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Nursing Caring Efficacy Among Nurses in Al-Thowrah Hospital in Sana'a City-Yemen

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Abstract

Background: *Self-efficacy is important in nursing practices. The self-efficacy of nurses influences the attitudes and behaviour of nurses; it is related to nurses' knowledge of the existing protocols and its actual implementation. Self-efficacy is a mediator between knowledge and action and also influences the treatment selection taken by nurses.* ***Aim:*** *To assess the caring efficacy among nurses working in Al-Thowrah hospital - Sana'a city.* ***Methods:*** *A descriptive, cross-sectional study was carried out from April to May 2019 at Al-Thowrah Hospital, Sana'a City, Yemen. A convenient sample of 112 nurses were admitted to this study. Self-administered caring efficacy scale questionnaire was used to collected data.* ***Results:*** *The mean age of the participated nurses was 29±5.16 years. Nearly three quarters of them were females, and more than the half were married. The majority of them held diploma in nursing. The mean caring efficacy scale scores among participants was 3.99±0.47, ranged from 2.72–5.29. No statistical significant differences in demographic characteristics of nurses in related to overall CES accept for duration of working in Unit.* ***Conclusion****: The results indicated low level of caring* efficacy *among nurses. Belief in one's ability to express caring, develop caring relationship with patients generally higher in female nurses than males and in bachelor nurses than diploma. The working duration in the current unit was a predictor of caring efficacy among nurses'.*

Keywords: Nursing; Caring; Caring Efficacy Scale; Yemen**.**

Introduction

The Caring Efficacy Scale (CES) was developed as a tool for conducting patient outcome and cost studies. The CES assesses how strongly one has developed a caring relationship with the client or patient.

During the past 3 decades, caring has emerged as a central component of nursing[1,2]. Caring defines nursing's unique area of practice and provides direction for growth as a profession[3]. Swanson defines caring as the way for one person to relate with another person through a foundation of personal commitment and responsibility. Swanson further explains that caring relationships which are a central concern to nursing include nurses to client, nurses to nurse, and nurse to self[4]. Andershed and Olsson (2009)[5] describe this theory as a guide to effective and sensitive clinical practice. Nelson (2011)[6] reported that we are making a mistake when we do not consider the act of caring as a formal structure in situations that involve our patients and their families. The literature shows that often, the perceptions of needs and

caring are often incongruent between the nurses that provide care and the family members that are the recipients of care[7,8].

Aim of the study

The aim of the study was to assess the nursing caring efficacy among nurses working in Al-Thowrah hospital in Sana'a City-Yemen.

Subject and Methods

A descriptive cross-sectional study was carried out from April to May 2019 at Al-Thowrah Modern General Hospital, Sana'a City, Yemen. A convenient sample of 112 nurses at the above mentioned setting was admitted to this study.

The nurses were selected according to the following criteria: (1) unit should service largely general medical-surgical patients. (2) Unit had to practice one of the following three modalities: team nursing, total patient care, or primary nursing. Self-administered questionnaire was used to collect the necessary data.

The study tool was composed of two parts, the demographic characteristics of nurses and the Caring Efficacy Scale (CES). The Coates' CES[9] is a 30 item with six-point Likert scale designed to measure caring attitudes, skill, and behaviors. Scoring ranges from -3 (strongly disagree) to +3 (strongly agree).

The positive and negative items are balanced in this instrument. Items numbered answered with "-3" were coded as "1", "-2=2", "-1=3", "+1=4", etc., except for items numbered 1, 8, 12, 13, 15, 16, 17, 20, 21, 24, 26, 27, 29, and 30, which were reverse scored with a response of "-3" coded as "6", "-2=5", "-1=4" etc. per the author's instructions. This form has yielded an alpha of .85 in previous research [(10)]. Data were entered and analyzed using SPSS version 20 for windows. Entered data were checked for accuracy then for normality. t-test was used to determine the differences in the mean scores between 2 groups and one-way ANOVA was used to determine the differences in the mean scores between more than 2 groups.

Qualitative variables were expressed as number and percentages while quantitative variables were expressed as mean and standard deviation (SD). A p-value ≤ 0.05 was considered significant. Oral informed consent was obtained from the study participants.

Results

- ***Demographic characteristics***

One hundred and twelve nurses were participated in the present study. Table 1 shows the mean nurses' age was 29 years and SD 5.16 years. Nearly three quarters (73.2%) of them were females, and more than the half (57.1%) were unmarried. The majority (90.2%) had diploma in nursing, compared to only (9.8%) for the bachelor graduates.

Table 1 shows the association between the nurses' demographic characteristics and overall CES score. The results showed increased in the mean CES score as nurses get older, the exception was among those aged 31-35 years, the relationship between CES score and age was statistically insignificant (p = 0.5).

Although the married nurses had higher mean CES score than married, the differences between groups was insignificant (p = 0.48). Female nurses had higher mean CES score than males, but the significant differences between CES score and sex was not (p=0.46).

No statistical significant differences between level of education and CES score (p= 0.34).

