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Nursing Competency on Safety Practices and Quality Care

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ABSTRACT

Quality care and safety nursing practice are essential to a health care provider. As front liners in a health care setting, it gives a positive impact not only to the patients but most especially to nurses. There are six capabilities developed by the Quality and Safety Education for Nursing (QSEN) venture and, these are the accompanying: understanding focused consideration, cooperation and joint effort, proof-based practice, quality improvement, wellbeing, and informatics. The purpose of descriptive correlation research design is to determine a particular phenomenon in which the relationship of the variability is being considered by the investigator to be a nursing phenomenon that warrants solution accomplished only upon the application of the scientific body of nursing research. In this manner one can determine if there is a noteworthy connection between medical attendant's qualities nursing care and statistic profile of the attendants and its nursing competency on wellbeing rehearses. Moreover to test if there are variables that predict on quality nursing care. In general, the participants strongly agreed on the indicators being provided. The demographic profile does not matter at all may it be new graduates or even the experienced ones for as long as they have the heart to serve the people, Quality nursing care will always be there. Whatever the status of the participants, they all have the heart to carry the torch of serving the people, in particular, their patients.

Keywords: quality care, teamwork, and collaboration, evidence-based practice, safety, informatics

INTRODUCTION

Skills, knowledge, and attitude are without a doubt the key part to be competent in one's very own profession. In the field of nursing, it is fundamental to be skillful to most likely have a firm contact and association with the patients. It promotes positive outcomes to the patients thus attain quality nursing care and safety nursing practice. Just like in a hospital setting, it is good to know the competency of an employee most especially nurses if how far their knowledge and how competent they are in dealing with the patient. That is why the investigator was able to integrate such study like this to be able to determine the competency of nurse's base on the standard being undertaken. The Nursing and Midwifery Board of Ireland (2000) states that competent nurse abides not only specific roles. They also hold many additional attributes such as knowledge, technical and practical skills, interpersonal skills, the ability to think critically, and to practice safely and effectively based on evidence. It also involves working with other health care professionals to be able to demonstrate a professional attitude.

Regardless of the heavy scrutiny and initiative in processing patients, harm may seem to continue in health care with alarming frequency. There are six competencies built up by the Quality and Safety Education for Nursing (QSEN) project and these programs are the following: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. As front-line caregivers, nurses encounter inherent risks in their daily work. Infusion therapy is high risk with multiple potential risks for patient harm (Journal of Infusion Nursing, 2017).

Caring is such an essential part of nursing practice. It is what defines us. Caring nurses are competent nurses. They understand people's health and health-related needs. They are equipped with clinical and technical knowledge for delivering research-and evidence-based care. Such care and competence are delivered with empathy, respect, and dignity. People expect to receive care from us regardless of color, race, religion, age, ideology, and context. This is exactly what service to humanity is all about (Palaganas, 2014).

Improvement in patient safety outcomes begins with a deeper awareness of how quality and safety are intertwined into daily practice routines. Safety can be defined as the elimination of risk. Safe nursing practice is focused on a consistent awareness of the potential risks for patient harm in a given setting. It is also reliant on specific nursing actions designed to reduce that risk, such as the use of the independent double check of a high-risk medication administration. These

activities require consistent use by all staff, despite adverse conditions such as fatigue or work- load (Barnsteiner, 2012).

Working experience may sometimes define nurses on to what extent is their capability in rendering nursing care; the capacity to deal with the patients' needs in order to come up with an effective therapeutic relationship. This type of relationship differs from a social and intimate relationship in many ways because it focuses on the needs, experiences, feelings, and ideas of the patient only (Videbeck, 2011). The extent on rendering effective nursing care has to do with the working phase of the nurse-client relationship in which the client's problems are identified and solutions are explored, applied, and evaluated but not necessarily making the client too much dependent to the nurse. Human services experts are embracing imaginative intercessions that depend on best practice just as strong research-based proof. Evidence-based practice is one such technique; it is the industry standard because of its potential to effectively handle clinical issues and provides better patient care (Majid et al., 2011).

Evidence-based practice is established as a proven intervention. This has been a growing trend over the past few decades; as more research reveals proven practices, nurses are relying more upon such proven methods. This is driven by the growing demand for the provision of higher quality of care and patent safety, reduced costs, and greater efficiency. Research has revealed that EBP also provides greater consistency in care from institution to institution and provider to provider. According to Majid et al. (2011), "Evidence-based practice (EBP) provides nurses with a method to use critically appraised and scientifically proven evidence for delivering quality health care to a specific population."

In connection to Benner's phases of clinical abilities, in which she presented the idea that so as to create aptitudes and comprehension of patient consideration, master medical caretakers can make it after some time by methods for a sound instructive bases and furthermore a huge number of involvement in discrete substance, this hypothesis trusts that nursing background is pre-imperative for turning into a specialist (Benner, 1982). Benner's hypothesis perhaps considered to be mostly consented to Differentiated Nursing Practice which is one of the various methods of Organizing Patient Care under Organizing. Separated Nursing Practice alludes to an endeavor to isolate job dependent on training or experience or a mix of (Marquis & Huston, 2009). This kind of method of arranging persistent consideration furthermost examined that utilizing fundamental licensure as the shared factor for most nursing position causes discord among medical attendants and perplexity among wellbeing buyers (Fox, 2006).

Furthermore, Fox states that expecting similar performance from nurses with varying educational preparation can lead to role confusion, stress, burn-out as nurses struggle to develop role competencies for which they have not been prepared. The philosophy behind the differentiated nursing practice is that RN's should work within the role structure and responsibilities that correspond best with their capabilities.

Indeed, quality patient care, nursing services, and nurse's competences have to do primarily with the last step of Management Process, and that is controlling which is relevant to be implemented throughout all phases of management process but does not necessarily mean the end of the management process. Defining and measuring the quality of care is essential for health care providers to demonstrate accountability to insurers and patients.

According to the definition of the Institute of Medicine in 1994, health care quality is the degree to which health services for individuals and populations increase in the likelihood of desired health outcomes and consistent with current nursing professional knowledge. While this definition is widely accepted, parts of it merit further examination. The first is the assertion that quality does not exist unless desired health outcomes are attained. Outcomes are the only indicator of quality. Sometimes, the patient receives the best possible care with the information available, and poor outcomes occur. At other times, poor care may still result in good outcomes or maybe from inexperienced personnel. Using outcomes alone as a way to measure quality care is flawed (Huston, 2003).

