RESEARCH ARTICLE

Evidence-Based Practice Competency, EBP Beliefs and Research Utilization among Ghanaian Nurses: A Mediation Analysis

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Abstract

Purpose: The disparity between conducting research and putting it into practice has remains a global healthcare issue, with less than 50% of nurses utilizing research. This study aims to determine the level and relationship between Evidence-based practice (EBP) competency, current EBP beliefs and research utilization among nurses.

Design and Methods: This quantitative study utilized a descriptive-correlational design and mediation analysis. A purposive sampling was used to select six Christian Health Association of Ghana (CHAG) hospitals. Simple random sampling was used to recruit 544 nurses from the six CHAG hospitals. The study utilized mean and standard deviation, Pearson Correlation, ANOVA, and GLS mediation analysis. The researcher obtained ethical approval from the Saint Louis University Research Ethics committee and, the institutional review board of the CHAG.

Findings: The results showed that nurses had a low level of EBP competency (M=2.27, SD= 0.255), strong positive EBP beliefs (M=2.58, SD=0.322) and low research utilization (M=2.57, SD=0.300). There was a moderately significant positive relationship between EBP competency and research utilization (r= .431, p= .000), EBP competency and EBP beliefs (r= .327, p= .000) and EBP beliefs and research utilization (r= .306, p= .000). There is no significant difference in terms of EBP competency and research utilization when EBP training attendance was considered. Nurses with 1-2 years of experience had a higher level of EBP competency. Theatre nurses had a higher level of EBP competency, however, emergency nurses had a lower level of research utilization than nurses in the surgical unit. EBP beliefs mediated the relationship (B= 0.0604, z= 3.99, p < .001) between EBP competency and research utilization.

Conclusions: Nurses in CHAG hospitals have a limited ability to implement the EBP process. The respondent perceived the value of EBP in nursing practice to be significant and has the confidence to implement the EBP process. The nurses' respondents use of research in nursing practice is limited due to the organizational barriers in CHAG institutions in Ghana. Based on the findings, it is recommended for nurse administrators and policy makers to prioritize the provision of adequate resources, support, EBP policies and targeted training programs to facilitate a culture of evidence-based practice and research utilization in CHAG institutions. By improving EBP competency and promoting research utilization, nurses can enhance the quality and safety of patient care.

Keywords: *Evidence-based practice, Competencies, Research utilization, EBP beliefs*

Introduction

Nurses are one of the primary utilizers of research in practice to promote patient safety (Majid et al., 2011). Joyce and Cartwright (2019) emphasized that the disparity between conducting research and putting it into practice has become a global nursing issue that has drawn the attention of international health organizations. In response, the International Council of Nurses (ICN), American Nurses Association (ANA) and The Institute of Medicine (IOM)

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established goals and guidelines for healthcare decisions to be backed by accurate best available evidence that is up-to-date. Despite the efforts of international health organizations, Duff et al. (2019) determined that less than 50% of nurses utilize research in nursing practice. McGinnis et al. (2009) identified that most evidence used in practice was beyond 17 years old.

In this study, evidence-based practice (EBP) competency is operationally defined as an individual's perceived personal cognitive, psychomotor, and affective ability to implement the EBP process. Studies reported in different settings have shown varied nurses' levels of evidence-based practice competency. In public teaching hospitals (Atakro et al., 2020 & Camargo et al., 2018) and hospitals with adequate EBP support (Aynalem et al., 2021 & Dereje et al., 2019) nurses possessed a moderate to a high level of EBP competency. On the contrary, studies conducted in public hospitals (Assefa & Shewangizaw, 2021; Fu et al., 2020; Melynk et al., 2017; Verloo et al., 2016) and hospitals in rural settings (Yiridomoh et al., 2020) suggest that nurses had a low level of EBP competency due to a lack of internet access, technological competence, and managerial support.

EBP belief is an individual factor influencing research utilization into practice and EBP implementation. EBP beliefs in this study are operationally defined as an individual perception EBP value and the confidence to put the EBP process into practice. Previous literature suggests that nurses believe positively about EBP (Arde, 2018; Pereira et al., 2018; Verloo et al., 2016). However, other studies have also concluded that nurses negatively believe in EBP (Gifford et al., 2018; Vehviläinen-Julkunen, 2016). Gifford et al. (2018) concluded that nurses in lower-income countries believed that EBP could only be utilized when there is a clinical problem but not as a daily practice. Possessing a positive or negative belief towards EBP can influence research utilization in practice.

Research is the foundation of safe and quality nursing care (Abujaber & Nashwan, 2018). This study defines research utilization as an individual's use of research-based knowledge in nursing practice. Previous studies suggest that nurses in teaching hospitals have a high level of research utilization in their nurse's practice. This claim is supported by the study of Kyalo et al. (2015), where 70.5% of nurses utilize research in their nursing practice, and Sanluang and Aungsuroch (2016), where research is used among nurses in Thailand, was moderate. The high level of research utilization among nurses in teaching hospitals is attributed to the resources and research culture of the institutions.

However, in public hospitals, Dagne and Tebeje (2021) and Kousar et al. (2017) concluded that nurses showed low research utilization in nursing practice. The authors noted that non-intentional research utilization was a common practice among nurses. This conclusion suggests that most nurses are unaware when their practice is guided by research.

In Africa, Ghana has one of the lowest rates of research utilization among nurses. Approximately 54% of nurses in Zambia, 30.9% of nurses in Nigeria, and only 25.3% of nurses in Ghana integrate research into their practice (Aynalem et al., 2021). Fu et al. (2020) proposed that nurses' EBP competency and EBP belief may be a precondition for effective research utilization in the clinical setting. However, reviewing past literature has provided conflicting results on the influence of evidence-based practice competency on research utilization (Kim et al., 2015; Skela-Savič et al.,2017) Moreover, previous studies have focused on EBP competency and beliefs towards the implementation of EBP (Cruz et al., 2016; Pereira et al., 2018), with a lack of focus on EBP competency and research utilization when mediated by EBP beliefs.

The empirical evidence from this study will contribute to nursing practice, administration, research, policies, and education. It will provide nurses with valuable insights into their beliefs, competency, and practices, serving as an indicator of progress in EBP competency and research utilization. Nurse administrators in CHAG institutions will gain knowledge on the resources and support needed to promote research utilization. Policymakers can use the study results to understand EBP competency, beliefs, and research utilization among nurses and develop institutional policies accordingly. The study will also fill the gap in understanding the influence of EBP competency and beliefs on research utilization. For nursing education, the findings will guide educators in incorporating activities that foster students' interest in research and EBP, preparing them for their transition into nursing practice.

Therefore, this study sought to determine the level of EBP competency and beliefs and its relationship with research utilization among nurses.

Methods and Procedures

Research Design. This quantitative study utilized a descriptive-correlational design with mediation analysis.

Locale and Population. Ghana is located in the western part of Africa. The researcher used the purposive sampling technique to choose six Christian Health Association of Ghana (CHAG) hospitals from six major regions: Ashanti region, Greater Accra region, Bono, Bono East region, Ahafo Region, and Northern region of Ghana.