With respect to the job status, those worked full time duty had higher CES score than those doing part time or

casual employment. The difference between groups was not statistically significant (p = 0.30).

Table 1: Demographic characteristics by overall caring efficacy scale

Demographic characteristics	Caring efficacy	
	Mean ±SD	p-value
Age		
• ≤ 25 years	3.91± 0.40	0.50
• 26-30 years	4.04± 0.50	
• 31-35 years	3.98± 0.53	
• ≥ 36 years	4.09± 0.44	
Sex		
• Male	3.93± 0.46	0.46
• Female	4.01± 0.47	
Marital status		
• Married	4.01± 0.50	0.48
• Unmarried	3.96± 0.42	
Level of education		
• Diploma in nursing	4.1± 0.60	0.34
• Bachelor in nursing	3.6± 0.52	
Job status		
• Full time duty	4.01± 0.48	0.30
• Part time duty	3.77± 0.32	
• Casual duty	3.91± 0.22	

- ***Years of experience, work duration & area of experience***

Table 2 shows years of experience, work duration and area of experience. The results of the study showed that, high percentage (44.6%) of nurses working for 5 years or less followed by (38.4%) for those working for a period between 6–10 years.

The mean working years in nursing was 6.85 years and SD 5.18 years. With respect to the working years in current unit/ ward, (25.9%) of the nurses worked in current unit/ ward for a period between 0–11 months followed by 22.3% who worked for 1–2 years and equal percentages (17%) worked for the other three periods. The area of experience showed high percentage (37.5%) of the nurses worked in Medical-Surgical wards followed by 25.9% in ICU. Although, the CES score increased as years of experience increased, the difference between groups was not statistically significant (p=0.28).

In relation to the working duration in the units, nurses working for 11 years or above had the highest mean score, the difference between groups was statistically significant (p = 0.05). As regards, area of experience, showed higher mean CES score among nurses working in medical surgical ward, while the lowest score was among nurses working in emergency. There was no significant difference between groups (p=0.64). Table 2.

Table 2: Year of experience, working duration and area of experience by overall caring efficacy scale

Variables	Caring efficacy	
	Mean ±SD	**p-value**
Years of experience		
• ≤ 5 years	3.91± 0.42	0.28
• 6-10 years	4.02± 0.53	
• 11-15 years	4.04± 0.41	
• ≥ 16 years	4.16± 0.40	
Duration of working		
• < 1 year	4.03± 0.44	0.04
• 1 - 2 years	3.75± 0.42	
• 3 - 5 years	4.00± 0.45	
• 6 - 10 years	4.09± 0.55	
• ≥ 11 years	4.13± 0.42	
Area of experience		
• Obstetrics & Gynecology	3.92± 0.46	0.64
• Rehabilitation	3.92± 0.21	
• Emergency	3.80± 0.38	
• Medical – Surgical	4.08± 0.49	
• ICU	3.97± 0.46	

- **Caring Efficacy Scale**

The results of the present study showed that, the overall mean of CES scores 3.99 (0.47), ranged from 2.72–5.29.

The highest mean score (5.29) was related to the item "I feel comfortable in touching my patients in the course of caregiving", followed by (4.96) for "I can usually get patients to like me". On the other hand, the least mean score (2.72) was related to "If I find it hard to relate to a patient, I'll stop trying to work with that person" followed by (2.75) related to "I often become overwhelmed by the nature of the problems patients are experiencing". There was statistically significant relations with almost all the CES items accept three items namely: "I do not feel confident in my ability to express a sense of caring to my patient", "Even when I really try, I can't get through to difficult patients" and "I don't use creative or unusual ways to express caring to my patients". More details presents in table 3.

Table 3: Mean & standard deviation of the caring efficacy scale

Caring Efficacy Scale Items	Mean±SD
I do not feel confident in my ability to express sense of caring to my patient.	3.5±1.8
If I am not relating well to a patient, I try to analyze what I can do to reach him/her.	4.7±1.1
I feel comfortable in touching my patients in the course of caregiving.	5.3±1.1
I convey a sense of personal strength to my patients.	4.7±1.3
Patients can tell me most anything and I won't be shocked.	4.5±1.4
I have an ability to introduce a sense of normalcy in stressful conditions.	4.8±1.2
It is easy for me to consider the multifacets of a patient's care, at the same time as I am listening to them	4.5±1.2
I have difficulty in suspending my personal beliefs and biases in order to hear & accept patient as a person	3.7±1.6
I can walk into a room with presence of serenity and energy that makes patients feel better.	4.8±1.2
I am able to tune into a particular patient & forget my personal concerns.	4.5±1.3
I can usually create some way to relate to most any patient.	4.7±1.1
I lack confidence in my ability to talk to patients from backgrounds different from my own.	3.8±1.5
I feel if I talk to patients on an individual, personal basis, things might get out of control.	3.5±1.5
I use what I learn in conversations with patients to provide more individualized care.	4.2±1.3
I don't feel strong enough to listen to the fears and concerns of my patients.	3.4±1.5
Even when I'm feeling self-confident about most things, I still seem to be unable to relate to patients.	3.7±1.5
I seem to have trouble relating to patients.	3.9±1.5
I can usually establish a close relationship with my patients.	4.3±1.5
I can usually get patients to like me.	4.9±1.1
I often find it hard to get my point of view across to patients when I need to.	3.7±1.3
When trying to resolve a conflict with a patient, I usually make it worse.	4.4±1.6
If I think a patient is uneasy or may need some help, I approach that person.	4.7±1.2
If I find it hard to relate to patient, I'll stop trying to work with him/her.	2.7±1.6
I often find it hard to relate to patients from different culture than mine.	3.1±1.4
I have helped many patients through my ability to develop close, meaningful relationships.	4.5±1.3
I often find it difficult to express empathy with patients.	3.5±1.5
I often become overwhelmed by the nature of the problems patients are experiencing.	2.7±1.5
When a patient is having difficulty communicating with me, I am able to adjust to his/her level.	4.2±1.4
Even when I really try, I can't get through to difficult patients.	3.5±1.5
I don't use creative or unusual ways to express caring to my patients.	3.5±1.6