The interconnection from quality patient care, length of working experience, Benner's theory of competencies, differentiated nursing practices as part of organizing, and factors affecting achievement of quality patient care as part of controlling has been furthermost elaborated in this introductory part of the study, clearly distinguishing this study's primary purpose and variability's. All the variability want to provide the answer on the influence of length of nursing experience towards rendering optimum patient care and its implication to the nursing performance within the selected locale and target samples. Moreover, whatever outcomes of this study will somehow contribute to the nursing profession particularly on the increase in patient's satisfaction towards nursing care. The investigator does not purport in exploiting inexperienced nursing professionals and criticize their capabilities in rendering care particularly the nurses of the host institution, but to provide information basing from the scientific body of research that this problem is generally extinct for this study is imperative.

FRAMEWORK

The thoughts of this study primordially originated from the hypothesis of an all-around acclaimed nursing scholar Benner (1984) in her hypothesis entitled "Phases of Clinical Competences." She speculated that it could pick up information and abilities while never learning the hypothesis. She further clarifies that the improvement of learning in connected trains, for example, drug and nursing is made out of the expansion of down to earth information through research and the portrayal and comprehension of the "know how" of clinical experience.

Benner (1984) was able to describe five levels of nursing experience as Novice, Advance Beginner, Competent, Proficient, and Expert. Each level reflects movement from reliance on past abstract principles to the use of past concrete experience as paradigms and change in perception of the situation as a complete whole in which certain parts are relevant (Benner, 1982). Each step builds on the previous one as abstract principles are refined and expanded by experience and the learners' gains clinical expertise.

Novice nurses are considered by Benner (1984) to be a beginner with no experience and are needed to be taught by general rules to help perform the task. They are observant, context -free, independent of specific area, and applied universally. Somehow they are also considered to be limited in behavior and inflexible. Advanced beginner nurses perhaps can now be able to demonstrate acceptable performance and has gained prior experience in actual situations to recognize recurring meaningful components. They are principle governed individual that can relate to experiences and can begin to formulate to guide action.

Competent nurses, as typically determined by Benner (1984) are those who have 2-3 years experience on the job on the same area or in a similar day to day situations, and are more aware of long term goals. They can gain perspectives from planning their own actions based on conscious, abstract, and analytical thinking that can help to achieve greater efficiency and organization. Proficient nurses are individuals that can perceive and understand the situation as a whole part. Their understanding is more holistic and have well-improved decision making. They primarily learn from their personal experiences on what to expect in certain situations and how to modify plans.

The last is Expert Nurses described by Benner (1984) as to be no longer relying on principles, rules, and guidelines, to connect situation in determining

actions. They have many background of experience that can intuitively grasp clinical situations. Their performance is indeed flexible and highly proficient.

Benner's hypothesis changed the calling's comprehension of being a specialist, putting the assignment, not on the attendant with the most generously compensated or most lofty position, however on the medical caretaker who gave "the most choice nursing care." It perceived that nursing was ineffectively served by the worldview that required all of nursing hypothesis to be scientists and researchers, but instead presented the progressive idea that the training itself could and ought to educate hypothesis.

This theory guided this study throughout the entire research process in order to come up with the desire results. The theory of Benner served as a living reminder to the researcher to this study's primary purpose.

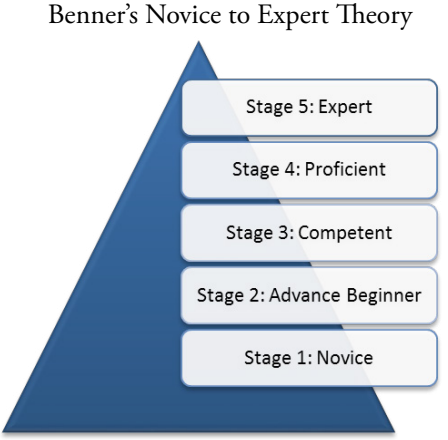

Figure 1. Benner's Novice to Expert Triangle

Another model used by the investigator was the study of Health Professions Education: A Bridge to Quality in 2003 which addresses the challenges outlined that will require profound changes in how health systems are designed. At the heart of such systems are the skilled health care professionals without whom such a redesign could not take place. Preparing health care professionals to take on this task requires a common vision across the professions centered on a commitment to, first and foremost, meeting patients' needs as envisioned in the Quality Chasm report (Institute of Medicine, 2001). The committee recommends the following as an overarching vision for all programs and institutions engaged in

the education of health professionals:

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.

To this end, the committee proposes a set of simple, core competencies that all health clinicians should possess, regardless of their discipline, to meet the needs of the 21st-century health care system:

Provide patient-centered care. Identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

Work in interdisciplinary teams. Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.

Employ evidence-based practice. Integrate the best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.

Apply quality improvement. Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; design and test interventions to change processes and systems of care, with the objective of improving quality.

Utilize informatics. Communicate, manage knowledge, mitigate error, and support decision making using information technology.

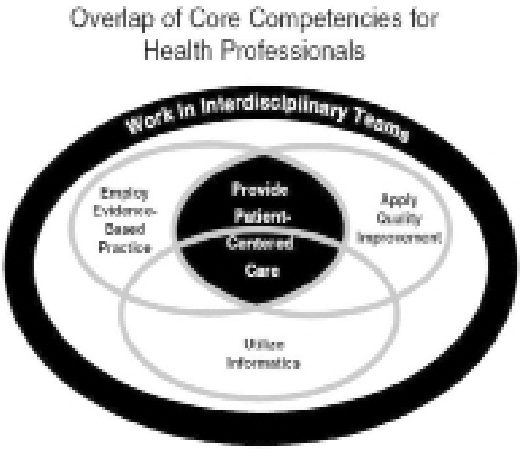

Figure 2. Relationship among core competencies for health professionals

As a guide in formulating its five competencies, the committee examined core skills outlined in the Quality Chasm report and other core competencies formulated within and across the health professions. Following a brief review of that committee process, this chapter describes each competency in greater detail and contrasts these competencies with the corresponding current approaches in practice. Also provided is a scenario illustrating the effect on patient care when health care professionals do not apply such competencies (Health Professions Education: A Bridge to Quality, 2003).

