the primary health care unit of the medical services department.

As I have stated my thesis proposal and plans for the study. I am hoping for your favorable response on this matter. Any extent will be highly appreciated. In lieu, if permitted on the use of the said questionnaire tool. I would like to request for psychometric properties and how to analyze the statistical result.

Sincerely Yours,

Atenogenes Potito R. Asuncion
 University of the Philippines
 Open University
 Student Number: 2014-92135
 Email add: atenogenespotito.asuncion@upou.edu.ph
 Tel Number: 0097477938614

From: Atenogenes Potito Asuncion <genepotit@gmail.com>, atenogenespotito.asuncion@upou.edu.ph

Subject: Permission to use Caring Efficacy Scale Date: April 28, 2019, at 11:19:45 AM GMT+3
To: carolie.coates@gmail.com, coatescj@comcast.net

April 28, 2019

Dear Dr. Coates,

Greetings in Peace!

My name is Atenogenes Potito R. Asuncion, a registered nurse in the Philippines and a registered general nurse in Qatar. I am currently working in Doha, Qatar as a primary health care nurse and a graduate student taking up Master of Arts in Nursing, Major in Adult Health Nursing at the University of the Philippines Open University.

I would like to ask for your permission to use NQSSI as part of my questionnaire in my thesis study ***“Nurse competency and caring efficacy among primary health care nurses of the medical services department in Qatar”***. My proposed date of study will be conducted in July 2019

General Objective: To examine the relationship between nurse competency and caring efficacy among nurses in primary health care units of the medical services department.

Specific Objectives:

1. To describe the socio-demographic characteristics of primary health care nurses in terms of age, gender, educational attainment, years of nursing experience, and length of service in current practice.
2. To determine the level of nurse competency among nurses of the primary health care unit of the medical services department.
3. To determine the level of caring efficacy among nurses of the primary health care unit of the medical services department.
4. To determine the relationship between socio-demographics and nurse competency among nurses in the primary health care unit of the medical services department.
5. To determine the relationship between socio-demographics and caring efficacy among nurses in the primary health care unit of the medical services department.
6. To correlate nurse competency and caring efficacy among nurses in the primary health care unit of the medical services department.

Research Questions:

1. What is the level of nurse competency among nurses of the primary health care unit of the medical services department?
2. What is the level of caring efficacy among nurses in the primary health care units of the medical services department?
3. Is there a relationship between socio-demographics and the nurse competency among nurses in the primary health care units of the medical services department?
4. Is there between socio-demographics and the nurse's perception to express caring behavior (caring efficacy) among nurses of the primary health care unit of the medical services department?
5. Is there a correlation between nurse competency and caring efficacy among nurses in the primary health care units of the medical services department?

A quantitative methodology using a descriptive correlational design, for it aims to describe, the variables and the relationships that exist naturally between and among them. The primary purpose of the study is to address the research questions and its relations between nurse competency and the nurse's expression of caring behaviors (caring efficacy), alongside with socio-demographic variables. The research methodology determines the nurse's competency and the nurses' perceived ability to express caring behaviors (caring efficacy). A cross-sectional, correlation design would be appropriate to use in this study since the variables of interest will be studied from representatives from different areas of primary health care units of medical services department, within a subset of a target population and will be determined for correlations at a single point in time. Moreover, given that knowledge, skills, attitudes, demographic factors, and practice of nurses have taken place even before the conduction of the study, it can be understood that such variables cannot be controlled or manipulated. This type of non- experimental research design would be enough to correspond to or answer the purpose of the study.

The target population will be primary health care nurses of the medical services department, Doha, Qatar. The total population N= 165 will be drawn from licensed registered general nurses, in Doha, Qatar assigned in different areas of primary health care units covered by the medical services department in Doha, Qatar. The questionnaire for data collection will be divided into three sections: (1) demographic survey (2) NQSSI Scale (3) Caring Efficacy Scale.