Furthermore, the researcher used simple random sampling to recruit 544 respondents nurses from CHAG Hospitals in the six selected regions in Ghana. The respondent's inclusion criteria

Table 1. *Work Related Variables of Respondents*

	Demographic	Frequency	Percentage
Years of Experience			
	1-2 Years	257	47.2 %
	3-5 Years	164	30.1 %
	6-9 Years	88	16.2 %
	10 Years and Above	35	6.4 %
EBP Training			
	None	262	48.2 %
	1-2	176	32.4 %
	3-5	86	15.8 %
	6 and above	20	3.7 %
Clinical Unit of Assignment			
	Medical Unit	173	31.8 %
	Theatre Unit	50	9.2 %
	Maternity Unit	46	8.5 %
	Emergency Care Unit	95	17.5 %
	Surgical Unit	120	22.1 %
	Intensive Care Unit	60	11.0 %

were: full-time nurse employee of the selected hospitals and the nurse must have at least one year of working experience. The respondent's exclusion criteria were: nurse administrators, a part-time employee, a float nurse in the current unit, nurses with less than one year of working experience.

The demographic profile of the respondents in terms of the years of experience, the number of EBP training attended, and the clinical unit of assignment are described in table 1.

Data Gathering Tools. This study adopted the Evidence-Based Practice Competency Questionnaire Professional version (EBP-COQ Prof), a standardized tool developed by Ruzafa‐Martínez et al. (2020) The EBP-COQ Prof tool had internal reliability with a Cronbach alpha of 0.8.). In this study, the EBP-COQ Prof yielded a Cronbach alpha of 0.859. The respondents rated each item using a 5-point Likert scale from strongly agree to strongly disagree.

The study adopted the EBP Belief Scale, a standardized self-assessment tool developed by Melynk and Fineout-Overholt (2008). The Cronbach's alpha of the tool is .90, with a Spearman-Brown r of 0.87. In this study, the EBP Belief Scale yielded a Cronbach alpha of 0.846. The nurses rated the items on a 4-point scale from strongly agree to strongly disagree.

Lastly, the study adopted the Research Utilization Questionnaire (RUQ) further revised by Wallin et al. (2003). The Cronbach's alpha of the tool ranged from 0.71-0.90. In this study, research utilization yielded a Cronbach alpha of 0.783. The respondents rated each item using a 5-point Likert scale from strongly agree to strongly disagree.

Data Gathering Procedures. The researcher obtained ethical approval from the Saint Louis University Research Ethics committee under protocol number SLU-REC 2022-001 and the institutional review board of the CHAG with protocol number CHAG-IRB06012022. The researcher employed (6) six research assistants in Ghana with quantitative research experience. The research assistants began data collection after approval and endorsement by the head nurses or nurse administrators. Data collection commenced on April 4th, 2022 to June 30th, 2022. Upon receiving informed consent, the respondents filled out the research questionnaires. The respondents were given a day to be able to fill out the questionnaire during their non-duty hours to avoid disruption of daily nursing routines. The research assistants encoded the data with frequent monitoring and instructions from the researcher. The research assistant sent the encoded data on an EXCEL sheet to the researcher via email for data analysis.

Statistical Tool and Treatment. The study utilized descriptive and inferential statistics to analyze the data using the Jamovi Statistical Software. The statistical technique to be employed in the study was as follows: percentages, frequency distribution, mean, standard deviation, Pearson Correlation Coefficient, ANOCA and GLS mediation analysis.

Ethical Considerations. The respondents were informed about the purpose of the study, and informed consent were sought from the respondents. Participation was solely voluntary, and no compensation was given to the participants. The respondents had the right to refuse or withdraw from the study without facing any penalty. The respondents were treated fairly and equally without any judgment. Anonymity and privacy was adhered to throughout the study in which the respondents' identity and any identifiable information were not included in the study report. Only aggregate data was presented in the study report.

Results

The findings of the study as presented in Table 2. suggests that the level of EBP competency among the respondents is low. However, despite the low level of EBP competency the respondents possess a positive belief about the value and confidence towards EBP as presented in Table 3. In terms of research utilization, the respondent's level of research utilization in the clinical setting is low as presented in Table 4.

Table 5 presents the relationship between EBP competency, EBP beliefs, and research utilization. The statical results showed a moderately significant positive relationship between EBP competency and research utilization (r= .431, p= .000), EBP competency and EBP beliefs (r= .327, p= .000) and EBP beliefs and research utilization (r= .306, p= .000).

In terms of differences, EBP competency and research utilization showed no significant difference when EBP training

Table 2. *Level of EBP Competency among Ghanaian Nurses*

Domain	Mean (M)	Standard Deviation (SD)	Interpretation
EBP Attitude	2.84	0.491	Moderate Competence
EBP Knowledge	2.07	0.341	Low Competence
EBP Skills	2.08	0.433	Low Competence
EBP Utilization	2.16	0.385	Low Competence
Overall EBP Competency	**2.27**	**0.255**	**Low Competence**

Legend: 4.20-5.00 (Very High Competence), 3.40-4.19 (High Competence), 2.60-3.39 (Moderate Competence), 1.80-2.59 (Low Competence), 1.00-1.79 (Very Low Competence)

Table 3. *The Current EBP Beliefs among Ghanaian Nurses*

Domain	Mean	Standard Deviation	Interpretation	Qualitative Descriptor
Overall EBP Beliefs	2.58	0.322	Positive Belief	Nurses' beliefs about the value of EBP and their confidence to implement it are strong

*Legend:*3.33-4.00 (Positive Belief), 2.50-3.32 (Positive Belief), 1.70-2.49 (Negative Belief), 1.00-1.69 (Negative Belief)

Table 4. *The Level of Research Utilization among Ghanaian Nurses*

Domain	Mean	Standard Deviation	Interpretation
Attitude towards Research	2.82	0.419	Moderate Research Utilization
Availability and support to implement research findings	2.42	0.523	Low Research Utilization
The use of research findings in daily practice	2.39	0.315	Low Research Utilization
Overall Research Utilization	**2.57**	**0.300**	**Low Research Utilization**

Legend: 4.20-5.00 (Very High Research Utilization), 3.40-4.19 (High Research Utilization), 2.60-3.39 (Moderate Research Utilization), 1.80-2.59 (Low Research Utilization), 1.00-1.79 (Very Low Research Utilization)

Table 5. *The Relationship Between EBP Competency, EBP Beliefs, and Research Utilization among Ghanaian Nurses*

		EBP Competency	EBP Beliefs	Research Utilization
EBP Competency	Pearson Correlation	1	.327*	.431**
	Sig. (2-tailed)		.000	.000
	N	544	544	544
EBP Beliefs	Pearson Correlation	.327**	1	.306**
	Sig. (2-tailed)	.000		.000
	N	544	544	544
Research Utilization	Pearson Correlation	.431**	.306**	1
	Sig. (2-tailed)	.000	.000	
	N	544	544	544

**. Correlation is significant at the 0.01 level (2-tailed).

Table 6. *Mediation Effect of EBP Beliefs on EBP Competency and Research. Utilization*

				95% C.I. (a)				
Type	**Effect**	**Estimate**	**SE**	**Lower**	**Upper**	**β**	**z**	**p**
Indirect	EBP COM ⇒ EBP B ⇒ RU	0.0710	0.0178	0.0362	0.106	0.0604	3.99	< .001
Component	EBP COM ⇒ EBP B	0.4130	0.0511	0.3128	0.513	0.3274	8.08	< .001
	EBP B ⇒ RU	0.1720	0.0375	0.0986	0.245	0.1845	4.59	< .001
Direct	EBP COM ⇒ RU	0.4354	0.0472	0.3428	0.528	0.3703	9.22	< .001
Total	EBP COM ⇒ RU	0.5064	0.0455	0.4172	0.596	0.4307	11.12	< .001

Note. Confidence intervals computed with method: Standard (Delta method)

attendance is considered. In terms of years of experience, Post-hoc comparison using the Tukey Post-Hoc Test showed that nurses with 1-2 years of experience have a higher level of EBP competency. In terms of clinical unit of assignment, Post hoc comparison using the Tukey Post-Hoc Test indicated that theatre nurses have a higher level of EBP competency when compared to other clinical units. Additionally, in terms of research utilization, post-hoc comparison using the Tukey Post-Hoc Test showed that that emergency nurses have a lower level of research utilization as compared to surgical nurses.