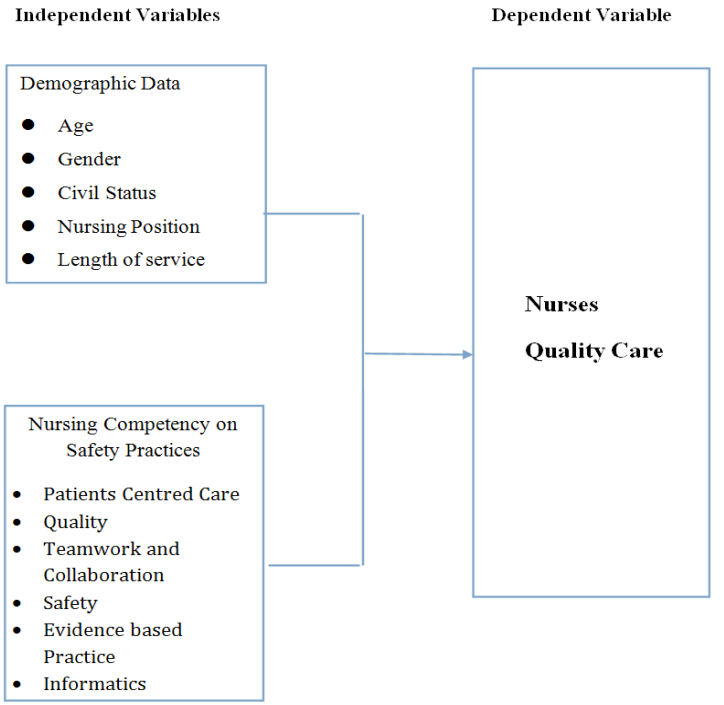

Figure 3. Schematic presentation showing variables of the study

OBJECTIVES OF THE STUDY

This study focused on the influence of nursing competency on safety practices and their implication to patients' satisfaction on quality nursing care performances specifically within the host institution. Specifically, it sought to determine: (1) the demographic data of the participant's in-terms of Age, Gender, Education, Nursing Position and Length of service; (2) the level of nursing competency on safety practices in terms of Patient Centred Care, Teamwork and collaboration, Evidence- Based Practice, Quality Improvement, Safety and Informatics; (3) the level of quality nursing care; (4) If there is any significant relationship between nurse's quality nursing care and; demographic profile, patient- centered care, teamwork and collaboration, evidence- based practice, quality improvement, safety and informatics; and (5) which variables predict the nurses' quality nursing care.

METHODS

The chosen locale for this study was the Bukidnon Provincial Hospital Manolo, standing within the province of Bukidnon situated in Region 10, Philippines. It is a public institution that falls under the regulation of the Department of Health, Philippines. The emergency clinic gives pediatrics, obstetrics-gynecology, therapeutic and careful administrations. Another chosen locale for this study was a private hospital namely the Madonna and Child Hospital which is located at Cagayan de Oro City. Madonna and Child Hospital is one of the oldest medical institutions in Cagayan de Oro City. It was established in 1976 as an answer to the need for a reliable maternal and pediatric hospital. Kagay-anons in need of proper healthcare and those seeking for experience and expertise in terms of medical issues trusted the hospital. Over the years, Madonna and Child Hospital has become the go-to medical institution for many Kagay-anons. Aside from providing medical services to patients in need of doctor's attention, Madonna and Child Hospital is also known for its Refractive Laser and Surgicenter, a center that caters to the needs of people with vision problems, particularly those who are required to undergo refractive laser surgery. The clinic is inside the compound of the hospital. Madonna and Child Hospital is where you will find some of Cagayan de Oro's best medical professionals.

This study adopted a descriptive research design and purposive sampling procedure. It is descriptive because it opted in studying a particular phenomenon in which the relationship of the variability is being considered by the investigator to be a nursing phenomenon that warrants solution accomplished only upon the application of the scientific body of nursing research. While a purposive example is a non-likelihood test that is chosen dependent on qualities of a populace and the target of the investigation. Purposive inspecting is otherwise called judgmental, specific, or abstract examining.

The descriptive quantitative method is a research methodology used to translate numeric data or explain raw data for the purpose of answering research questions or testing hypotheses (Polit & Beck, 2010). The descriptive quantitative study is an appropriate method for conducting a research study on a large population to generate the same study's outcomes. The method was selected to generate an explanation of the importance of determining the competency levels of knowledge, skills, and attitudes of participant nurses to perform their assigned jobs efficiently and safely. The competency assessment results aimed to provide Nurse Educators and Managers with information that could be used

to identify those nurses who need performance improvement plans to practice independently with safely (Bartels & Bednash, 2005).

These selected nursing core competencies were: 1.) Patients Centred Care 2.) Quality 3.) Teamwork and Collaboration 4.) Safety 5.) Evidence- Based Practice 6.) Informatics. (Institute of Medicine 2003 competencies for nursing)

The proposed participants for this study to generate relevant data was a sample of the population of nurses currently employed and assigned in Bukidnon Provincial Hospital Manolo and Madonna and Child Hospital. The participants were chosen in a non-randomized selection process regardless of age, gender, civil status, socio-economic status, and nursing position. In-relation to a non-randomized selection process, the investigator used non-probability sampling specifically purposive sampling with work experience of 6 months and above regardless of their work status.

Since survey design and quantitative design are being evoked, self-made survey questionnaire was adapted and modified containing questions that were addressed all the variability presented in the conceptual framework of this study. Thinking about the members and to maintain a strategic distance from conceivable research control and inclination as far as the outcome; the specialist chose to figure many surveys, for the medical attendant being assessed. The nurse's questionnaires were divided into three parts: part 1 involved questions about the participants' demographic data, part 2 Nursing core competency. The questionnaires were adapted and modified from the Institute of Medicine, Health Professions Education. Part 3 was for the quality nursing care, the MMQNC initially developed by Jelinek and others (1974), and later refined and tested by Haussmann and associates (1976), was designed to measure the quality of nursing care will be provided to groups of patients. Regarding the rating of nurses' performance, it was based according to the investigator's jurisdiction upon weighing collated response from the nurses. Cronbach alpha was used to measure the internal consistency reliability with an interpretation of Reliable. Decision made was to proceed to the administration of the survey questionnaire.

Scoring Scale for Part 2 and Part 3 of the questionnaires

Score	Mean score	Verbal description	Interpretation
5	4.50- 5.00	Strongly Agree	Yes, I agree entirely
4	3.50-4.49	Agree	Yes, I agree to some degree
3	2.5-3.49	Neither agree or disagree	Doubtful
2	1.50-2.49	Disagree	No, I do not agree entirely
1	1.00-1.49	Strongly disagree	No, I do not agree at all

Research Protocol

To ensure the quality and reliability of research findings, the investigator observed the following University Protocol. The investigator sought approval from the adviser after careful assessment and review of the manuscript for the project paper. The Dean of the School of the Graduate Studies approved the schedule for the defense of the project proposal after a thorough assessment, and review of the final manuscript. After the proposal defense, the investigator accomplished the Research Ethics Application Form and submitted it to the Office of the Vice President for Research, Publication and Extension together with the approved research proposal. The Assistant Vice President for Research, Publication, and Extension reviewed the proposal and Research Ethics Form for completeness and compliance with the University format and guidelines. The research ethics form was then forwarded to the Assistant Vice President for Research, Publication, and Extension and Vice President for Research, Publication, and Extension for further review and approval of the Research Ethics Review Committee. The investigator wrote letters and secured permission from the Medical Director, Chief Nurse of the private hospital. The investigator also secured the participants' consent to participate in the study. Moreover, the participants were assured that all their responses would be treated with the utmost confidentiality. Provision of the final manuscript. The investigator provided the adviser the copy or the manuscript for assessment and review of the quality and relevance of the paper before the scheduling of the final research presentation. Once the paper was approved by the adviser, it was forwarded to the Graduate Studies Research Coordinator for further review of the completeness of the paper. The Coordinator then met with the dean for the scheduling of the paper presentation. After the final paper

presentation, the investigator incorporated all the corrections and suggestions of the Research Panel. It was then reviewed by the adviser and the panel members. After the paper was approved by the panel, it was then submitted to the Research and Publication Office for Plagiarism and Grammarly Tests. The investigator then forwarded the final paper to their assigned editor. After incorporating all the corrections, the investigator submitted the final paper to the adviser and Research Panel for signature and approval for binding.