Data gathering will be entered into IBM Statistical Package for the Social Sciences (SPSS) Statistics 20.0 software. Descriptive statistics will be used to summarize the collected data. Frequency and univariate statistics will run for all continuous variables on NQSSI, caring efficacy scale, and socio-demographic data. Accordingly, a level of 0.05 will be used for all inferential statistics to compare differences in socio-demographics to nurse competency and caring efficacy in the primary health care unit of the medical services department.

As I have stated my thesis proposal and plans for the study. I am hoping for your favorable response on this matter. Any extent will be highly appreciated. In lieu, if permitted on the use of the said questionnaire tool. I would like to request for psychometric properties and how to analyze the statistical result.

Sincerely Yours,

Atenogenes Potito R. Asuncion
University of the Philippines
Open University
Student Number: 2014-92135
Email add: atenogenespotito.asuncion@upou.edu.ph

Appendix D

GRANTED PERMISSION TO USE THE INSTRUMENT

From: piscotty@umaryland.edu
Subject: Re: FOLLOW-UP PERMISSION TO USE NQSSI
Date: Wednesday, May 22, 2019, at 12:59 PM
To: genepotit@gmail.com, atenogenespotito.asuncion@upou.edu.ph

Dear Atenogenes,

You have my permission to use the NQSSI. Please find the tool and related articles attached.

Thanks,

Dr. Piscotty

**Ronald (Ron) J. Piscotty,
Jr., Ph.D., RN-BC, FAMIA
Assistant Professor
University of Maryland School of Nursing
Organizational Systems and Adult Health
Nursing Informatics Specialty
655 West Lombard Street,
Baltimore, MD 21201, Rm. 445D
586 588 0271 (cell) | 410 706 6508
(office) | 410 706 3289 (fax)
piscotty@umaryland.edu
<https://www.nursing.umaryland.edu/directory/ronald-piscotty/>**

From: carolie.coates@gmail.com, coatescj@comcast.net
Subject: Re: FOLLOW-UP PERMISSION TO USE CES
Date: Thursday, May 16, 2019, at 11:29 PM
To: genepotit@gmail.com, atenogenespotito.asuncion@upou.edu.ph

Dear Atenogenes,

You have my permission to use the Caring Efficacy Scale. Please find the tool attached.

Thanks,

Dr. Coates
Carolie Coates, Ph. D.
1441 Snowmass Court, Boulder, Colorado 80305 USA for permission and scoring information.
Email: coatescj@comcast.net tel. fax: 303-499-57

Appendix E
INDIVIDUAL INFORMED CONSENT
Informed Consent

This informed consent form is intended for professional nurses who are currently employed at the Ministry of Interior Medical Services Department, Doha, Qatar and who I am inviting to participate in my research entitled “Nurse Competency and Caring Efficacy among primary health care nurses of a medical services department in Qatar”

Name of Principal Investigator: Atenogenes Potito R. Asuncion **Name of Organization:** University of the Philippines Open University **Name of Project:** Thesis N300

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

Part I: Information Sheet Introduction

I am, Atenogenes Potito R. Asuncion, taking a Master’s Degree in Nursing and as part of my academic requirement in partial fulfillment for graduation. I am doing a research study on Nurse Competency and Caring Efficacy among primary health care nurses of the medical services department in Qatar. I am going to give the you information and I would like to invite you to be part of my research study. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask me or the Arabic interpreter.

Purpose of the research

This research aims to examine the relationship between nurse competency

and caring efficacy among nurses in primary health care units of medical services department. The results will help all professional nurses and organizational stakeholders to understand the essential qualities of the nursing profession in terms of nurse competency and the factors that influence the effective caring behavior of nurses in the primary health care setting.

Type of Research Intervention

This research will involve your participation in being a participant/respondent in the current study.

Participant Selection

You are being invited to take part in this research because you are currently working as a staff nurse in the ministry of interior, medical services department, Doha Qatar, based on the inclusion and exclusion criteria of this study. Your honest responses to the following questions are highly valued. This will enable the researcher to describe the demographic profile and measure the knowledge, attitudes, and practices of nurses on caring efficacy towards the nursing practice environment in the primary health care setting.