Table 6 shows the mediating role of EBP beliefs on EBP competency and research utilization among Ghanaian nurses. The findings suggests that EBP beliefs partially mediates the relationship between EBP competency and research utilization.

Discussions

The findings of the study showed that Ghanaian nurses had an overall low EBP competency to implement the EBP process. The findings of the study are consistent with Fu et al. (2020), Harper (2017), and Melynk et al. (2017). Fu et al. (2020) study conducted among Chinese nurses noted that their self-assessment of EBP competency was low. Similarly, Melnyk et al. (2017) study conducted among 2,344 USA nurses showed that USA nurses did not believe that they met the required EBP competencies. The low level of EBP competency among Ghanaian nurses can be attributed to several factors. Firstly, Ghanaian nurses in this study lacked exposure to EBP skill-building training and seminars. The findings of this study revealed that 48.2% of nurses had attended no EBP training, and only 3.7% of nurses had attended six or more EBP training during their employment. The results led to a similar conclusion where Aynalem et al. (2021) study provides evidence that only 23% of nurses in Ethiopia received EBP training which also contributed to the low EBP competency among Ethiopian nurses.

In the Ghanaian setting, guidelines and protocols are not updated regularly based on evidence (Atakro et al., 2020). Atakro et al. (2020) added that Ghanaian nurses with 1-5 years of experience rely on nurses with more clinical years of experience and doctors' orders due to the unclear job description on nurses' expectations towards the use of evidence in practice. Additionally, nurses in Ghana due to the lacked adequate resources to facilitate the enhancement of their EBP competency such as EBP skills-building activities, internet, library, and electronic databases. In addition, Bayuo (2017) mentioned that there is a lack of EBP mentors and champions in the healthcare system to equip nurses with EBP utilization competence and change within the organization to facilitate a culture of EBP.

Despite the low level of EBP competency, nurses possess a positive belief towards EBP. This shows that Ghanaian nurses in this study valued EBP and it's importance in providing quality patient care as EBP is integrated in the Ghanaian nursing curriculum. Consistent with other studies on EBP beliefs (Cruz et al., 2016; Leufer et al., 2021; Stokke et al., 2014) showed a positive belief among nurses strengthens use of research-based knowledge among nurses in the clinical setting.

Low research utilization suggests that nurses' attitude towards research, availability, and support to implement research findings and use of research in daily practice is inadequate. The findings of this study are in accordance with Dagne and Tebeje (2021) and Kousar et al. (2017). Although Ghanaian nurses agreed that research was performed within the community and workplace, they lacked time to read the research, did not have access to research findings within the workplace, and the unit managers did not support research utilization. Moreover, in Ghana, the allocation of time to engage in research activities while on duty is not given to nurses and is perceived to be an activity to be engaged during non-duty hours. Lack of time to read research among nurses and the lack of resources and adequate support were consistent with the findings of previous research studies (Da'seh & Rababa, 2021; Hu et al., 2019; Mahaki et al., 2016; McCleary & Brown, 2003; Melnyk et al., 2012).

The findings of this study have contributed to the understanding of the level and relationship between EBP competency, EBP beliefs, and research utilization among Ghanaian nurses in CHAG hospitals. The strength of this study lies in its large sample size of 544 nurses, which increases the generalizability of the findings among CHAG hospitals in Ghana. However, there are a few limitations to this study. Firstly, the study was conducted within six CHAG hospitals in Ghana and, therefore, cannot be generalized beyond this specific type of organization. The study relied on self-reported measures, which may introduce response bias or social desirability bias, affecting the accuracy of the data collected.

Conclusions and Recommendations

In order to utilize the best research during nursing decision-making, planning patient care, and generally guiding Ghanaian nurses in CHAG hospitals, the findings support that nurses need to improve their EBP competency, strengthen their EBP beliefs and the provision of adequate support and resources by the organization is essential to sustain the utilization of research-based knowledge. It is recommended that nursing administrators integrate the expectations of research utilization and EBP during the clinical lifespan of nurses and provide adequate resources and support to increase the level of research utilization. Policymakers are encouraged to set clear organizational EBP and research utilization goals and standards. In nursing research, it is recommended that future studies utilize qualitative approval to understand how culture influences EBP in the Ghanaian context.

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Let us never consider ourselves finished, nurses. We must be learning all of our lives.

Florence Nightingale, *founder of modern nursing*

RESEARCH ARTICLE

Assessment of the Spiritual Nursing Care Competencies of Nursing Students in the Ilocos Region, Philippines: A Descriptive Correlational Study

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Abstract

The study aimed to assess the spiritual nursing care competencies of BSN students in Region 1 through the utilization of a descriptive-correlational research design involving the 424 Levels 2 - 4 BSN students and 125 clinical instructors from 14 selected higher education institutions. Data were gathered through questionnaires and were analyzed using frequency percentage, mean, and Pearson Correlation Coefficient. Findings revealed that the extent of the spiritual nursing care competencies of BSN students in Region 1 is moderate (spiritual nursing knowledge: $\bar{x}$ = 11.18; spiritual values: $\bar{x}$ = 3.77; and spiritual nursing skills: $\bar{x}$ = 2.76). There is a very weak positive, statistically significant correlation between the students' year level and spiritual values (r = 0.135, SD = 0.63, p < 0.01) and spiritual nursing skills (r = 0.153, SD = 0.62, p < 0.01). Furthermore, a very weak inverse significant relationship was revealed between the school category (r = -0.113, SD = 0.62, p < 0.05) and the level of accreditation (r = -0.101, SD = 0.62, p < 0.05) to their spiritual nursing skills. The BSN students in Region 1 are reasonably competent in rendering spiritual nursing care. Their year level, school category, and school accreditation are important factors to better spiritual nursing skills. As they advance in the year level, they are likely to assimilate spiritual values that are indispensable in delivering spiritual nursing care. However, amidst this favorable competence, clinical instructors still see the students as work in progress, capable of excelling. Thus, the utilization of the training module, which is an output of this endeavor, can help the nurse educators mold BSN students to advance their spiritual nursing care competence.

Keywords: *Spiritual Nursing Care Competencies, Spirituality, Assessment*

Introduction

Spiritual care is an integral and indispensable element in the practice of nursing. It is an important aspect of care because addressing the patients' spiritual needs is a component of the holistic nature of nursing care that pose a considerable challenge in realizing the meaning of spiritual care.

Despite the increasing focus on spiritual dimension, nurses' confidence in dealing with spiritual concerns are still confronted (Royal College of Nursing, 2010). Many factors affect the capability of nurses in assisting patients with their spiritual needs. Narayasamy (2001) asserted that less emphasis is given to spiritual aspects, and is under-utilized while other authors attempt to explain the inadequacy of spiritual caregiving in practice. Perry (2016) for instance mentioned lack of time and administrative support. The most debated reason for not providing spiritual care revolves around lack of educational preparation (Leeuwen et al., 2008) while Lewinson et al. (2015) acknowledged the factor of underrepresentation of spiritual care content in nursing education and practice. With all the mentioned issues, the importance of developing competent spiritual care nurses through intensive training becomes an idea to be reckoned with. This may be carried out significantly early in the student nurses' training during the four years of nursing education.