The success of any research depends on the kind of data yielded, how these data are being collected, collated and subjected to appropriate testing tools, and how these are analyzed and interpreted. Approval for permission from people who are in authority was consulted before study conduction, specifically the Liceo de Cagayan School of Graduate Studies and The Bukidnon Provincial Hospital Chief of Hospital and Nursing Administration Chief, Madonna and Child Hospital. Once approved, the investigator was then sent an informed consent to the participants asking for their approval to participate in the study followed by the floating of the research questionnaire. Ethical principles were always observed, and from any point at any time, both participants & sub-participants decided to terminate him/her from the study was respected and accepted.

The collected data was treated according to descriptive statistics, analyzed and integrated through the frequency counts, percentages, and weighted mean while the statement of the problems highly equipped with hypotheses was treated according to inferential statistics.

The answers of the questionnaires were calculated and tabulated for data analysis. The investigator was used descriptive statistics approach and followed the sequence method of analysis such as mean, standard deviation, and frequency.

Also, to test the relationship, inferential statistics method was Pearson Product moment of correlation and multiple regressions. The corresponding results support the certification of the collected data from the survey.

According to the Institute of Work and Health (2016), validity and reliability are concepts in research and their use is more complex. Validity is the ability of the instrument to measure what it is intended to measure. According to Smith (1991), it is the degree to which the investigator has measured what he has set out to measure.

Reliability was established by conducting a pilot test. The pilot test was done by collecting data subjects not included in the sample. Data collected from the pilot test was then analyzed using SPSS student version (Statistical Package for Social Sciences), Cronbach alpha was used to measure the internal consistency

reliability.

The questionnaire was pilot-tested and subjected to reliability test at the Office of the Vice President for Research, Publication, and Extension of Liceo de Cagayan University.

For Objective 1, the percentage, and frequency were utilized to determine the participants' profile.

For Objectives 2 and 3, Mean, and Standard Deviation were utilized to distinguish the dimension of competency and nursing quality consideration. The noteworthy dimension of alpha = 0.05 was utilized as the premise.

Objective 4 was dealt with utilizing the Pearson Product Moment of connection for correlativity of critical relationship.

Objective 5 was treated using multiple regressions to shows which variables best predict.

RESULTS AND DISCUSSION

This section shows the information assembled and examination just as the translation of the information. 1. For the method of investigation, elucidating insights, for example, the recurrence and rate circulation were utilized for issue 1 to be explicit on the statistic information of the members as the unit of examination. For issue no. 2 and 3, mean, standard deviation and verbal portrayal were utilized to almost certainly present the information dependent on the dimension of competency of the members. For issue no. 4, Pearson R correlation utilized as the premise to decide the noteworthy distinction between the medical attendant's quality consideration and statistic profile. Furthermore, for issue no. 5, multiple regressions were utilized to decide the factors anticipate the attendant's quality nursing care.

Objective 1: To determine the demographic data of the participants in terms of gender, age, education, job title, and total years of experience.

Table 1

Demographic profile of the participants

CATEGORIES		FREQUENCY	PERCENTAGE
Gender		83	41.50
Male			
Female		117	58.50
	Total	200	100.00
AGE			
22-30 years old		104	52.00
31-41 years old		81	40.50
42-52 years old		9	4.50
52 years old and above		6	3.00
	Total	200	100.00
EDUCATION			
Diploma in Nursing		38	19.00
Bachelor Degree in Nursing		152	76.00
Advanced Degree		10	5.00
	Total	200	100.00
JOB TITLE			
Staff Nurse		138	69.00
Charge Nurse		41	20.50
Head Nurse		6	3.00
Nursing Supervisor		9	4.50
Nursing Educator		6	3.00
Deputy Nursing Director		0	0.00
Nursing Director		0	0.00
	Total	200	100.00
TOTAL YEARS OF EXPERIENCE			
1-5 years		109	54.50
6-10 years		60	30.00
11-15 years		19	9.50
16-20 years		10	5.00
20 years and above		2	1.00
	Total	200	100.00

Table 1 shows the demographic profile of the participants with regards to gender, age, education, job title and years of experience. The table depicts that there are more female participants who participated in the study with approximately 58.5% and there are only 41.1% of male participants who participated in the study. Florence Nightingale considered nursing as an appropriate activity for ladies since it was an expansion of their household jobs. Songbird's picture of the attendant as a subordinate, supporting, household, unassuming, generous just as not very taught wound up predominant in the public arena. The social development of being a medical attendant has regularly implied a minding,

persevering lady. Jobs like sustaining, mindful, reliance, accommodation given to her are inverse from the ones that are credited to men in the public arena (Evans, 1997).

In age category, most of the participants were at the early adulthood age of 22 years old to 32 years old with 52% of its total population and, on the other hand, there were only 3% of the age 52 years and above and, it has the lowest number of participants. Professional empowerment and competency of nurses are among the concerns of human resource management in healthcare systems worldwide. World Health Organization (WHO) requires all the member countries to report and implement their plans for strengthening nurses and equipping them with professional competency. Having competency leads to an improved quality of patient care and increased patient satisfaction with the nurses and helps promote nursing as a profession and improve nursing education and clinical nursing (Nobahar, 2016).

For education, category most of the participants had a Bachelors Degree in Nursing with approximately 76% of the total population and 5% of which came from an advanced degree holder. The American Association of the Colleges of Nursing (AACN) has gathered broad research that shows that higher nursing instruction has a noteworthy effect on clinical results. Attendants with a BSN have better patient results, including lower death rates and lower inability to protect rates too. The examination additionally shows that BSN holders have the higher capability in making great determinations (Medical caretaker Journal Social Community for Nurses Worldwide).