Voluntary Participation

Your participation in this research is entirely voluntary. The risk of participating in the study is not anticipated. However, you may choose to answer voluntarily or you may withdraw at any time without penalty.

Procedures

Participants you will be advised to strictly not to use any resources related

to the current research study, then answering the questionnaire. The survey packet questionnaire contained a cover letter that includes a description of the study, approximate length of time needed to complete the instruments, the voluntary nature of participants, and the methods of confidentiality. Besides, the survey packet questionnaires, consisting of a socio-demographic survey, nurse quality, and safety self-report questionnaire and a caring efficacy scale questionnaire. A duly accomplished questionnaire must submit to the bin located on the designated nursing reception area or directly to the researcher.

Duration

As a participant, you will answer a set of questionnaires on nurse competency and caring efficacy should take no more than 30 minutes; however, collection of accomplished forms (during working hours as well) by the researcher will be extended for a week to allow maximum time for the sampled nurses to decide and respond and for gathering answered forms.

Benefits

There are no direct benefits to you from joining this study. However, the results will help all nurses and organizational stakeholders to understand the essential qualities of the nursing profession in terms of nurse competency and the factors that influence the effective caring behavior of nurses in the primary health care setting.

Confidentiality

Rest assured, the collected information will be used mainly for academic purposes and will be treated confidentially at all times.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect job performance evaluation. You may stop participating in the research study

Part II: Certificate of Consent

I have been invited to participate in research entitled: "Nurse Competency and Caring Efficacy among primary health care nurses of the medical services department in Qatar".

I have read the foregoing information and explained it to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant: _____

Signature of Participant: _____

Date: _____

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the above information as stated.

I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher /person taking the consent: _____

Date: _____

Appendix F

RESEARCH INSTRUMENTS

PART I: DEMOGRAPHIC TOOL

RESPONDENT NO: _____

The following questions will consider basic demographic information about you:

1. AGE: _____
2. GENDER
_____ MALE
_____ FEMALE
3. NATIONALITY:
PLEASE SPECIFY: _____
4. MARITAL STATUS:
_____ SINGLE
_____ MARRIED
_____ SEPERATED
_____ DIVORCED
_____ WIDOW
5. EDUCATIONAL ATTAINMENT:
_____ DIPLOMA
_____ ASSOCIATE DEGREE
_____ BACCALAUREATE DEGREE
_____ MASTERAL DEGREE
_____ DOCTORAL DEGREE
6. YEARS OF NURSING EXPERIENCE:
_____ 0-5 YEARS OF NURSINGEXPERIENCE
_____ 6-10 YEARS OF NURSINGEXPERIENCE
_____ 11-15 YEARS OF NURSINGEXPERIENCE
_____ 16-20 YEARS OF NURSINGEXPERIENCE
_____ 21-25 YEARS OF NURSINGEXPERIENCE
_____ 26-30 YEARS OF NURSINGEXPERIENCE
_____ 31-35 YEARS OF NURSINGEXPERIENCE
_____ 36-40 YEARS OF NURSINGEXPERIENCE
7. LENGTH OF SERVICE IN CURRENT PRACTICE AREA:
_____ 0-5 YEARS OF NURSINGSERVICE
_____ 6-10 YEARS OF NURSINGSERVICE
_____ 11-15 YEARS OF NURSINGSERVICE
_____ 16-20 YEARS OF NURSINGSERVICE
_____ 21-25 YEARS OF NURSINGSERVICE
_____ 26-30 YEARS OF NURSINGSERVICE
_____ 31-35 YEARS OF NURSINGSERVICE
_____ 36-40 YEARS OF NURSINGSERVICE
8. NURSING PRACTICE AREA (FACILITY):

_____ EMERGENCY
_____ OUT PATIENT: PLEASE SPECIFY: _____
_____ DENTAL
_____ OUTSIDE CLINIC: PLEASE SPECIFY: _____

PART II: NURSE QUALITY AND SAFETY SELF- INVENTORY SCALE (NQSSI)

