FACTORS INFLUENCING VIEW OF HEALTHCARE PROFESSIONALS ON SPIRITUAL NEEDS OF PATIENTS

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ABSTRACT

Dying process can take different forms, may be perceived differently by persons present during the process, and it can be differently asses by dying because of their individuality. We must realize that every death is related to leave-taking man what man liked, with those whom he loved and who were close to him. Man is preparing himself to the dying during all his life, because the way of life is the way to death and man is trying to take it, but he must learn it. We often might think that in dying we are losing happiness, peace, values that we profess and everything we owned. This raises contradictory reactions in dying and in those that are touched by death. The patient in terminal stage of the disease is entrusted to palliative care, which currently aims to ensure to provide for patients a good quality of life until the end. On the other hand, consciousness of mortality often gives life balance and teaches human responsibility for the rest of their life. Some values in these period accents and some diminish the significance. Spiritual needs are closely related to the search for the meaning of life and death and cannot be limited to religiosity, although in most cases they are in this way understood.

Keywords: Spiritual Needs, Healthcare Professionals, Patients' Needs, Death, Dying

INTRODUCTION

In the modern era, health is increasingly understood from the perspective of the needs where the spiritual well-being of the patient to belongs. Some people think it dominates in many cases only in dying patients. Dying is also defined as inaccurately bounded process leading to death and clini-

cally characterized by progressive failure of vital functions that is irreversible. “The patient in terminal stage of the disease is entrusted to palliative care, which currently aims to ensure to provide for patients a good quality of life until the end [1]”. (Slamková & Poledníková, 2013). “Spirituality and spiritual needs have a particular importance in the terminal stage of the disease. Satisfying spiritual needs helps more tolerable to cope with suffering. Satisfying spiritual needs is of great importance for the sick person [2]”. (Zrubáková & Herinková, 2015). In the process of perception of death an important role plays religious belief and belief in the afterlife. The conventional wisdom is that believers are easier accepting death as faithless. “Similarly, the belief in God can help to surviving relatives of the dying person [3]”. (Markova, 2010) “The consciousness of mortality often gives life balance and teaches human responsibility for the rest of their life [4]”. (Vojtíšek, Dušek, & Motl, 2012)

Aim:

The aim of the study was to determine how the practice length of healthcare workers affects relation to the patient’s spirituality, communication as well as professionalization and improving the quality of care for the patient’s spirituality. Based on the survey we set three hypotheses: H_1 we assume that there is a statistically significant difference in the correlation between practice length and attitude to the patient’s spirituality; H_2 we assume that there is a statistically significant difference in the correlation between practice length and communication with the patient; H_3 we assume that there is a statistically significant difference in the correlation between practice length and professionalization to improve the quality of care for the patient’s spirituality. The study will help improve the preparation of students for future employment in health care.

Research sample consisted of a total 433 respondents, of which 43 were men (9.9%) and 390 were women (90.1%). In terms of jobs majority was of nurses 375 (86.6%), other positions are represented several times lower: paramedics 28 (6.5%), medical assistants 14 (3.2%), midwives 10 (2.3%) and sanitarists-caregivers 6 (1.4%). The most numerous age group was between 35-44 years (40.9%), 25 to 34 years (24%), 45-54 years (23.6%), under 20 20 (4 , 6%) and above 55 30 participants (6.9%). Length of experience was also similarly represented. The largest group 10-21 years of practice (32.8%), 22-31 years (25.9%), 5-9 (15.5%), under 5 (12.7%) and over 32 years practice (13.2%). In terms of work most respondents is working at standard treatment unit / the wards at the hospital (36.5%), in outpatient casualty treatment departments (24.5%), independent ICU (18%), social facilities and HNCA - home nursing care agency (15.2%), Department of Anesthesiology and IM and operating theaters 5 (1,2%), education and management 5 respondents (1.2%) and other workplaces reported 2.2% of respondents. Research output as variable is also used religion. No religion is a set of 15%, 77.4% of respondents are believers, others - 7.6% did not care about religion (Table 1).