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Integrating spirituality into the nursing curriculum, as mentioned by Wallace-Kazer et al. (2008), entails the commitment of the school of nursing and universities. Yilmaz and Gurler (2014) posited that integrating the concept of spirituality into the undergraduate nursing curriculum increases the knowledge, attitudes, and awareness associated with the spirituality of nursing students.

Generally, teaching spiritual care remains uncertain as to its execution, course design, delivery and course content (Dugan et al., 2011) as there are limited resources and lack models to benchmark from (Yimaz & Gurler, 2014). It must be noted, however, that there is already an existing memorandum on the inclusion of spiritual nursing care in the curriculum. The CHED through its Memorandum Order no. 14 series of 2009 prescribed the integration of Spiritual Care as an elective subject in its new Policies and Standards for Bachelor of Science in Nursing Program. This Memo was then updated in 2017 (CMO # 15 s. 2017) with the recommended course descriptive name: Religion, Religious Experiences, and Spirituality. These memoranda demonstrate CHED's support for spiritual nursing care. However, its effects on students' spiritual nursing care performance have yet to be determined, warranting usefulness of this study in determining how this memorandum has been translated into practice.

This study aimed to assess the spiritual nursing care competencies of BSN students. Results may serve as a reference in designing an educational program on which the objectives, competencies, and contents may be based from. Outcomes may provide nurse educators a more profound insight into appropriate training and education for student nurses. This study may pave the way for new approaches to teaching spiritual care nursing to student nurses in the future. The study findings were also used to create a spiritual care training module that that clinical instructors may use in teaching Spiritual Care Nursing. Nursing administrators may also use this as a component for their service programs, improving BSN students' spiritual nursing care competence.

Methods

A descriptive-correlational research design was utilized to assess the spiritual nursing care competencies of BSN students. The study was conducted in 14 universities and colleges offering the program in Bachelor of Science in Nursing in the four provinces of Region 1. All the 14 HEIs offers the subject Spiritual Care Nursing, now known as Religion, Religious Experiences, and Spirituality.

The study involved two groups of respondents. The first group were the 424 level 2, 3, and 4 student nurses officially enrolled during the school year 2017-2018, who were selected through stratified sampling. In this study, a significant percentage of the student nurse respondents are on Level 3 (193 or 45.52 %) and belong to Level 2 – Accredited HEIs (208 or 49.06%). The

Table 1. *Distribution of the Respondents*

Province	Universities and Colleges of Nursing	Number of Student Respondents	Number of CI Respondents
Ilocos Norte (3)	Divine Word College of Laoag	31	6
	Northern Christian College	22	3
	Northwestern University, Inc.	42	6
Ilocos Sur (2)	St. Paul College of Ilocos Sur	7	5
	University of Northern Philippines	38	20
La Union (3)	Don Mariano Marcos Memorial State University – Agoo Campus	28	11
	Lorma Colleges, Inc.	34	18
	Union Christian College	36	6
Pangasinan (6)	Lyceum-Northwestern University	17	2
	Pangasinan State University- Bayambang Campus	41	5
	University of Luzon	20	10
	University of Pangasinan	37	18
	Urdaneta City University	31	10
	Virgen Milagrosa University Foundation	40	5
	TOTAL	**424**	**125**

majority of them came from private HEIs (286 or 67.45%) and were enrolled in the Spiritual Care Nursing subject (114 or 73.08%).

The second group of respondents included 125 clinical instructors (CI) from the different universities and colleges of nursing who followed up students in the clinical area for at least five months or one term and were selected through purposive sampling. The CI respondents assessed the extent of the spiritual nursing care competencies (skills) of BSN students in general regarding their skills. The majority of the respondents came from private HEIs (79 or 63.2%), while a significant percentage (44 or 35.2 %) of them followed- up students in various levels (multilevel) and are teaching in Level 2-Accredited HEIs (58 or 46.4%).

A questionnaire consisting of two parts was the primary data gathering tool for the study.

Part 1 asked for the demographic profile of the respondents. Part 2 were statements related to the student nurses' spiritual nursing care competencies focused on a) spiritual nursing knowledge, b) spiritual values, and c) spiritual nursing skills. Items on spiritual values were lifted from the Spirituality and Spiritual Care Rating Scale (SSCRS) developed by McSherry et al. (2002) of the Royal College of Nursing. The questionnaire on students' spiritual nursing knowledge and spiritual nursing skills were subjected to content validation and reliability testing with the following results: knowledge CVI = 0.983 and $\alpha = 0.901$; and skills CVI = 0.98 and $\alpha = 0.729$.

In gathering data, the researcher initially obtained permission from the Saint Louis University Research Ethics Committee (SLU-REC), with an approval certificate number SLU – REC 2017 – 149. Permission to administer questionnaire was obtained from the presidents and, consequently, from the universities' deans and colleges of nursing in Region I. The respondents' rights were protected through written informed consent, disclosing the study's full information as to its purpose, procedural requirements, risks, and benefits. This also included acquiring of written assent and consent from parents for students below 18 years of age. For ethical reasons, the researcher warranted confidentiality, anonymity, and privacy of the respondents through number-coding.

In determining the strength of association among variables, the researcher used the Pearson product-moment correlation coefficient. A software package, the SPSS (Statistical Package for the Social Science) statistics, was utilized in data analysis.

Results

This section presents the study's findings on the extent of spiritual nursing care competencies of BSN students in Region 1

Table 2. *Characteristics of the Respondents*

Student Respondents' Characteristics	N	%
Year Level		
Level 4	149	35.14 %
Level 3	193	45.52 %
Level 2	82	19.34 %
TOTAL	**424**	**100.00 %**
School Category		
Government	138	32.55 %
Private	286	67.45 %
TOTAL	**424**	**100.00 %**
School's Accreditation Level		
Level 4	34	8.02 %
Level 3	134	31.60 %
Level 2	208	49.06 %
Level 1	17	4.01 %
No Accreditation	31	7.31 %
TOTAL	**424**	**100.00 %**
With or without Spiritual Care Nursing elective subject *(level 4 only)*		
Enrolled	114	73.08 %
Not Enrolled	42	26.92 %
TOTAL	**149**	**100.00 %**
Clinical Nurse Instructors' Characteristics	**N**	**%**
Year Level		
Level 4	24	19.2 %
Level 3	34	27.2 %
Level 2	23	18.4 %
Multilevel	44	35.2 %
TOTAL	**125**	**100.00 %**
School Category		
Government	46	36.80 %
Private	79	63.20 %
TOTAL	**125**	**100.00 %**
School's Accreditation Level		
Level 4	18	14.40 %
Level 3	41	32.80 %
Level 2	58	46.40 %
Level 1	2	1.60 %
No Accreditation	6	4.80 %
TOTAL	**125**	**100.00 %**

as assessed by the students themselves, the extent of their spiritual nursing skills as assessed by their clinical instructors, and the relationship of the study's variables.

Extent of Spiritual Nursing Care Competencies of BSN Students

Spiritual nursing care competencies include BSN students' spiritual nursing knowledge, spiritual values, and spiritual nursing skills. This section provides the study's findings on the extent of the BSN students' spiritual nursing care competencies.