For job title category, 69% of the participants were staff nurses in the research venue hospitals and only 3% were nursing educators who teach future nurses to be competent in their career. According to the Nurse Theory, staff nurses can work in a variety of settings such as at a local clinic, healthcare facility, doctor's office, community health care center, hospital or in a number of other health care organizations. Those who work as staff nurses are able to perform duties such as recording patient vital signs, checking blood pressure, administering IV's (Intravenous therapy), administering medicine, monitoring patients recovery, handling and preparing medical equipment, assisting patients who are part of a rehabilitation program, and assisting other medical specialists with medical related tasks, so that the medical specialist can focus on work that requires more specialized care and attention and is otherwise unable to be performed by a staff nurse. Lastly, for complete long stretches of involvement, 54.5% of the members have 1-5 years of experience and 1% of which has an affair of 20

years or more. An able attendant, by and large, has a few years' understanding at work in a similar field. For instance, a few years in serious consideration. The experience may likewise be comparative everyday circumstances. These attendants are increasingly mindful of long haul objectives, and they increase point of view from arranging their very own activities, which causes them to accomplish more noteworthy effectiveness and association. Capability changes occur after some time. A medical caretaker's or birthing specialist's dimension of ability is affected by their instructive readiness, recurrence of clinical presentation and the length of their experience, specifically, clinical settings. Since skill is not steady, the individual specialist is required to constantly reconsider his/her ability to know of new practice in various circumstances. Each medical attendant and birthing specialist is responsible for expert activities and, in that capacity, they should reject designated or relegated jobs or exercises on the off chance that they judge their capability to be restricted. On the off chance that they distinguish a capability shortfall, they should take proper measures to pick up skill (Nursing and Midwifery Board of Ireland, 2015).

Objective 2: To determine the level of competency in terms of; Patient-Centered Care; Teamwork and Collaboration; Evidenced Base Practice; Quality Improvement; Safety and Informatics.

Table 2

Nursing competency on patient-centered care

Indicators	Mean	S D	Verbal Description
I evoke understanding qualities, inclinations and communicated needs as a component of clinical meeting, execution of consideration plan and assessment of consideration.	4.49	0.672	Agree
I impart tolerant qualities, inclinations and communicated needs to different individuals from social insurance group.	4.53	0.566	Strongly agree
I give understanding focused consideration affectability and regard for the assorted variety of human experience.	4.53	0.575	Strongly agree
I evaluate the nearness and degree of agony and enduring.	4.59	0.628	Strongly agree
I evaluate the dimensions of physical and passionate solace.	4.52	0.575	Strongly agree
I connect with patients or assigned surrogates in dynamic organizations that advance wellbeing, security and prosperity, and self-care the board.	4.53	0.575	Strongly agree
I encourage educated patient assent for consideration.	4.64	0.550	Strongly agree

Table 2 Continued

Indicators	Mean	SD	Verbal Description
I depict how assorted social, ethnic and social foundations work as wellsprings of patient, family, and network esteems.	4.35	0.706	Agree
I show far reaching comprehension of the ideas of torment and enduring, including physiologic models of torment and solace.	4.44	0.646	Agree
I inspect how the wellbeing, quality and cost viability of social insurance can be improved through the dynamic association of patients and families.	4.51	0.601	Strongly agree
I investigate moral and legitimate ramifications of patient-focused consideration.	4.52	0.625	Strongly agree
I talk about standards of compelling correspondence.	4.68	2.858	Strongly agree
I inspect nursing jobs in guaranteeing coordination, reconciliation, and coherence of consideration.	4.59	0.569	Strongly agree
I regard and energize singular articulation of patient qualities, inclinations and communicated needs.	4.54	0.617	Strongly agree
I esteem the patient's aptitude with claim wellbeing and side effects.	4.48	0.549	Agree
I look for learning openings with patients who speak to all parts of human decent variety.	4.47	0.566	Agree
I am energetically bolster understanding focused consideration for people and gatherings whose qualities contrast from possess.	4.46	0.599	Agree
Overall Mean	**4.516**	**0.582**	**Strongly Agree**

Table 2 presents the level of competency in terms of patient centered care, among all the indicators presented, above the highest mean of 4.68 is where nurses discuss effective communication. Moreover the lowest indicator has a mean of 4.44 where nurses demonstrate a comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.

A research paper on, "Communication in Nursing Practice" (2014) found that restorative guardians who show obligingness, thought and security to their patients — through both their exercises and words — are regularly continuously compelling in setting up a similarity. Studies demonstrate that great correspondence among medical caretakers and patients have numerous advantages. To begin with, it extraordinarily adds to the capacity to give patients individualized consideration. Medicinal orderlies who put aside the push to grasp the stand-out troubles and stresses of their patients will be better organized to advocate for the good of them and suitably address issues as they develop. This increasingly significant focus on correspondence routinely prompts better patient outcomes as well.

Second, patients who feel like they are getting the majority of the attendant's consideration amid communication are bound to unveil the genuine degree

of their emotions, and side effects a lot faster. Patients may likewise feel more fulfillment with their consideration if the medical caretaker gives them full focus.

Third, relational correspondence can fulfill the intrinsic needs of the patient as sketched out in Maslow's progressive system of necessities. Those necessities incorporate the sentiments of security, love and certainty, which are all critical amid a patient's treatment and recuperation. It demonstrates that correspondence with nurses benefits the patients, as well as the medical caretakers too. Medical attendants who discuss well with their associates will work in general observer an improvement in assurance just as employment fulfillment. A 2014 article titled Effective Interpersonal Communication: A Practical Guide to Improve Your Life repeats the adverse impacts of poor work environment correspondence. High turnover rates, expanded pressure, and lower assurance and occupation fulfillment are among the numerous drawbacks (Kourkota, 2014).

Table 3

Nursing competency on teamwork and collaboration

Indicators	Mean	SD	Verbal description
I exhibit consciousness of claim qualities and restrictions as a colleague.	4.42	0.628	Agree
I act with respectability, consistency and regard for varying perspectives.	4.48	0.657	Agree
I coordinate the commitments of other people who assume a job in helping tolerant/family accomplish wellbeing objectives.	4.54	0.641	Strongly agree
I speak with colleagues, adjusting own style of conveying to requirements of the group and circumstance.	4.54	0.671	Strongly agree
I exhibit promise to group objectives.	4.46	0.565	Agree
I depict possess qualities, impediments, and qualities in working as an individual from a group.	4.49	0.626	Agree
I portray extents of training and jobs of social insurance colleagues.	4.51	0.641	Strongly agree
I break down contrasts in correspondence style inclinations among patients and families, medical attendants and different individuals from the wellbeing group.	4.53	0.649	Strongly agree

Table 3 Continued

Indicators	Mean	SD	Verbal description
I examine successful systems for imparting and settling strife.	4.41	0.576	Agree
I recognize claim potential to add to compelling group working.	4.59	0.552	Agree
I acknowledge significance of intra-and between expert joint effort.	4.54	0.640	Strongly agree
I esteem collaboration and the connections whereupon it is based.	4.54	0.583	Strongly agree
I add to goals of contention and contradiction.	4.47	0.649	Agree
Overall Mean	**4.503**	**0.620**	**Strongly agree**

Legend: Score	Scale	Verbal Description/ Interpretation
5	4.50-5.00	Strongly agree
4	3.50-4.49	Agree
3	2.50-3.49	Neither
2	1.50-2.49	Disagree
1	1.00-1.49	Strongly disagree

Table 3 depicts the teamwork and collaboration among the nurse participants. The result revealed that nurses acknowledge their own potential to contribute to team functioning has the highest mean of 4.59 however the lowest indicator has a mean of 4.41 where nurses discuss effective strategies for communicating and resolving the conflict. For the overall result, nurses strongly agrees on the indicators being indicated above with a mean of 4.50.

