



Research Article

Professional Quality of Life and Clinical Competencies among Korean Nurses

Kyunghee Kim, PhD,¹ Yonghee Han, PhD,² Yeunhee Kwak, PhD,¹ Ji-su Kim, PhD^{1,*}¹ Red Cross College of Nursing, Chung-Ang University, Seoul, South Korea² Department of Nursing, Hallym Polytechnic University, Chuncheon, South Korea

ARTICLE INFO

Article history:

Received 23 September 2014

Received in revised form

18 December 2014

Accepted 13 March 2015

Keywords:

clinical competence
clinical nurse specialist
cluster analysis
quality of life

SUMMARY

Purpose: Clinical competence among nurses is an essential requirement for the provision of safe and effective patient care. This study aims to classify types of professional quality of life experienced by Korean nurses, and examine the relationship between demographic and professional characteristics and clinical competence among nurses experiencing each type.

Methods: A total of 335 nurses completed questionnaires assessing professional quality of life, clinical competence, and demographic and professional characteristics. Following identification of the underlying factors of professional quality of life, we classified participants into three clusters.

Results: There were significant differences in age, marital status, religion, educational status, and position between clusters. Results also revealed that nurses with high compassion satisfaction and low compassion fatigue (burnout, secondary traumatic stress) tended to have higher clinical competence.

Conclusions: This study demonstrated that it is possible to directly examine the relationship between professional quality of life level and clinical competence among nurses. Thus, interventions to increase nurses' compassion satisfaction and relieve compassion fatigue are needed, as professional quality of life may affect clinical competence.

Copyright © 2015, Korean Society of Nursing Science. Published by Elsevier. All rights reserved.

Introduction

Nurses require highly specialized clinical competencies to accurately determine patients' states and predict and cope with problems that may occur during treatment [1]. Clinical competence is defined as "the ability of the registered nurse to integrate and apply the knowledge, skills, judgments and personal attributes required to practice safely and ethically in designated role and setting" [2]. Several issues in recent healthcare environments contribute to the need to assess nurse competence [3]. For instance, previous studies related to nurses' clinical competence have shown that factors associated with nursing performance and competence differ according to the type of department, and that nursing performance and competence increase with age, work experience, and level of education [4–6]. Therefore, most studies of the factors affecting clinical nurses' performance and competence have focused on work-related characteristics (e.g., job stress, job satisfaction, demographic characteristics). In addition, other studies

have examined the relationship between nurses' critical thinking skills and self-leadership [1,4–7].

More recently, attention has been focused on concepts related to quality of work life, which has been found to be closely related to nursing job performance, including clinical performance and competence [8]. Because quality of work life is also related to job performance, professional quality of life (ProQOL) is increasingly viewed as important. Nevertheless, no previous research has addressed the relationship between the clinical competence and ProQOL among nurses.

The term "professional quality of life" refers to the positive and negative emotions that an individual feels about his or her job as a helper. Compassion satisfaction (CS), burnout (BO), and compassion fatigue (CF) (also known as secondary traumatic stress [STS]) are all elements of ProQOL that can be experienced by workers in service industries that aid persons with afflictions [9,10]. Nurses, in particular, are professionals highly likely to experience CF, which can negatively affect their mental and physical health as well as job performance [11]. CF can also cause nurses to lose their objectivity and empathy for patients. Specifically, they may be driven to avoidance as a way of escaping the pain that empathy for patients can cause. Consequently, CF and associated avoidance behavior can eventually lower the quality of nurses' clinical performance and

* Correspondence to: Ji-su Kim, Faculty of Red Cross College of Nursing, Chung-Ang University, 84 Heukseok-Ro, Dongjack-Gu, Seoul 06974, South Korea.

E-mail address: jisu80@cau.ac.kr

competence [12,13]. However, previous ProQOL studies among Korean nurses have only examined nurses who work in specialty departments (e.g., emergency rooms, intensive care units, oncology wards), rather than examining CF and nursing competencies. Furthermore, CF research has been neglected in favor of studies examining the relationship between job-related factors (e.g., job satisfaction and job stress) and demographic characteristics [13–15]. The results of these studies have been inconsistent, and no empirical studies have examined the relationship between nurses' ProQOL and their clinical performance or competence.

ProQOL is composed of three subfactors (CS, BO, STS), and standardizing each variable as a z score (rather than simply summing the scores), allows for interpretations based on types classified by the combination of individual subfactor scores [10]. However, previous ProQOL studies have analyzed each individual subfactor rather than the types, making it difficult to examine nurses' ProQOL at an integrated level. For this reason, the current research was conducted with the aim of classifying the ProQOL types of Korean nurses through cluster analysis, and then identifying differences in clinical competencies for each type.