A. Spiritual Nursing Knowledge

Table 3 shows the extent of spiritual nursing knowledge of the BSN students in Region 1. These competencies deal with specific information for a student nurse to provide spiritual care for their patients. The frequency and percentage of those who got the correct answers for each item are shown in the table.

The computed mean total score of 11.18 signifies that the student nurse respondents have "Moderate" spiritual nursing knowledge. Throughout the 15 items on knowledge, almost all of the respondents answered three of them correctly (416 or 98.10%). On the other hand, the spiritual nursing knowledge about nursing interventions that promote spiritual health that is not limited to offering one's presence and supporting the client's religious practices only achieved a trivial number of correct answers from the students (122 or 28.80%). Nearly only a quarter of the number of respondents had the right spiritual nursing knowledge on this item.

B. Spiritual Values

Spiritual values pertain to the essential and lasting beliefs or ideals of a student nurse that significantly influence behavior and attitude and may serve as personal guidelines in rendering spiritual care.Table 4 reveals the spiritual values of BSN students in the Ilocos Region.

Table 3. *Frequency and Percentage Distribution of Spiritual Nursing Knowledge*

Spiritual Nursing Knowledge	*F*	% of Correct Answers
1. Spirituality is a multidimensional phenomenon that involves a belief in a relationship with some higher power or divine being. It is influenced by life experiences, coping skills, and individual belief systems.	416	98.1
2. To implement spiritual care, nurses need to be skilled in establishing a trusting nurse-client relationship.	412	97.2
3. The initial spiritual assessment should collect information not only about spiritual beliefs and practices affecting health but also about how the client desires spiritual care from the health care team.	409	96.5
4. The level to which nurses nurture and care for themselves influences their ability to function effectively in their healing role with their clients.	406	95.8
5. Just as individuals develop physically, cognitively, and morally, they also develop spiritually. Thus, in providing spiritual care, it is important to consider individuals' life stages.	403	95
6. Nurses need to follow ethical guidelines for providing spiritual care and not to impose personal beliefs or practices on clients.	400	94.3
7. Spiritual care is not just about religious beliefs and practices.	379	89.4
8. Spiritual distress is reflected in various behaviors including depression, anxiety, verbalization of unworthiness, and fear of death.	377	88.9
9. Spiritual care is very much dependent upon the personal attributes and qualities displayed by the nurse in the interaction and dealings with patients.	355	83.7
10. All clients need to be screened for spiritual needs, however, only those who indicate needs require a pertinent, in-depth assessment.	274	64.6
11. The spiritual needs of clients and support persons often come into focus at a time of illness.	233	55
12. The nursing process, which includes assessing, diagnosing, planning, implementing, and evaluating, can be applied both to physical and spiritual health.	205	48.3
13. Therapeutic communication and interpersonal skills assist nurses in meeting the needs of the human spirit.	187	44.1
14. Clients have the right to receive care irrespective of their individual spiritual and religious values.	164	38.7
15. Nursing interventions that promote spiritual health are not limited to offering one's presence and supporting the client's religious practices.	122	28.8
Mean = 11.18	**DR = Moderate Knowledge**	

Legend:

Excellent Knowledge	*scores of 12 – 15*	*182*	*42.92%*	*Minimal Knowledge*	*scores of 4 – 7*	*9*	*2.12%*
Moderate Knowledge	*scores of 8 – 11*	*232*	*54.72%*	*Limited Knowledge*	*scores of 1 – 3*	*1*	*0.24%*

The overall mean rating of 3.77 suggests that the extent of the BSN students' spiritual values is "favorable" corresponding to 260 (61.32%) respondents. Item analysis shows that the BSN student respondents believe that nurses can "provide spiritual care by showing kindness, concern, and cheerfulness when giving care" ($\bar{x}$ = 4.26), "provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient" ($\bar{x}$ = 4.23), and "spirituality includes peoples' morals" ($\bar{x}$ = 4.23), all of which are interpreted as "Highly favorable" values. Meanwhile, the belief that spirituality is not concerned with a view and faith in a god or supreme being had the lowest mean rating of 2.48 interpreted as "Slightly Favorable."

C. Spiritual Nursing Skills as Assessed by the Students

The spiritual nursing skills relate to the abilities and capacities acquired through deliberate, systematic, and sustained effort to smoothly and adaptively carry out spiritual nursing care activities and functions. Exhibited in Table 5 is the extent of the BSN students' spiritual nursing skills.

The extent of the respondents' spiritual nursing skills in general, is "Moderate" ($\bar{x}$ = 3.00). Taken singly, they have moderate skills on assessment ($\bar{x}$ = 3.13), which ranked the highest; on diagnosis ($\bar{x}$ = 2.98), ranking the least; on planning ($\bar{x}$ = 3.15); on implementation (($\bar{x}$ = 3.06); and on evaluation (($\bar{x}$ = 3.08). Of all the items on implementation, the item "providing quiet time for meditation, prayer, and relaxation ($\bar{x}$ = 3.27)" is the only item that got "Excellent Skill." A mean rating of 3.22 and 3.20 respectively for asking how to be most helpful, then actively listen, reflect, and seek clarification and use therapeutic communication when providing spiritual care to patients indicates that they have "Moderate Skills."

Table 4. *Mean Ratings of the Extent of Spiritual Values of BSN Students*

Spiritual Values	Mean	DR
1. Nurses can provide spiritual care by showing kindness, concern, and cheerfulness when giving care.	4.26	Highly Favorable
2. Nurses can provide spiritual care by having respect for privacy, dignity, and religious and cultural beliefs of a patient.	4.23	Highly Favorable
3. Spirituality includes peoples' morals.	4.23	Highly Favorable
4. Spirituality is about having a sense of hope in life.	4.15	Favorable
5. Nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles.	4.12	Favorable
6. Spirituality is concerned with a need to forgive and a need to be forgiven.	4.10	Favorable
7. Spirituality is a unifying force which enables one to be at peace with oneself and the world.	4.04	Favorable
8. Spirituality involves personal friendships, relationships.	4.02	Favorable
9. Nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need.	3.97	Favorable
10. Nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness.	3.97	Favorable
11. Nurses can provide spiritual care by arranging a visit by the hospital chaplain or the patient's own religious leader if requested.	3.96	Favorable
12. Spirituality has to do with the way one conducts one's life here and now.	3.91	Favorable
13. Spirituality is about finding meaning in the good and bad events of life.	3.83	Favorable
14. Spirituality does not apply to atheists or agnostics.	3.15	Moderately Favorable
15. Spirituality does not include areas such as art, creativity and self-expression.	2.92	Moderately Favorable
16. Spirituality involves only going to church/place of worship.	2.61	Moderately Favorable
17. Spirituality is not concerned with a belief and faith in a god or supreme being.	2.48	Slightly Favorable
Overall	**3.77**	**Favorable**

**Negatively stated items were reversely scored*

Legend:	*Scale*	*Interpretation*	*Qualitative Description*
	4.20 - 5.00	*Highly Favorable (HF)*	The student nurse possesses highly positive spiritual values in rendering spiritual care nursing.
	3.41 – 4.20	*Favorable (F)*	The student nurse has reasonably positive spiritual values in rendering spiritual care nursing.
	2.61 – 3.40	*Moderately Favorable (MF)*	The student nurse has moderately positive spiritual values in rendering spiritual care nursing.
	1.81 – 2.60	*Slightly Favorable (SF)*	The student nurse has partially negative spiritual values in rendering spiritual care nursing.
	1.00 – 1.80	*Not Favorable (NF)*	The student nurse holds negative spiritual values in rendering spiritual care nursing.