Medical caretakers esteem cooperation and the connections and acknowledge the significance of intra-and between expert joint efforts. "Medicinal services are a perplexing substance, requiring the coordination of various gifted people to give top- notch care," says Susan Alexander, an attendant professional at Riverside Family Health in Alabama. She clarifies that advanced groups give better help to patients, even amid times of pressure.

Table 4

Nursing competency on evidence based practice

Indicators	Mean	SD	Verbal description
I partake successfully in proper information accumulation and other research exercises.	4.31	0.696	Agree
I base individualized consideration plan on patient qualities, clinical ability and proof.	4.27	0.706	Agree
I take part in organizing the workplace to encourage coordination of new proof into models of training.	4.39	0.633	Agree

Table 4 Continued

Indicators	Mean	SD	Verbal description
I counsel with clinical specialists before choosing to veer off from proof based conventions	4.46	0.640	Agree
I show learning of essential logical techniques and procedures.	4.44	0.606	Agree
I depict EBP to incorporate the parts of research proof, clinical skill and patient/family esteems.	4.39	0.640	Agree
I depict dependable hotspots for finding proof reports and clinical practice rules.	4.36	0.726	Agree
I acknowledge qualities and shortcomings of logical bases for training.	4.53	0.649	Strongly agree
I esteem the requirement for moral direct of research and quality improvement.	4.52	0.657	Strongly agree
I welcome the significance of normally perusing applicable expert diaries.	4.42	0.718	Agree
I esteem the requirement for ceaseless improvement in clinical practice dependent on new learning.	4.57	0.571	Strongly agree
Overall Mean	**4.59**	**0.657**	**Strongly agree**

Legend:	Score	Scale	Verbal Description
	5	4.50-5.00	Strongly agree
	4	3.50-4.49	Agree
	3	2.50-3.49	Neither
	2	1.50-2.49	Disagree
	1	1.00-1.49	Strongly disagree

Table 4 presents the level of nursing competency on safety practices in terms of Evidenced Base Practice. The results show that the highest mean is 4.57 where respondents value the need for continuous improvement in clinical practice based on new knowledge. This is more on the trainings and seminars being attended by the nurses, where they valued whatever serving training seminars were being conducted in the institution. The lowest indicator has a mean of 4.27 representing individualized care plan on patient values, clinical expertise, and evidence.

In human services, ceaseless quality improvement (CQI) is utilized conversely with TQM. CQI has been utilized as a way to create clinical practice and depends on the rule that there is an open door for development in each procedure and on each event. Numerous hospital quality confirmation (QA) programs for the most part center around issues distinguished by administrative or accreditation associations, for example, checking documentation, surveying crafted by oversight boards of trustees, and examining credentialing forms (Chassin, 1996).

Table 5

Nursing competency on quality improvement

Indicators	Mean	SD	Verbal description
I look for data about results of consideration for populaces served in consideration setting.	4.35	0.68	Agree
I look for data about quality improvement extends in the consideration setting.	4.36	0.69	Agree
I distinguish holes among neighborhood and best practice.	4.44	0.55	Agree
I work on adjusting the points, measures and changes associated with improving consideration.	4.45	0.61	Agree
I structure a little trial of progress in every day work (utilizing an experiential learning technique, for example, Plan-Do-Study-Act).	4.24	0.78	Agree
I portray techniques for finding out about the results of consideration in the setting in which one is occupied with clinical practice.	4.46	0.65	Agree
I perceive that nursing and other wellbeing callings understudies are portions of frameworks of consideration and care forms that influence results for patients and families.	4.41	0.60	Agree
I clarify the significance of variety and estimation in surveying nature of consideration.	4.45	0.62	Agree
I welcome that ceaseless quality improvement is a fundamental piece of the day by day work of all wellbeing experts.	4.51	0.61	Strongly agree
I esteem possess and others' commitments to results of consideration in neighborhood care settings.	4.56	0.53	Strongly agree
I value the estimation of what people and groups can to do to improve care.	4.61	0.54	Strongly agree
Overall Mean	**4.566**	**0.62**	**Strongly agree**

Legend: Score	Scale	Verbal Description/ Interpretation
5	4.50-5.00	Strongly agree
4	3.50-4.49	Agree
3	2.50-3.49	Neither
2	1.50-2.49	Disagree
1	1.00-1.49	Strongly disagree

Table 5 demonstrates the dimension of nursing competency on wellbeing as far as quality improvement. The outcome uncovered that medical attendants value the esteem people and groups and what it can do to improve care with the most astounding mean of 4.61. Essentially, this is about cooperation and coordinated effort among the staff of the establishment to probably give quality nursing care and quality improvement. The most minimal means among the marker is 4.24 where medical attendants planned a little trial of progress in daily

work (utilizing an experiential learning technique, for example, Plan-Do-Study-Act).

In conveying social insurance, successful cooperation can quickly and emphatically influence understanding security and result. The requirement for successful groups is expanding because of expanding co-morbidities and expanding intricacy of specialization of consideration (Barbicker et al., 2014).

Table 6

Nursing competency on safety

Indicators	Mean	SD	Verbal description
I exhibit compelling utilization of innovation and institutionalized practices that help wellbeing and quality.	4.64	2.962	Agree
I show successful utilization of systems to diminish danger of mischief to self or others.	4.42	0.711	Agree
I impart perceptions or concerns identified with perils and blunders to patients, families and the medicinal services group.	4.52	0.641	Strongly agree
I take an interest suitably in breaking down mistakes and structuring framework enhancements.	4.55	0.663	Strongly agree
I inspect human components and other essential security structure standards just as ordinarily utilized risky practices, (for example, work-around and perilous contractions).	4.46	0.692	Agree
I portray factors that make a culture of wellbeing, (for example, open correspondence procedures and hierarchical blunder revealing frameworks).	4.46	0.640	Agree
I portray general classes of blunders and dangers in consideration.	4.46	0.2.10	Agree
I talk about potential and genuine effect of national patient security assets, activities and guidelines.	4.49	0.617	Agree
I esteem the commitments of institutionalization/unwavering quality to security.	4.58	0.587	Strongly agree
I value the subjective and physical cutoff points of human execution.	4.58	0.605	Strongly agree
I esteem cautiousness and observing (even of possess execution of consideration exercises) by patients, families, and different individuals from the social insurance group.	4.50	0.618	Strongly agree
Overall Mean	**4.513**	**0.778**	**Strongly agree**