Discussion

During the past 3 decades, caring has emerged as a central component of nursing[1,2]. Caring defines nursing's unique area of practice and provides direction for growth as a profession[3]. The mean CES score was 3.99 and SD 0.47, which indicated low level of CES score. This result was in accordance with Coat 1997[9], while it was slightly lower than Steckler 2012[11]. On the other hand, it was much lower than that found in many studies[12-16]

In relation to age of nurses and caring efficacy showed that no differences between age and caring efficacy of nurses (p = 0.492). Age is not related to self-efficacy.[17] Different research results found that personal characteristics including age were related to nurses' self-efficacy, older nurses had higher self-efficacy in giving caring to patients.[18]

Increasingly mature and productive age will influence a person's thinking and perception of their ability to perform tasks, and it will affect the self-efficacy. Age is one of the factors that affect a person's self-efficacy.[1] Age will effect on how to think and work, the more mature a person is, the more mature he or she will be in thinking and the better the performance.[19]

The results of the study showed that the average nurse, both young and old had a positive feeling towards their ability to complete the task and could find a solution to solve the problem.

In relation to the years in current position Ward/ Unit, nurses working, no differences were found to exist between years in current position and caring efficacy, this result was in accordance with Reid 2012[20] in which the differences between CES score and working duration in unit showed statistically significant differences. With respect to the working duration in the hospitals, the mean CES score steadily increased as working years increased. This result was supported by Coates 1997, she indicated that, higher levels of caring efficacy were found among more experienced nurses[9] .

Our study similar to the results of different studies found that the length of work and the long-serving were related to the self-efficacy (p = 0.007).[21] Length of work is weak but significant with self-efficacy (p < 0.0001).[22] As you get older, the nurse's experience will also increase. Individual experience influences self-efficacy. The longer a person works, the caring efficacy increases.

Our study in accordance with other studies [20,23] the result indicated that older and more experienced nurses showed higher levels of caring efficacy. In contrast, Lawrence (2002)[24] reported that older nurses scored lower on the CES for age and years of experience. Furthermore, Shamloo et al 2012[13] reported that age did not significantly predict caring attitudes. As years of experience in nurses increased in the current study, confidence in their ability to conduct caring behaviors to patients was also shown to increase. It is then possible that over time nurses will regain belief in their caring abilities as they learn to do more with less in their clinical practice .

The majority of nurse was a diploma of nursing, The differences between the CES and nurses' education was not found, this was in accordance with the study conducted by Reid, 2012[20] in which, those with bachelor certificate had the highest CES score levels and the results were shown to be significant [20]. Our study was agreed with study conducted by Hanny et al (2008)[25]. They found no significant difference in the mean self-efficacy of nurses based on education levels. The level of education was not related to nurses' self-efficacy.[21,26]

In relation to job status, levels of caring in nurses worked full time were not different with those in part time and casual employees. This result was in contrast with Reid, 2012[20], in which those in part time employment had the highest CES mean score. In line with Fassetta 2011[27], the results showed that sex was not significant factors in caring efficacy. This result was in contrast with other studies[28,29] who identified statistically significant differences between sex and caring.

As regards, scope of experience showed the highest mean CES score among nurses working in medical surgical ward. On the other hand, as that reported by Lawrence[24] the least score was among emergency nurses. The lower CES scores in emergency may be partially explained by the task-orientated focus. In addition, nurses in emergency room are subjected to potentially greater stresses related to over-crowding, and bed shortages. These situations may impede a nurse's belief in his/her caring ability, and therefore may be responsible for the lower caring efficacy scores[21].

Conclusion

It can be concluded from the present study that, CES score indicated low level of caring behavior in the present study. The results also indicated that the dynamics or quality of the work environment may influence an individual's caring efficacy .

Recommendations

Implementation of behavior change strategies to increase caring behavior on the part of caregivers and improve the communications skills of nurses with patients.

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