Purpose

The purpose of this study was to delineate the relationships between the three variables characterizing ProQOL (CS, BO, STS) among Korean nurses as well as classify types of nursing-related ProQOL. Subsequently, this will assist in the development of interventions to improve nurses' ProQOL, clinical performance, and competence. The specific purposes of this study were to identify the (a) levels of the three factors in ProQOL, (b) ProQOL types for the three factors using cluster analysis, (c) differences between demographic characteristics and ProQOL types, (d) levels of clinical competencies, (e) differences between demographic characteristics and clinical competencies, and (f) differences between ProQOL type and clinical competencies.

Methods

Study design, sample, and data collection

This cross-sectional study examines the relationship between types of ProQOL and clinical performance and competence among clinical nurses. A power analysis conducted using the G*Power 3.1.4 program indicated that a sample of 305 or more participants would be required to have 95% power to detect an effect of size 0.25 (a medium effect size) in an analysis of variance (ANOVA) examining differences among the five groups [16]. We recruited nurses who had worked for more than 1 year in any of the three hospitals affiliated with a university in two provinces in South Korea. Four hundred questionnaires were distributed in the three hospitals from June 20 to June 27, 2014, and 370 copies were returned (response rate: 92.5%). After poorly completed questionnaires (e.g., they were not fully completed) were excluded, data from 335 participants were used in the final analyses. Thus, the sample was an appropriate size.

Instruments

The ProQOL is a 30-item self-report measure developed by Stamm [9,10], who provided the researchers with permission for its use in the current study. The Korean translation of version 5 of the ProQOL tool was used in this study. The ProQOL instrument contains three subscales, which cover the three subfactors of ProQOL (i.e., CS, BO, and STS). Each subscale consists of 10 questions, with each item rated on a 5-point Likert scale. A higher score on a

subscale signifies a higher degree of the corresponding subfactor. However, the three subscale scores are not simply summed to obtain the overall ProQOL score. Instead, the scores for all of the questions are standardized into z scores, with a mean of 50 and variance of 10. At the time of the instrument's development, the Cronbach's alpha values were .88 for CF, .75 for BO, and .81 for STS. In the present study, the Cronbach's alphas were .88 for CS, .71 for BO, and .77 for STS, respectively.

Park, Park, Kim, and Sung [17] developed the Clinical Competence Instrument used to evaluate Korean nurses' clinical performance and competence. Its validity has been established [18] and it is available for use by members of the Korean Hospital Nurses Association. This instrument has a total of 30 questions divided into four subscales, including 20 questions about competence in providing nursing care, 3 about competence in supporting patients, 2 about competence in communicating with patients and their families, and 5 about attitudes towards nursing care. Each item is rated on a 5-point Likert scale, with higher scores signifying higher clinical performance and competence. At the time of the instrument's development, the Cronbach's alpha for the total score was .93, while it was .92 for the competence in providing nurse care, and .76 for the subfactors (competence in supporting patients, competence in communicating with patients and their families, and attitudes towards nursing care). In the present study, the Cronbach's alpha for the total score was .96, while they were for .96 for competence in providing nursing care, .76 for competence in supporting patients, .81 for competence in communicating with patients and their families, and .76 for attitudes towards nursing care.

Data analysis

The data were analyzed as follows using SPSS 21.0 statistical software (SPSS Inc., Chicago, IL, USA). To identify demographic characteristics associated with the participants' ProQOL, clinical performance, and competence scores, we conducted frequency analysis to generate descriptive statistics. For scores on the CS, BO, and STS subscales, minimum, maximum, and quartile scores as well as means and standard deviations were calculated. As advised in the ProQOL manual [10], in preparation for cluster analysis, scores on the CS, BO, and STS subscales were standardized to a mean of 50 and a standard deviation of 10. Then, the influences of the three subfactors on the ProQOL score were equalized, and a K-mean cluster analysis was conducted. K-mean clustering aims to partition n observations into k clusters whereby each observation belongs to the cluster with the nearest mean, serving as a prototype of the cluster. In order to identify the demographic factors associated with the observed differences in clinical competence scores between the clusters, a least significant difference (LSD) analysis was conducted using Chi-squared test, ANOVA, and post hoc test.

Ethical considerations

This study received ethical approval (1041078-201405-HR-085-01) from the Institutional Review Board of the Chung-Ang University. The purpose of the study, guarantee of anonymity and confidentiality, the voluntary nature of participation, and freedom to withdraw at any time were explained to all participants, and their written consent was obtained prior to participation.

Results

Level of ProQOL

Table 1 shows the mean CS, BO, and STS scores of the 25th, 50th, and 75th percentiles, the raw and standardized scores of the

Download English Version:

<https://daneshyari.com/en/article/2645172>

Download Persian Version:

<https://daneshyari.com/article/2645172>

[Daneshyari.com](https://daneshyari.com)