Legend: Score	Scale	Verbal Description/ Interpretation
5	4.50-5.00	Strongly agree
4	3.50-4.49	Agree
3	2.50-3.49	Neither
2	1.50-2.49	Disagree
1	1.00-1.49	Strongly disagree

Table 6 shows the dimension of nursing competency as far as wellbeing. Results demonstrate that medical attendants emphatically concur that they exhibit compelling utilization of innovation and institutionalized practices that help wellbeing and quality. Since mistakes are brought about by procedure disappointments framework, it is vital to embrace different procedure improvement strategies to distinguish wasteful aspects, inadequate consideration, and preventable blunders that can impact changes related to the frameworks. Each one of these methods includes evaluating execution and utilizing discoveries to advise on change (McNally, 1997).

Medical attendants' cautiousness at the bedside is basic to their capacity to guarantee quiet wellbeing. It is intelligent; like allocating expanding quantities of patients in the long run trade -offs medical attendants' capacity to give safe consideration. A few original investigations have exhibited the connection between medical attendant staffing proportions and patient security, archiving an expanded danger of patient wellbeing occasions, dreariness, and even mortality as the number of patients per nurture increments (Quiet Safety Network, 2019).

Table 7

Nursing competency on informatics

Indicators	Mean	SD	Verbal description
I look for instruction about how data is overseen in consideration settings before giving consideration.	4.49	0.694	Agree
I apply innovation and data the board instruments to help safe procedures of consideration.	4.51	0.626	Strongly agree
I utilize correspondence advances to organize care for patients.	4.48	0.641	Agree
I clarify why data and innovation abilities are basic for safe patient consideration.	4.51	0.618	Strongly agree
I distinguish fundamental data that must be accessible in a typical database to help persistent consideration.	4.52	0.603	Strongly agree
I perceive the time, exertion, and ability required for PCs, databases and different advances to wind up solid and successful instruments for patient consideration.	4.55	0.555	Strongly agree
I welcome the need for all wellbeing experts to look for deep rooted, ceaseless learning of data innovation abilities.	4.55	0.556	Strongly agree
I esteem medical attendants' inclusion in plan, determination, usage, and assessment of data advancements to help persistent consideration.	4.56	0.581	Strongly agree
I ensure privacy of secured wellbeing data in electronic wellbeing records.	4.65	0.555	Strongly agree
Overall Mean	**4.533**	**0.603**	**Strongly agree**

Legend: Score	Scale	Verbal Description/ Interpretation
5	4.50-5.00	Strongly agree
4	3.50-4.49	Agree
3	2.50-3.49	Neither
2	1.50-2.49	Disagree
1	1.00-1.49	Strongly disagree

Table 7 displays the dimension of nursing competency as far as informatics. This table shows how innovation contributes to medical attendants in conveying quality nursing care. Medical caretakers firmly concur on the pointer where nurture fundamentally secure privacy of ensured wellbeing data in electronic wellbeing records. It has the most noteworthy mean of 4.65. As medical caretakers, through the Nightingale Pledge and all resulting nursing codes, we have recognized the requirement for classification; we made this point well before national enactment was ever examined. The Code for Nurses, distributed by the American Nurses Association (ANA) Ethics Committees, "is the standard by which moral direct is guided and assessed by the calling" (ANA, 1994). Arrangement 3 of the present Code of Ethics for Nurses expresses: "The medical caretaker advances, advocates for, and endeavors to ensure the wellbeing, security, and privileges of the patient" (ANA, 2001).

Objective 3: To determine the Level of Quality of Nursing Care.

Table 8

Level of the quality nursing care

Indicators	Mean	SD	Verbal description
The condition of the patient is assessed on admission.	4.74	0.451	Strongly agree
Data relevant to hospital care are ascertained on admission.	4.73	0.450	Strongly agree
The current condition of the patient is assessed.	4.75	0.446	Strongly agree
The written plan of nursing care is formulated.	4.64	0.503	Strongly agree
The plan of nursing care is coordinated with the medical plan of care.	4.66	0.536	Strongly agree
The need for physical comfort and rest is attended.	4.72	0.513	Strongly agree
The need for physical hygiene is attended.	4.72	0.472	Strongly agree
The patient is protected from accident and injury.	4.66	0.525	Strongly agree
The need for nutrition and fluid balance is attended.	4.72	0.493	Strongly agree
The need for elimination is attended.	4.68	0.480	Strongly agree
The need for skin care is attended.	4.68	0.468	Strongly agree
The patient is oriented to hospital facilities on admission.	4.61	0.632	Strongly agree
The patient's privacy and civil rights are honored.	4.71	0.589	Strongly agree
The patient is taught measures of health maintenance and illness prevention.	4.75	0.459	Strongly agree
The patient's family is included in the nursing care process.	4.73	0.456	Strongly agree
The patient's response to therapy is evaluated.	4.75	0.446	Strongly agree
Isolation and decontamination procedures are followed.	4.66	0.545	Strongly agree
Safety and protective procedures are followed.	4.70	0.530	Strongly agree
The unit is prepared for emergency situations.	4.63	0.529	Strongly agree
Environmental and support services are provided.	4.60	0.567	Strongly agree
Overall Mean	**4.94**	**0.505**	**Strongly agree**

Legend: Score	Scale	Verbal Description/ Interpretation
5	4.50-5.00	Strongly agree
4	3.50-4.49	Agree
3	2.50-3.49	Neither
2	1.50-2.49	Disagree
1	1.00-1.49	Strongly disagree

Table 8 presents the level of quality nursing care. Nurses participants strongly agree based on the indicators given (Mean- 4.94; SD-0.505). Indicator no. 3, 14 and 16 ties the knot obtaining the highest mean of 4.75, which barely shows that nurses assessed the current condition of the patient, taught health measure maintenance and illness prevention and evaluated the response of the therapy. Also, indicator no. 20 has the most reduced mean of 4.60 where medical attendants gave patients natural and bolster administrations. Wellbeing evaluation is imperative and regularly initial phase in recognizing the patient's concern. Wellbeing appraisal recognizes the therapeutic need of patients. Patients' wellbeing is evaluated by leading physical examination of the patient (Jayanthi, 2018).

Objective 4: To determine if there is any significant relationship between nurse's quality care and; demographic profile, patient- centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety and informatics.