Table 5. *Extent of Spiritual Nursing Skills of BSN Students*

Spiritual Nursing Skills	As assessed by the Students		As assessed by the Clinical Instructors	
	Mean	DR	Mean	DR
ASSESSMENT				
1. Ensure sensitivity on the patient's behavior, verbalization, affect, attitude, and interpersonal relationships, which may provide cues to spiritual and religious preferences, strengths, concerns, or distress.	3.13	Moderate Skill	2.93	Moderate Skill
2. Take into consideration patients' dietary preferences based on their faith (e.g., as a Muslim, Jehovah's Witness, Adventist).	3.12	Moderate Skill	3.06	Moderate Skill
3. Examine how the patient's spiritual beliefs and practices affect his coping.	3.01	Moderate Skill	2.85	Moderate Skill
4. Determine patients' spiritual beliefs and practices and ascertaining those that are most important to him.	3.00`	Moderate Skill	2.85	Moderate Skill
5. Ask the patient about how he may like to receive support on spirituality from the health care team.	2.96	Moderate Skill	2.62	Moderate Skill
6. Ask the patient about the presence of spiritual support or counselor, which he may be regularly meeting, and determine his desire for a visit.	2.94	Moderate Skill	2.59	Moderate Skill
7. Verify the presence of religious items of patients such as rosary beads, Buddha beads, bible, etc.	2.86	Moderate Skill	2.62	Moderate Skill
OVERALL (ASSESSMENT)	***3.00***	***MODERATE SKILL***	***2.79***	***MODERATE SKILL***
DIAGNOSIS 1. Utilize the North American Nursing Diagnosis Association (NANDA) approved nursing diagnoses in labeling patients' spiritual needs.	3.04	Moderate Skill	2.77	Moderate Skill
2. Consider that spiritual problem may provide the diagnostic label, which can either be spiritual distress, readiness for enhanced spiritual well-being, and risk for spiritual distress.	2.93	Moderate Skill	2.69	Moderate Skill
OVERALL (DIAGNOSIS)	***2.98***	***MODERATE SKILL***	***2.73***	***MODERATE SKILL***
PLANNING 1. Consider and recognize spiritual limitations.	3.27	Excellent Skills	2.78	Moderate Skill
2. Devise ways to assist patient in achieving a sense of hope through attaining spiritual strength, serenity, and satisfaction.	3.18	Moderate Skills	2.72	
3. Identify interventions to help patient achieve the overall goal of maintaining or restoring spiritual well-being.	3.16	Moderate Skills	2.82	Moderate Skill
4. Establish desired spiritual care outcomes, which are short, measurable, attainable, realistic, and time-bounded.	3.14	Moderate Skills	2.75	Moderate Skill
5. Formulate means to help patients draw on and use inner resources more effectively and find the meaning of existence and present situation.	3.02	Moderate Skills	2.66	Moderate Skill
OVERALL (PLANNING)	***3.15***	***MODERATE SKILLS***	***2.75***	***MODERATE SKILL***
IMPLEMENTATION 1. Provide quiet time for meditation, prayer, and relaxation.	3.27	Excellent Skills	2.92	Moderate Skill
2. Ask how to be most helpful, then actively listen, reflect, and seek clarification.	3.22	Moderate Skills	2.99	Moderate Skill
3. Make use of therapeutic communication when providing spiritual care to the patient.	3.20	Moderate Skills	2.99	Moderate Skill
4. Physically present and available to help the client determine religious and spiritual choices.	3.16	Moderate Skills	2.88	Moderate Skill
5. Provide privacy for the patient to pray with others or be read to by members of their faith.	3.15	Moderate Skills	2.89	Moderate Skill
6. Provide spiritual care to all patients regardless of their condition.	3.14	Moderate Skills	2.83	Moderate Skill
7. Help the patient develop and accomplish short-term goals and tasks.	3.11	Moderate Skills	2.90	Moderate Skill
8. Hold the patient's hand or placing a hand gently on the arm (if comfortable with touch) to make him feel that I am available to help him.	3.00	Moderate Skills	2.86	Moderate Skill
9. Orient patient and family to the hospital unit, including the directions to the hospital chapel.	2.99	Moderate Skills	2.81	Moderate Skill
10. Refer the patient for counseling, therapy, support groups, or hospice.	2.96	Moderate Skills	2.56	Moderate Skill
11. Accomplish written nursing reports in the spiritual functioning of my patients. (eg. The stipulation of spiritual care in FDAR documentation)	2.96	Moderate Skills	2.54	Moderate Skill
12. Provide appropriate religious materials, artifacts, or music as requested.	2.93	Moderate Skills	2.55	Moderate Skill
13. Coordinate spiritual care in multidisciplinary consultation.	2.92	Moderate Skills	2.54	Moderate Skill
14. Refer the patient to the spiritual advisor of choice.	2.90	Moderate Skills	2.59	Moderate Skill
OVERALL (IMPLEMENTATION)	***3.06***	***MODERATE SKILLS***	***2.77***	***MODERATE SKILL***
EVALUATION 1. Appraise the effectiveness of spiritual care with the patient and the healthcare team.	3.10	Moderate Skills	2.70	Moderate Skill
2. Utilize the measurable desired outcomes developed during the planning stage to determine whether goals or desired outcomes have been achieved.	3.07	Moderate Skills	2.71	Moderate Skill
OVERALL (EVALUATION)	***3.08***	***MODERATE SKILLS***	***2.71***	***MODERATE SKILL***
OVERALL (SPIRITUAL NURSING SKILLS)	**3.06**	**MODERATE SKILLS**	2.75	**MODERATE SKILL**

Legend:

Scale	***Interpretation***	***Qualitative Description***
3.25 – 4.00	*Excellent (ES)*	*The student nurse possesses exceptional spiritual nursing skills.*
2.50 – 3.24	*Moderate Skills (MS)*	*The student nurse has adequate spiritual nursing skills*
1.75 – 2.49	*Minimal Skills(mS)*	*The student nurse has partially adequate spiritual nursing skills.*
1.00 – 1.74	*Limited Skills*	*The student nurse has poor and inadequate spiritual nursing skills.*

Clinical Instructor's Assessment of Student's Spiritual Nursing Skills

Presented in Table 5 is the extent of spiritual nursing skills of BSN students as assessed by their clinical instructors in the five areas of the nursing process: assessment, diagnosis, planning, implementation, and evaluation.

With the grand mean rating of 2.75, the clinical instructors evaluated the students, skills as "Moderate" (Please see Table 4). All their skills on the five (5) steps of the nursing process: assessment ($\bar{x}$ = 2.79), diagnosis ($\bar{x}$ = 2.73), planning ($\bar{x}$ = 2.75), implementation ($\bar{x}$ = 2.77) and evaluation ($\bar{x}$ = 2.71) were all rated as "Moderate".

Related Variables to Spiritual Nursing Care Competencies

The study's findings on the association of related variables to spiritual nursing care competencies are presented in this section.

A. Year Level

Shown in Table 6 are the spiritual nursing care competencies of the students and its relationship by their year levels.

When spiritual nursing knowledge is analyzed across year level, the results show *no significant relationship for level 1 or 4 students* ($\bar{x}$ = 11.41, SD = 1.58 and $\bar{x}$ = 11.00, SD = 1.85 respectively). However, *a very weak positive relationship, which is statistically significant, exists between the year level and spiritual values* (r = 0.135, SD = 0.63, $p < 0.01$)*; and their extent of spiritual nursing skills* (r = 0.153, SD = 0.62, $p < 0.01$).