Instruction: Please rate yourself on your knowledge, skills, attitudes of each six components using the following scale:

RATING SCALE:

Strongly Disagree	1
Disagree	2
Somewhat Disagree	3
Neutral	4
Somewhat Agree	5
Agree	6
Strongly Agree	7

Patient-Centered Care (PCC): Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.							
1. I feel confident I have the necessary knowledge to practice patient-centered care.	1	2	3	4	5	6	7
2. I feel confident I have the necessary skills to practice patient-centered care.	1	2	3	4	5	6	7
3. I feel confident I have the necessary attitudes to practice patient-centered care.	1	2	3	4	5	6	7
Teamwork and Collaboration (T&C): Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.							
4. I feel confident I have the necessary knowledge to ensure an effective nursing practice based on teamwork and collaboration.	1	2	3	4	5	6	7
5. I feel confident I have the necessary skills to ensure an effective nursing practice based on teamwork and collaboration.	1	2	3	4	5	6	7
6. I feel confident I have the necessary attitudes to ensure an effective nursing practice based on teamwork and collaboration.	1	2	3	4	5	6	7

Evidence-Based Practice (EBP): Integrate best practice with clinical expertise and patient/family preferences and values for delivery of optimal health care.							
7. I feel confident I have the necessary knowledge to achieve an evidence-based nursing practice.	1	2	3	4	5	6	7
8. I feel confident I have the necessary skills to achieve an evidence-based nursing practice.	1	2	3	4	5	6	7
9. I feel confident I have the necessary attitudes to achieve an evidence-based nursing practice.	1	2	3	4	5	6	7
Quality Improvement (QI): Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.							
10. I feel confident I have the necessary knowledge to participate in quality-improvement in nursing practice.							
11. I feel confident I have the necessary skills to participate in quality-improvement in nursing practice.							
12. I feel confident I have the necessary attitudes to participate in quality-improvement in nursing practice.							
Safety (S): Minimizes the risk of harm to patients and providers through both system effectiveness and individual performance.							
13. I feel confident I have the necessary knowledge to deliver safe nursing care.							
14. I feel confident I have the necessary skills to deliver safe nursing care.							
15. I feel confident I have the necessary attitudes to deliver safe nursing care.							
Informatics (I): Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.							
16. I feel confident I have the necessary knowledge to integrate and use technology in nursing practice.							
17. I feel confident I have the necessary skills to integrate and use technology in nursing practice.							
18. I feel confident I have the necessary attitudes to integrate and use technology in nursing practice.							

**Piscotty, R., Grobbel, C., & Abele, C. (2013). Initial psychometric evaluation of the nursing quality and safety self-inventory. *Journal of Nursing Education*, 52(5), 269-274; Piscotty, R., Grobbel, C., & Tzeng, H. M. (2011). Integrating quality and safety competencies into undergraduate nursing using student-designed simulation. *Journal of Nursing Education*, 50(8), 429-436. Email communication of permission to use from the Author. May 22, 2019.

PART III: CARING EFFICACY SCALE (CES)

Instructions: When you are completing these items, think of your recent work with patients/ clients in the clinical setting. Circle the number that best expresses your opinion.

RATING SCALE:

-3 strongly disagree	+3 strongly agree
-2 moderately disagree	+2 moderately agree
-1 slightly disagree	+1 slightly agree

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Strongly Agree	Moderately Agree	Slightly Agree
1.	I do not feel confident in my ability to express a sense of caring to my clients/patients	-3	-2	-1	+1	+2	+3
2.	If I am not relating well to a client/patient, I try to analyze what I can do to reach him/her	-3	-2	-1	+1	+2	+3
3.	I feel comfortable in touching my clients/patients in the course of caregiving	-3	-2	-1	+1	+2	+3
4.	I convey a sense of personal strength to my clients/patients	-3	-2	-1	+1	+2	+3