Table 9

The relationship between quality care and; demographic profile, patient- centred care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

Variables	Pearson Correlation Coefficient	Probability	Interpretation
Gender	-.036	.617	Not significant
Age	.115	.106	Not significant
Education	-.085	.226	Not significant
Job title	-.106	.137	Not significant
Experience	.082	.250	Not significant
Patient centered care	.516	.000	Significant
Teamwork and collaboration	.444	.000	Significant
Evidence based practice	.456	.000	Significant
Quality improvement	.489	.000	Significant
Safety	.422	.000	Significant
Informatics	.522	.000	Significant

Table 9 demonstrates the relationship between quality consideration and; statistic profile, persistently focused consideration, cooperation and coordinated effort, proof-based practice, quality improvement, wellbeing, and informatics. The outcome uncovered that there is no noteworthy contrast between medical attendant's quality consideration and statistic profile as per sex, age, instructive

foundation, work title and length of experience of the members since the p estimation of the said pointer is more noteworthy than the p esteem alpha of 0.05. Then again for the nursing competency on wellbeing rehearses as far as patient focused consideration, cooperation and joint effort, proof-based practice, quality improvement, security and informatics the outcome demonstrates that there is a critical contrast since the likelihood estimation of the said indicators are not exactly the p esteem alpha of 0.05.

Late statistic movements will have real ramifications for the U.S. medicinal services framework, both as far as the conveyance of patient consideration and the act of nursing. As per specialists at Kansas State University, improved general wellbeing and clinical consideration have prompted an expansion in the normal life expectancy, implying that constantly 2020 more than 20 percent of the populace will be age 65 or more seasoned. People beyond 85 years old make up the quickest developing gathering. This will prompt broadened treatment of long haul perpetual conditions, testing the medicinal services framework's capacity to give proficient consideration.

Also, the assorted variety of the all-inclusive community is a pertinent subject on the psyches of numerous medical caretakers. Since multiculturalism influences the idea of ailment and infection just as dreariness and mortality, attendants must figure out how to adjust their training to different social qualities and convictions. Important components incorporate national starting point, religious alliance, language, sex, sexual introduction, age, inability, financial status and that is just the beginning. Understanding social decent variety is turning into an everyday obligation regarding numerous medical attendants.

Such changes in the populace are noteworthy for medical attendants. Nursing practice, training, and viewpoints must adjust and react to changing socioeconomics because medical attendants assume an undeniably vital job in medical services conveyance (Campbellsville University, 2016).

Expanding proof shows hierarchical administration at the cutting edges of consideration is fundamental to accomplish change; authority pledge to making a security culture fortifies a wellbeing outlook among all staff and creates practices important to accomplish upgrades. Wellbeing is firmly connected to demeanors and conduct, and winning mentalities over the consideration group are essential to the culture at both the unit and the authoritative dimension. Frames of mind and practices are hard to change; new competency models can extend limit concerning medical caretakers to grow sincerely canny pioneers who help lead hierarchical change in creating and supporting societies of security (Armstrong & Sherwood, 2012).

Objective 5: To determine which variables predict the nurse's quality nursing care.

Table 10

Multiple regression analysis among the independent and dependent variable.

Variables	Un standardized coefficient		Standardized coefficient	t	Sig.
	B	Std. error	Beta		
Constant	2.144	.254		8.439	.000
Patient centered care	.295	.088	.335	3.358	.001
Informatics	.210	.074	.262	2.853	.005

Table 10 uncovers the relapsed investigation of the factors predicting the medical attendant's quality nursing care. The coefficient of assurance uncovered that quality contributed 35.2%. Nonetheless, tolerant focused consideration has a p estimation of 0.001 pursued by informatics which got a p estimation of 0.005 which implies that the two factors anticipate the medical attendant's quality nursing care. So since the p esteem is under 0.05 accordingly, speculation is neglected to be acknowledged. Persistently, focused consideration is the best indicator since the beta under standardized coefficient has the most astounding number of .335 among the other.

The outcomes were bolstered by the investigation of Delaney (2018) that Patient-focused Consideration (PCC) has risen as an essential way to deal with human services. This methodology underscores organizations in wellbeing among patients and human services experts, recognizes patients' inclinations and qualities, advances adaptability in the arrangement of social insurance and looks to move past the customary paternalistic way to deal with medicinal services. Accordingly, notwithstanding the physical parts of social insurance, the PCC approach recognizes a patient's convictions and qualities towards prosperity.

The upsides down of applying data innovation in all parts of nursing, including clinical territories, the board, instruction and research and its effect on social insurance have been looked into. Today, the subjects of clinical nursing data frameworks, choice emotionally supportive networks, and medicinal analytic frameworks are related to gathering quiet data. Concerning innovation rich condition, medicinal services and emergency clinic data frameworks designers and the nature of these considerations are improving. Expanding understanding

security prompt a proof based nursing, nursing informatics which have improved for the benefit of understudies and graduates by Columbia School of Nursing (Darvish et al., 2014).

CONCLUSIONS

In general, the participants strongly agree on the indicators being provided. The demographic profile does not matter at all to a newly graduate nurse or even the experienced ones for as long as they have the heart to serve the people, quality nursing care always be there. Even the status of the participants, all has the heart to carry the torch of serving the people particularly their patients. There is indeed no significant relationship between nurses' quality care and demographic profile but there is a significant difference on the level of nursing competency on safety practices in terms of patient-centered care, teamwork and collaboration, evidenced-based practice, quality improvement, safety and informatics.

Two variables predict the nurse's quality nursing care: patients centered care and informatics. The participants were indeed a patient's advocate for patients are at the center of their care. They can collaborate; unity and camaraderie is the key. Thus, to be able to improve the quality nursing care evidence-based practice is essential to impart nursing care safely to the patients and have a vision on information dissemination that is thru proper communication. Communication is very important since it maintains a strong relationship towards colleague and most especially to the patients.

RECOMMENDATIONS

The findings, conclusions and implication of the study summed up to some recommendations:

1. For Hospital Administrators, there is a need for some training's and seminars to be able to enhance the skills, knowledge and attitude of the nurses. The researcher believes that education is a continues process thus education is very important for it cannot be taken away, one can have money, fame or anything but all of this will fade, but true education will always be there. And also for the purpose of an investment, nurses invested their time and everything to the institution so to give it back to them they have to invest nurses in the hospital to be able to impart quality nursing care and empower their staff through in service training and seminars;

2. Nursing Supervisors and Managers should have some refreshment to the staff most especially to some procedures that will surely be useful to the work environment. They may conduct return demonstration maybe to inculcate in their minds the importance of quality nursing care. Moreover, also to test their competency and evaluate themselves to how far they could render nursing competency;

3. For the future researcher, they may investigate other institution that might determine enhancement of quality nursing care services, and which will consider the relationship between medical doctors and nurse's relationship in the hospital as to how they collaborate to be able to conduct quality nursing care; and

4. For the nurses, the researcher suggests that they adhere to the holistic care to improve quality care.

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