B. School Category

Table 6 also sums up the spiritual nursing care competencies of BSN students according to school category (government or private) and the relationship between and among these variables.

No relationship exists between the school category and spiritual nursing knowledge and school category and spiritual values. Although there is a slightly higher mean rating for students coming from private HEIs, no significant relationship can be seen from both spiritual nursing knowledge ($\bar{x}$ = 11.19, SD = 1.66) and spiritual values ($\bar{x}$ = 3.80, SD = 0.64). However, *a very weak inverse significant relationship exists between the school category and spiritual nursing skills (r = -0.113, SD = 0.62, p < 0.05)*.

C. School's Accreditation Level

The summary of the BSN students' spiritual nursing care competencies by schools' accreditation level is also illustrated in Table 6. It also described the relationship between the level of accreditation and spiritual nursing care competencies. Higher education institutions may be accredited as level 4, level 3, level 2, level 1 and no accreditation.

It can be seen from the table that there is *no significant relationship between accreditation and spiritual nursing knowledge and values,* however, there is a *weak inverse statistical relationship between accreditation and spiritual nursing skills* (r = *-0.101, SD = 0.62, p < 0.05)*.

D. Spiritual Care Nursing Elective Subject

Provided in Table 6 is a run-through of the Spiritual Care Competencies of the Level 4 students regarding their enrollment or not in the Spiritual Care Nursing elective subject. In the CMO 14 series of 2009, Spiritual Care Nursing is an elective subject for the Level 4 students. It is the students' discretion whether they opt to enroll in the subject or not. However, in the new curriculum, the CMO 15 series of 2017, with its new descriptive name: Religion, Religious Experiences and Spirituality, electives recommended are based on institutional choice.

The table uncovered that *no relationship exists between the enrolment/not to Spiritual Care Nursing subject with spiritual nursing knowledge, spiritual values, and spiritual nursing skills.* Taken singly, a slightly higher mean rating in knowledge on Spiritual Care Nursing ($\bar{x}$ = 11.10, SD = 1.92) is derived from the students who were not enrolled in the Spiritual Care Nursing elective subject compared to those who were enrolled ($\bar{x}$ = 10.97, SD = 1.83) while a slightly higher mean rating for spiritual values ($\bar{x}$ = 3.91, SD = 0.60) and spiritual nursing skills ($\bar{x}$ = 3.24, SD = 0.55) was revealed from those who were enrolled. However, all these are considered to be statistically not significant.

Discussion

This study found that the BSN students in Region 1 have moderate extent of spiritual nursing care competencies. The students' year level has a very weak positive, statistically significant association with spiritual values and spiritual nursing skills. Furthermore, a very weak inverse significant link was identified between their spiritual nursing skills and the school category and level of accreditation. A thorough discussion of these findings are presented in this section.

Table 6. *Relationships on the Extent of Spiritual Nursing Care Competencies of BSN Students and some Variables*

A. Year Level				
Level 4	*Mean*	11.00	**3.89**	**3.2**
	SD	1.85	0.63	0.60
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Level 3	*Mean*	**11.41**	3.71	2.98
	SD	1.58	0.61	0.65
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Level 2	*Mean*	10.99	3.67	2.97
	SD	1.66	0.66	0.51
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
As a Whole	***Mean***	**11.18**	**3.77**	**3.06**
	SD	**1.71**	**0.63**	**0.62**
	r (424)	**-0.027**	**0.135****	**0.153****
	***p*-value**	**0.580**	**0.005**	**0.002**
	DR	**Moderate Knowledge**	**Favorable Values**	**Moderate Skills**
B. School Category				
Government	*Mean*	11.17	3.71	2.96
	SD	1.81	0.62	0.59
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Private	*Mean*	**11.19**	**3.80**	**3.11**
	SD	1.66	0.64	0.62
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
As a Whole	***Mean***	**11.18**	**3.77**	**3.06**
	SD	**1.71**	**0.63**	**0.62**
	r (424)	**-0.004**	**-0.064**	**-0.113***
	***p*-value**	**0.933**	**0.188**	**0.020**
	DR	**Moderate Knowledge**	**Favorable Values**	**Moderate Skills**
C. Accreditation Level				
Level 4	*Mean*	11.47	3.84	3.06
	SD	1.78	0.65	0.64
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Level 3	*Mean*	11.21	3.76	3.02
	SD	1.69	0.66	0.66
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Level 2	*Mean*	11.14	3.75	3.03
	SD	1.71	0.63	0.59
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Level 1	*Mean*	10.06	**3.98**	3.29
	SD	2.16	0.56	0.62
	DR	Moderate Knowledge	Favorable Values	Excellent Skills
No Accreditation	*Mean*	**11.68**	3.75	**3.32**
	SD	1.14	0.58	0.54
	DR	Excellent Knowledge	Favorable Values	Excellent Skills
As a Whole	***Mean***	**11.18**	**3.77**	**3.06**
	SD	**1.71**	**0.63**	**0.62**
	r (424)	**0.017**	**0.007**	**-0.101***
	***p*-value**	**0.732**	**0.892**	**0.037**
	DR	**Moderate Knowledge**	**Favorable Values**	**Moderate Skills**
D. Enrollment or Not to Spiritual Care Nursing				
Enrolled	*Mean*	10.97	**3.91**	**3.24**
	SD	1.83	0.60	0.55
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
Not Enrolled	*Mean*	**11.10**	3.82	3.07
	SD	1.92	0.73	0.70
	DR	Moderate Knowledge	Favorable Values	Moderate Skills
As a Whole	***Mean***	**11.0**	**3.89**	**3.20**
	SD	**0.85**	**1.12**	**0.90**
	r (156)	**-0.031**	**0.062**	**0.130**
	***p*-value**	**0.698**	**0.440**	**0.106**
	DR	**Moderate Knowledge**	**Favorable Values**	**Moderate Skills**

*** Correlation is significant at the 0.01 level (2-tailed)* **Correlation is significant at the 0.05 level (2-tailed)*

Extent of Spiritual Nursing Care Competencies of BSN Students

A. Spiritual Nursing Knowledge

The BSN students' understanding of the various spiritual care nursing concepts is adequate. However, the respondents' moderate extent of *spiritual nursing knowledge* implies the need for further explanations regarding varied concepts of spiritual nursing. It indicates the need to reiterate and explicate that spiritual nursing interventions are not limited to offering their presence and supporting the client's religious practices; rather it also involves the understanding that clients have the right to receive care irrespective of their individual spiritual and religious values, emphasizing knowledge of the therapeutic communication techniques, and that and interpersonal skills are necessary in meeting the needs of the clients' human spirit. Their knowledge on the sufficiency of how spiritual care is rendered (whether it is enough to offer one's presence or support patients' religious practices), may be a role that is ambiguous to these students. This may also be attributed to their deficiency of understanding regarding the multicultural faith systems, resulting to their lack of knowledge on dealing with diverse religious practices.