5.	Clients/ patients can tell me most anything and I won't be shocked	-3	-2	-1	+1	+2	+3
6.	I have an ability to introduce a sense of normalcy in stressful conditions	-3	-2	-1	+1	+2	+3
7.	It is easy for me to conside r the multifac ed of a client's / patient' s care, at the same time as I am listenin g to them.	-3	-2	-1	+1	+2	+3
8.	I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/ patient as a person.	-3	-2	-1	+1	+2	+3
9.	I can walk into a room with a presence of serenity and energy that makes clients / patients feel better.	-3	-2	-1	+1	+2	+3

10	I am able to tune into a particular client/patient and forget my personal concerns	-3	-2	-1	+1	+2	+3
11	I can usually create some way to relate to most any client/patient.	-3	-2	-1	+1	+2	+3
12	I lack confidence in my ability to talk to clients / patients from backgrounds different from my own	-3	-2	-1	+1	+2	+3
13	I feel if I talk to clients/patients on an individual, personal basis, things might get out of control.	-3	-2	-1	+1	+2	+3
14	I use what I learn in conversations with clients/patients to provide more individualized care.	-3	-2	-1	+1	+2	+3
15	I don't feel strong enough to listen to the fears and concerns of my clients/patients.	-3	-2	-1	+1	+2	+3

16	Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients/patients.	-3	-2	-1	+1	+2	+3
17	I seem to have trouble relating to clients/patients.	-3	-2	-1	+1	+2	+3
18	I can usually establish a close relationship with my clients/patients.	-3	-2	-1	+1	+2	+3
19	I can usually get patients/clients to like me.	-3	-2	-1	+1	+2	+3
20	I often find it hard to get my point of view across to patients/clients when I need to.	-3	-2	-1	+1	+2	+3
21	When trying to resolve a conflict with a client/patient, I usually make it worse.	-3	-2	-1	+1	+2	+3
22	If I think a client/patient is uneasy or may need some help, I approach that person.	-3	-2	-1	+1	+2	+3
23	If I find it hard to relate to a client/	-3	-2	-1	+1	+2	+3

	patient, I'll stop trying to work with that person.						
24	I often find it hard to relate to clients/ patients from a different culture than mine.	-3	-2	-1	+1	+2	+3
25	I have helped many clients/ patients through my ability to develop close, meaningful relationships	-3	-2	-1	+1	+2	+3
26	I often find it difficult to express empathy with clients/ patients.	-3	-2	-1	+1	+2	+3
27	I often become overwhelmed by the nature of the problem's clients/patients are experiencing.	-3	-2	-1	+1	+2	+3
28	When a client/ patient is having difficulty communicating with me, I am able to adjust to his/her level.	-3	-2	-1	+1	+2	+3
29	Even when I really try, I can't get	-3	-2	-1	+1	+2	+3

	through to difficult clients/ patients.						
30	I don't use creative or unusual ways to express caring to my clients/patie nts.	-3	-2	-1	+1	+2	+3

* Watson, J. (2009). Assessing and measuring caring in nursing and health sciences (2nd ed.). New York: Springer Publishing Company, LLC. Email communication of permission to use from the Author. May 16, 2019.

Appendix G

CURRICULUM VITAE

ASUNCION, ATENOGENES POTITO R., BSN, RN

HOME ADDRESS

BUILDING 85, FLAT #12

IBN OMRAN STREET

FAREEJ BIN OMRAN,

DOHA, QATAR



Telephone Number:

Mobile Number:

Email Address:

+

genepotit@yahoo.com

OBJECTIVE

I would like to work in an institution that values knowledge and provides opportunities and avenues for integration of clinical skills and adapting to its culture and vision in Nursing Profession. I look forward in applying in special areas to gain full competence in terms of theories and clinical practice.