Tab. 1
Frequency table of categorical variables: gender, age, position, workplace, length of practice, faith

		Absolute number	%
Gender	Masculine	43	9,9
	Feminine	390	90,1
Age	< 25 years	20	4,6
	25 - 34 years	104	24
	35 - 44 years	177	40,9
	45 - 54 years	102	23,6
	55 - 64 years	30	6,9
Work position	Nurse	375	86,6
	Midwife	10	2,3
	Paramedics	28	6,5
	Sanitarists-caregivers	6	1,4
	Healthcare assistant	14	3,2
Work place	Standard treatment unit / the wards at the hospital	158	36,5
	ICU	78	18
	Operating theaters	5	1,2
	Anesthesiology and IM	5	1,2
	Casualty treatment departments	106	24,5
	Social facilities and HNCA	66	15,2
	Others	10	2,2
	Education and Management	5	1,2
Length of practice	< 5 years	55	12,7
	5 - 9 years	67	15,5
	10 - 21 years	142	32,8
	22 - 31 years	112	25,9
	>32 years	57	13,2
Faith	Believers	335	77,4
	No religion	65	15
	Not given	33	7,6

METHODS:

To obtain relevant data, we used standardized questionnaires SNAP (Spiritual Needs Assessment for Patients) and SCCS (Spiritual Care Competence Scale). The obtained data were analyzed by descriptive characteristic for variables and subsequent testing of normality. Due to the sample size was used Kolmogorov-Smirnov test (KS-test). We evaluated the correlation by using SPSS 22 parametric Pearson correlation coefficient with a significance level of $p < 0.01$ and $p < 0.05$.

RESULTS:

Descriptive data for the whole file is provided in Table 2. Variable SNAP - psychosocial needs of the respondents amounted to an average score of 16.27 points (SD = 2.76) at a median and mode 17. The values varied between 7 and 20 points, 50% of all values around middle was located in the

range 14 - 19 points, which is practically above the theoretical middle (12.5) (as defined by subscales evaluating psychosocial needs – variable was minimum score 5 and a maximum of 20 points, while the score below 5 indicates no need and score above 5 indicates a higher degree of needs). Based on statistical calculations, we can talk about a higher level of psychosocial needs of respondents. Variable SNAP - spiritual needs reached the average in this file 42.03 (SD = 7.16) points, the median is 43, mode47 points, values are in the range of 15-52 points. The theoretical range is 13 to 52 points (mean 32.5). Due to the interquartile range in SCCS, which is from 37 to 48 points we can stated that 3/4 of values is in the second half of the theoretical range. In variable received from SCCS is average of 100.41 points (with SD = 17.92), median 102 and mode 95. Value range in our group was from 31 to 135 points, the interquartile range from 89 to 114 points . As in the previous cases, also in this variable is value above the theoretical range (81.5), or in the upper half of the theoretical value range, so we can talk again about a higher level of spiritual needs of the respondents.

Tab. 2
Descriptive characteristics of scales in questionnaires SNAP and SCCS

	SNAP Psychosocial needs	SNAP Spiritual needs	SCCS
N	433	433	433
Average	16,27	42,03	100,41
Median	17	43	102
Modus	17	47	95
SD – Standard deviation	2,76	7,16	17,92
Skewness	-0,58	-0,76	-0,44
Sharpness	-0,12	0,57	0,10
Minimum	7	15	31
Maximum	20	52	135
1st quartile	14	37	89
3rd quartile	19	48	114

Of the above characteristics we established results of testing normality. Due to the size of the sample was used Kolmogorov-Smirnov test, the results for all three variables can be seen in Table 3. Statistical significance for both SNAP subtests speak about abnormal distribution of variables (Sig. <0.001), in the case of SCCS variable distribution can be interpreted as normal for this research file.

Tab. 3
Results of testing normality scales SNAP and SCCS (Kolmogorov-Smirnov test)

	Kolmogorov-Smirnov		
	Statistic	df	Sig.
SNAP – psychosocial needs	0,123	433	0,000
SNAP – spiritual needs	0,096	433	0,000
SCCS	0,043	433	0,053

We assessed the relationship between used methodology and subscales. Due to the sample size, we used the parametric Pearson correlation coefficient. In Table 4 we can see that between the score SCCS and subscales SNAP - psychosocial needs is a weak positive correlation (r = 0.270; Sig. <0.001) and between the scores SCCS and subscales SNAP - spiritual needs is a moderate positive correlation (r = 0.366; Sig. <.001). Additional data in Table 4 tell us about the relationship between subscales SNAP - psychosocial needs, SNAP - spiritual needs, and subscales SCCS. All observed relations can be interpreted as a weak positive correlation (interval 0.1 to 0.3), with the exception in relations between SNAP - spiritual needs and SCCS - professionalisation and increasing the quality of care for spirituality (r = 0.321, Sig. <.001) as well as SNAP - spiritual needs and SCCS - personal support and advice to patients (r = 0.301, Sig. <0.001), which formally consider moderate.