B. Spiritual Values

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The result on the extent of *spiritual values* means that BSN students have reasonably positive values when rendering spiritual nursing care. The favorable spiritual values may be ascribed to the modeling shown by clinical instructors and the provision of emphasis on the process of spiritual formation in the curriculum. More so, values are ingrained throughout their nursing formation to promote the good of the patients (beneficence). The belief system is highly commendable as it is the foundation of respectful and value-laden care. These demonstrated characteristic traits are in fact some of the identified reasons for the existence of the subject Spiritual Care Nursing identified in CMO 14, s. 2009. The necessity to maintain these highly positive perceptions and attitudes of students on spirituality may further hoist their receptiveness to spiritual concerns of others. Conversely, the belief that spirituality is not concerned with a view and faith in a god or supreme being emphasizes that the BSN students do not necessarily need to have credence in God's supremacy to become spiritual. This corresponds to Watts (2017), who postulated that one need not believe in a god to have questions that scientific materialism cannot answer.

C. Spiritual Nursing Skills

The *spiritual nursing skills* relate to the abilities and capacities acquired through deliberate, systematic, and sustained effort to smoothly and adaptively carryout spiritual nursing care activities and functions. This area spans the nursing process five key steps namely: *assessment, diagnosis, planning, implementation, and evaluation*. Findings of the study signifies that the BSN students perform spiritual nursing skills in conformity with the accepted criteria for rendering spiritual nursing care. It further denotes that their skills are somehow sufficient or adequate to carry out tasks precisely and correctly. Their spiritual nursing skills are moderate because BSN students may have difficulty simulating the spiritual nursing skills modeled by their clinical instructors. To exacerbate the situation, the training hospitals' environment might not be conducive to the modeling of the spiritual nursing care skills during the Related Learning Experience (RLE). To explain, some RLE exposures are in emergent departments where immediate physical intervention is priority thus relegating spiritual care to the background. In detail, the BSN students' spiritual nursing skills on *assessment* manifests that they ensure sensitivity on patient's behavior, verbalization, affect, attitude, and interpersonal relationships, which may provide cues to spiritual and religious preferences, strengths, concerns, or distress. Their moderate spiritual nursing skill implies an understanding of others' spiritual needs and problems that may be very useful in the assessment process. Yet, spiritual nursing skills on *diagnosis* suggests that BSN students lack skills in formulating spiritual care-related diagnoses. They may fail to utilize the North American Nursing Diagnosis Association (NANDA) approved nursing diagnoses. This result emphasizes the need to master skills in the use of the NANDA approved nursing diagnoses, and or familiarization with the available NANDA approved nursing diagnoses for spiritual crises. On *planning,* it can be inferred that the capacity of students to conduct this skill is with a degree of acceptable competence. Planning is an intrinsic aspect of the nursing process that entails setting priorities, identifying expected outcomes, prescribing interventions, and identifying patient-centered goals. It is carried out through the deliberate use of critical thinking followed by a more profound judgment and problem-solving approach. Meanwhile, the extent of the BSN students' spiritual nursing skills on ***implementation*** may bring into a realization that student nurses know how to employ therapeutic techniques when caring for patients such as when to listen and when to talk or offer help to patients. This is also in accordance to the findings of Nero (2020), who found out that Ilocano nurses offers spiritual advising through active listening and giving support to the emotional and spiritual needs of an individual. These activities help the patient achieve internal peace. Further, on *evaluation*, as with the preceding areas, students have the competency to standard, although there is opportunity for improvement. One possible reason for the students' inability to excel in this domain can be traced back

to their professional counterparts, as aptly captured by Govier (2000) when he shared his predicaments about the difficulty of evaluating and the lack of precision caused by the spiritual dimension's subjectivity.

Clinical Instructor's Assessment of Student's Spiritual Nursing Skills

A clinical instructor is instrumental in the quality learning experience as much as the clinical experience is an essential aspect of the nursing education program. The role of the clinical instructor as a facilitator of learning is indispensable. Teaching and assessing are two dimensions within the learning process that seek to evaluate students' learning. As to the result of the clinical instructors' assessment on the spiritual nursing skills of BSN students, it entails that students perform spiritual nursing care skills in conformity with the acceptance criteria of delivering spiritual nursing care. This may signify that the spiritual nursing care skills, as attested by the clinical instructors, is insufficient. This may be due to what Linda et al. (2015) said in their article that no explicit instruction is existing on how spiritual care in nursing should be integrated into the undergraduate curriculum.

On *assessment,* the finding is suggestive that as per clinical instructors' evaluation, the BSN students' assessment skills are seemingly adequate. This may be credited to the availability of teaching-learning resources and experiences that are crafted to mold the students' competencies applicable in various situations. The adequacy of their spiritual nursing skills in assessment may also be ascribed to the offering of the subject Health Assessment which is offered early during the first year of the BSN curriculum.

In terms of *diagnosis*, result points out that although there is an acceptable level of competence for this area, BSN students may not be that proficient in designating nursing diagnoses for their patients' spiritual care needs. The clinical instructors' observations denote that NANDA approved diagnoses are not fully utilized in identifying and defining the spiritual nursing diagnoses and the care needs of clients by the BSN students. Their focus may be on the physiologic conditions, like during emergencies, such that spiritual care needs may have been neglected.

In the same way, the extent of the BSN students' spiritual nursing skills in terms of *planning* underscores that the planning skills of BSN students on spiritual nursing care is still deficient. This calls to mind that the integration of self-directed learning into nurse education programs is advantageous because it promotes critical thinking and decision-making skills among students. Furthermore, the clinical instructors' motivation has a significant impact on how BSN students embrace spiritual care in their clinical practice by identifying interventions in the planning phase to help clients achieve the overall goal of maintaining or restoring spiritual well-being.

Meanwhile, on *implementation*, the clinical instructors' evaluation of skills on spiritual nursing by the BSN students signifies that they have sensitivity to their patient's spiritual care needs and are competent in using oneself therapeutically when rendering spiritual care to their patients as verified by their clinical instructors. It entails their high regard for a therapeutic nurse-patient relationship to meet the patient's spiritual needs. Further, on BSN students' spiritual nursing skills on *evaluation,* clinical instructors perceived that student nurses are not so well-versed on or with regards to evaluating the effectiveness of spiritual care rendered. That is why the balance of teacher-directed learning and student-directed learning is vital. While the clinical instructor's reinforcement is crucial and their role in assisting the students in evaluating their spiritual interventions' effectiveness is equally valuable, the students are also encouraged to self-evaluate their performance and identify their areas of strengths and weaknesses.

Related Variables to Spiritual Nursing Care Competencies

A. Year Level

Further analysis of the results revealed that *year level* is not necessarily associated with their *spiritual nursing knowledge level* as spiritual care is already introduced early in the first year's professional nursing subjects. These are then reinforced in other professional nursing subjects in the higher years. Results are comparable to that of Folami and Onanuga (2018), which disclosed that the perceptions of spirituality and spiritual care by the BSN students had no affinity with their academic level. Additionally, as the year level increases, spiritual values may also increase. This may be explained by the fact that essential and lasting beliefs or ideals of a nurse that significantly influence behavior and attitude in the render of spiritual nursing care are modestly affected by their year levels. This may be so because values are learned through what is seen and experienced, yielding greater spiritual values among students at higher year levels. The weak positive statistically significant association between the year level and the extent of spiritual nursing skills may be due to the experiences gained from completing the course, which supports BSN students in acquiring skills. These skills are set for the BSN students to meet in order to obtain higher-level competencies or rising spiritual care abilities in their Related Learning Experience (RLE). More so, the BSN curriculum's contextualization into an outcomes-based curriculum through the CMO 15 series of 2017 ensures that BSN students are equipped with appropriate and purposeful learning experiences and opportunities.