EMPLOYMENT

January 2010 – Present

MINISTRY OF INTERIOR

Medical Services Department

PO Box 22898 Doha, Qatar

Nurse

January 2006 – February 2009

UNIVERSITY OF THE PHILIPPINES-PHILIPPINE GENERAL HOSPITAL

Taft Avenue, Manila, Philippines

Department of Emergency Medicine

Emergency Room Nurse II

January 2005 – July 2005

UNIVERSITY OF THE EAST

RAMON MAGSAYSAY MEMORIAL HOSPITAL

Medical Surgical Pay Floor

Aurora Boulevard Quezon City, Philippines

Medical Surgical 4 South Pay Staff Nurse

November 2000- November 2001

MARY CHILES GENERAL HOSPITAL

Pulmonary Department

667 Gastambide Street Sampaloc, Manila, Philippines

Trainee Respiratory Therapist

EDUCATION

GRADUATE STUDIES

University of the Philippines
Open University
Los Banos, Laguna, Philippines
Master of Arts in Nursing
Year 2014- Present

COLLEGE DEGREE

University of the East
Ramon Magsaysay
Memorial Medical Center
Aurora Boulevard, Quezon City
Bachelor of Science in Nursing
Year: 2000-2004

ASSOCIATE DEGREE

Mary Chiles College
667 Gastambide Street Sampaloc,
Manila, 1008
Associate in Respiratory Therapy
Year: 1997-2000

SECONDARY COURSE

University of the East
Secondary Laboratory Schools
Claro M. Recto Avenue, Manila
Secondary Course
Year: 1992-1996

ELEMENTARY COURSE

University of the East
Elementary Laboratory Schools
Claro M. Recto Avenue, Manila
Elementary Course
Year: 1986-1992

PERSONAL

DATE OF BIRTH	January 24, 1981
PLACE OF BIRTH	Manila, Philippines
CIVIL STATUS	Single
GENDER	Male
CITIZENSHIP	Filipino
RELIGION	Roman Catholic
HEIGHT	5 feet 7 inches
WEIGHT	135 lbs.
MOTHERS NAME	Asuncion, Edna Rasing
FATHERS NAME	Asuncion, Renato Rasay
Residence Address	1523 Maria Clara Street Sampaloc, Manila, 1008 Philippines
Telephone Number	(63) (02) 87123509

EMPLOYMENT HIGHLIGHTS

January 2010 – Present

MINISTRY OF INTERIOR

Medical Services Department

NURSE

Job Description:

- Establish nursing care objectives and priorities based on the assessment of patient's needs in relation to long and short-term treatment goals; involve and direct nursing care personnel in the administration of individual clinical therapy into the total-treatment plan.
- Provide expert patient assessment and formulate nursing diagnosis through such means as observation, inspection, palpation, auscultation, review of available records, and conducting interviews.
- Determine necessary data gathering for appropriate management and treatment of patients.
- Participate in formulating, interpreting, implementing, and evaluating objectives, policies, and procedures of nursing care.

- Plan, evaluate, and modify treatment programs based on data obtained through observation, interviews, and analysis of patient's records.
- Managed to take independent action ensuring professional and legal limits.
- Make decisions within the area of nursing care and in accordance with established treatment measures.
- Supervised the conduct of patients to protect and maintain safety.
- Advocate for the rights of patients. Acted as a patient advocate to ensure health care services are delivered in an ethical and culturally sensitive manner.
- Assisted the physicians with medical and minor surgical procedures.
- Ensured administration of medication, therapeutic agents, treatments, disease prevention, and restorative measures as ordered by a physician.
- Performs as a preceptor assisting in the training and development of new staff nurses in the area of assignment.
- Assessed the knowledge, skills and ability of the nursing staff to provide patient care.
- Responsible for organizing, planning, directing, providing and coordinating patient within the unit.
- Reviews all patients order, labs and test results and collaborate with the multi-disciplinary team to ensure quality patient outcomes.
- Evaluated and documented patient progress toward the attainment of expected outcomes utilizing interdisciplinary collaboration, appropriate quality indicators and multiple sources of data.