Tab. 4
Relations between SNAP subscales and scores SCCS and its subscales (Pearson correlation coefficients)

		SNAP Psychosocial needs	SNAP Spiritual needs
SCCS	r	,270**	,366**
	Sig.	0,000	0,000
	N	433	433
Attitude toward Patients' Spirituality	r	,170**	,151**
	Sig.	0,000	0,002
	N	433	433
Communication	r	,208**	,213**
	Sig.	0,000	0,000
	N	433	433
Assesment and Implementation of Spiritual Care	r	,212**	,282**
	Sig.	0,000	0,000
	N	433	433
Consent	r	,232**	,299**
	Sig.	0,000	0,000
	N	433	433
Personal Support and Advices	r	,193**	,301**
	Sig.	0,000	0,000
	N	433	433
Professionalization and Quality Improovement in Spiritual Care	r	,217**	,321**
	Sig.	0,000	0,000
	N	433	433

** Correlation is significant at the level p□ 0.01

H_1 was confirmed based on the evaluation Spearman's rank correlation coefficient. Nonparametric test was chosen because of the ordinal type of variable - length practice. The result is presented in Table 5, relationship value = 0.105 (Sig. < .05) is weak positive and statistically significant. Hypothesis H1 is affirmative, length of practice is proportionally related to attitude toward patients' spirituality, but the correlation is weak. "Nurses - involve salvaging not only sick part of the

human body, but it works with sick / dying man and subsequently with relatives / survivors. He acts on them by their professional interventions, as well as all his personality, relationship with them degree of professional qualities, level of competence and professional adaptation [5]". (Moraucikova, 2015)

Table 5
Evaluation of H1 (Spearman's rank correlation coefficient)

		Lenght of Practice
Attitude toward patients' spirituality	ρ	,105*
	Sig.	0,030
	N	433

* Correlation is significant at the level p□ 0.05

We evaluated H_2 using Spearman's coefficient of ordinal correlations. As can be seen in Table 6, it was found statistically significant weak positive correlation between the subscale SCCS - communication and lenght of practice (= 0.127, Sig. < 0.01). We present that with previous practice experience slightly increases the ability to communicate with the patient (SCCS). "It is important that professionals be properly prepared when patients need this communication. An evidence-based training intervention could provide such preparation [6]". (Henoch, Strang, Browall, Danielson & Melin - Johansson , 2015)

Tab. 6
Evaluation of H2 (Spearman's rank correlation coefficient)

		Lenght of Practice
Communication	ρ	,127**
	Sig.	0,008
	N	433

** Correlation is significant at the level p□ 0.01

H_3 hypothesis was also assessed by Spearman rank correlation coefficient, as in the previous calculations. The results are presented in Table 7. The length of practice and subscales SCCS - professionalization and improving the quality of care for spirituality we find as statistically significant weak positive correlation (= 0.121, Sig. < 0.05). With increasing length of practice is slightly increasing professionalization and improving the quality of care for spirituality.

Tab. 7
Evaluation H3 (Spearman's rank correlation coefficient)

		Lenght of Practice
professionalization and improving the	ρ	,121*
quality of care for spirituality	Sig.	0,012
	N	433

* Correlation is significant at the level p□ 0.05

CONCLUSION:

Each person is an individual of integrity that should be seen as a whole. In the process of the disease they are brought into interaction healthcare professionals and patients. Their interaction is influenced by several factors, which are not only external but internal. Gradually created a relationship between them can greatly affect the course of treatment and its outcome. The work of nurses is very difficult and requires particular knowledge, which must be complementary, because today's healthcare sector is in steadily progress. Caring for dying patients is among the most difficult work in health care, because it is not burdened only the physical side of health professionals, but rather their psyche. Such care is provided by a multidisciplinary team, which is composed of several experts, whose role on this team is irreplaceable. "Discerning the healing path comprises three stages: Tuning in on spirituality, Uncovering deep concerns and Facilitating the healing process. These three stages are accompanied all the way by the participants' willingness to overcome own comfort zone and Building a trusting relationship [7]". (Giske & Cone, 2015) The results, which confirmed our hypothesis stated that, for communication with patients and professionalization and improving the quality of care for the patient's spirituality has considerable influence length of practice of health workers.

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