January 2006 – February 2009

UNIVERSITY OF THE PHILIPPINES-PHILIPPINE GENERAL HOSPITAL

Emergency Room nurse II

Job Description:

- Provide emergency medical care to an average of 15 ill patients per shift within a 60-bed capacity of Emergency Services Department.
- Ensure the provision of quality emergency medical care to patients requiring emergency treatment in accordance with physician orders, hospital policy, and standard nursing practice.
- Perform patient assessment and nursing diagnosis.
- Assess patient condition in medical, surgical, neurological and trauma situations.
- Administering oxygen and special gas therapy using high flow and low system
- Have a back ground in basic ECG Tracing and Analysis
- Using humidity and aerosol mists to keep respiratory tract and to deliver medication
- Performing Cardio-Pulmonary Resuscitation (CPR) and assisting medical practitioner in providing artificial airway
- Using Ambu- bag in Special Cases
- Using Pulse-Oximeter, defibrillators, cardiac monitors, and infusion pumps in specialized critically ill clients
- Carry out prescribed medical treatments/procedures, initiate catheters/ IV's, and work closely with physicians and other healthcare staff to ensure optimal patient care.
- Monitor and chart patient's condition/vital signs, administer IV fluids and medications and observe for adverse side effects
- Evaluate episodic and acute responses to broad classifications of physical or psychosocial issues.
- Manage the planning and implementation of interventions.
- Coordinate patient referrals and discharge planning activities.
- Maintain medical charts at unit desk and communicate patient updates to physicians and incoming charge nurse.
- Uphold strict healthcare, nursing and hospital standards; maintain sterile procedures to prevent spread of disease and infection.

January 2005 – July 2005

UNIVERSITY OF THE EAST RAMON MAGSAYSAY MEMORIAL HOSPITAL

Medical Surgical 4South Pay Staff Nurse

Job Description:

- Assigned on Medical Surgical Ward, handled 17 patients a day excluding newborns rooming in.
- Handled cases with normal spontaneous deliveries, caesarean sections, and other OB-Gyne cases, patient with congestive heart failure, cardiovascular and cerebrovascular diseases. Chronic kidney disease, End stage renal disease (ESRD), hepatic encephalopathy, pneumonia, chronic obstructive pulmonary diseases, tuberculosis, rectal, colon, lung, bladder and breast cancer, patient undergoing kidney transplant, chemotherapy, hemodialysis and surgeries.
- Cared for patients with endotracheal tube hooked to mechanical ventilator and other equipment such as cardiac monitors, infusion pump, pulse oximeter etc.
- Patients with tracheostomy, colostomy, gastrostomy tube, chest tube thoracotomy, fed patients thru NGT, PEG, and T-Tube. Administered medications through oral, IV and parenteral.
- Assisted physicians on intubations and CPR.
- Administered emergency meds during CPR.
- Facilitated admissions discharged and transfer.
- Maintained patients record, completed chartings, progress notes, medications, taking and transcribing doctor's orders, consulted and referred to physicians regarding their patients.
- Performed health teachings to patients and relatives to improve health status.

November 2000- November 2001

MARY CHILES GENERAL HOSPITAL

Trainee Respiratory Therapist

Job Description:

- Performing Quick assessment (ROS)

- Performing Cardio-Pulmonary Resuscitation (CPR) and assisting doctor in providing artificial airway
- Using Ambu- bag in Special Cases
- Using Pulse-Oximeter, defibrillators, cardiac monitors, and infusion pumps in specialized critically ill clients
- Administering oxygen and special gas therapy using high flow and low system
- Using humidity and aerosol mists to keep respiratory tract and to deliver medication
- Drawing arterial blood gasses to determine adequate acid base balance and ventilation/perfusion disorder
- Administering bronchopulmonary hygiene, suctioning and chest physiotherapy which includes exercises to reduce effort of breathing as well as postural drainage, chest clapping, vibration and coughing procedures to help clear lungs from secretions
- Offering Respiratory Therapy Modalities such as Incentive Spirometry (IS) and Intermittent Positive Pressure Breathing (IPPB)
- Teaching clients on how to use metered dose inhalers (MDI), Peak Flow Rate, PEFr) and nebulizer kits
- Performing Lung volumes and capacity measurement, gas distribution and gas diffusion maneuvers
- Operating Mechanical Ventilators that replace or assists natural breathing and provide positive expiratory end pressure (CPAP)
- Performing Weaning procedure which includes traditional T-piece method or the intermittent mandatory ventilation (IMV), synchronized mandatory ventilation (SIMV)
- Proven to have acquired knowledge and clinical skill in respiratory therapy education, modalities, and procedure.

GOVERNMENT EXAMINATION TAKEN

- **Registered Nurse, June 2004**
Integrated Nurses Licensure Examination of the Philippines
PRC License Number 0358762
- **Nurse Specialist, June 2011**
Passed Nurse Prometric Examination
Supreme Council of Health
Doha, Qatar
QCHP License Number 3359

OTHER INFORMATION

- **Caring Healthcare Professional** with comprehensive training and experience as a Registered Nurse in the Emergency Room Department.
- **Highly skilled** in-patient care and needs assessment, dispensing medications, catheterization and IV procedures, charting, triage, critical care procedures, and staff supervision and mentoring.
- **Quick study** with ability to easily grasp and implement new ideas, concepts, and methodologies. At ease in fast-paced, high stress situations with emerging, changing and multiple responsibilities.
- **Strong** communication, interpersonal, analytical, administration, organizational, problem solving, and leadership skills. Thrive in both independent and collaborative work environments.
- **Comfortable** using a variety of computer programs and applications including MS Office Suites.

HONORS AND ACHIEVEMENTS

- **Nurse Specialist, June 2011** Passed Nurse Specialist Licensure Examination under Supreme Council of Health, Qatar via Pearson Vue Testing.
- **Registered Nurse, June 2004** Integrated Nurses Licensure Examination with **Professional Regulation Commission License Number 0358762**
- **Masigasig Nurse Awardee (Outstanding Emergency Room Nurse)** University of the Philippines, Manila-Philippine General Hospital Department of Emergency Medicine (Emergency Room) Year 2008
- **Unit Representative** Department of Emergency Medicine (Emergency Room) University of the Philippines, Manila- Philippine General Hospital (January- December 2006)

- **College Scholar, Nursing Alumni Association (Noveno Scholarship) University of the East Ramon Magsaysay Memorial Medical Center 3rd and 4th Year, 4 Semesters Year 2003-2004 Aurora Boulevard, Quezon City, Philippines.**
- **Rank 3rd, Nursing Oral Revalida Examinations, University of the East Ramon Magsaysay Memorial Medical Center 4th Year 1st Semester Year 2003-2004 Aurora Boulevard, Quezon City, Philippines.**
- **Rank 2nd, Nursing Skills Revalida Examinations, University of the East Ramon Magsaysay Memorial Medical Center 4th Year 1st Semester Year 2003-2004 Aurora Boulevard, Quezon City, Philippines.**
- **Certified Breast-Feeding Educator, by Lactation Consultation Services, USA, awarded at University of the East Ramon Magsaysay Memorial Medical Center, Aurora Boulevard, Quezon City, Philippines.**
- **Loyalty Awardee University of the East, Manila, Philippines, Elementary and Secondary Laboratory Schools**

CHARACTER REFERENCE

- **CARMELITA DIVINAGRACIA, Ph.D.**
MEMBER, BOARD OF NURSING
PHILIPPINE REGULATION COMMISSION
P. PAREDES STREET SAMPALOC MANILA, 1008
PHILIPPINES
TEL. No. (63) (917) 8945594
- **BELINDA CAPISTRANO, MAN, RN**
DEAN, COLLEGE OF NURSING
UNIVERSITY OF THE EAST
RAMON MAGSAYSAY MEMORIAL
MEDICAL CENTER, INC
AURORA BOULEVARD, QUEZON CITY 1113
PHILIPPINES
TEL. No. (632) 8-713-3309

DECLARATION

I hereby declare the above-mentioned information is true and verifiable to the best of my knowledge and I bear responsibility for the correctness of the above-mentioned particulars

ATENOGENES POTITO R. ASUNCION