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Influence Of Nurses Degree Of Competence On Self –Reported Practice Of Individualized Nursing Care In Uniosun Teaching Hosptal, Osogbo, Osun State

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Abstract: ***Nursing is a discipline that requires demonstration of minimum standard of 'competency' to gain registration as health professionals and to practice as registered nurses. One way nursing students demonstrate 'competency' is in the clinical setting. This study will therefore examine influence of nurses degree of competence on self-reported practice of individualized nursing care in selected units of UNIOSUN Teaching Hospital Osogbo.***

A non experimental descriptive design was used to study 187 nurses working at different wards of Osun State Teaching Hospital, Osogbo. The nurses sample was selected using both random and non random techniques. Data was collected with professional competence and individualized nursing care scales. A letter of introduction for permission to carry out the research was collected from the researcher's Head of Department and ethical clearance was sought from the ethical committee of UNIOSUN Teaching Hospital.

Finding revealed that, majority of the respondents were age 30years upwards and drawn from medical, surgical, orthopedic, emergency, special care baby unit, antenatal, pediatrics among others. Findings also shows that majority are well experience, and most wards has between 17-21 bed space.

The relationship between degree of competence and practice of individualized nursing care result that there is a relationship between degree of competence and practice of individualize nursing care [r= .0609;p=0.002]. Therefore, the null hypotensis which state that, there is no significant relationship between degree of competence and practice of individualized nursing care is here by rejected. While the alternative was upheld.

Therefore, there is a significant relationship between degree of competence and practice of individualized nursing care.

This study concluded that, majority of the respondent reported are competent and have good individualized nursing care. The study also concluded that, there is a significant relationship between degree of competence and practice of individualized nursing care.

Keywords: Nurses competence, influence, self-reported practice.

I. INTRODUCTION

BACKGROUND TO THE STUDY

Nursing is a discipline that requires demonstration of minimum standard of 'competency' to gain registration as health professionals and to practice as registered nurses (Australian Health Practitioner Agency, 2017). One way nursing students demonstrate 'competency' is in the clinical setting. Nurses' competence is based on the knowledge and skill acquired, while being trained to be a Nurse coupled with several experience gained, while in the clinic and on various

On-the Jobs training. Nursing training is a combination of theoretical and practical learning experiences that enable nursing students to acquire the knowledge, skills, and attitudes for providing nursing care (Nabolsi, Zumot, Wardam& Abu-Moghli, 2016). Nursing education is composed of two complementary parts: theoretical training and practical training (Borzou, Safari, Khodavisi&Torkaman, 2017). A large part of nursing education is carried out in clinical environments (Traut, 2016). One of the core reason for this is to produce, self-reliant nursing personnel, that are capable of taking right decisions with regards to care rendering under any condition and achieve a sustainable result. This goes a long way to determine quality of nursing practice rendition in the clinical setting, therefore self-reported practice is key to enhancing nursing profession.

In recent years, individualized nursing care has received a significant attention in health care system. All activities which are based on individual patients' needs are highly important with competency. The health care ethics, as well as nursing ethics has continually emphasized the importance and value of each patient as an individual. Focusing on a patient during the care process is one of the main reasons for supporting individualized nursing care. The need also borders on Individual differences among patients, in terms of their health, illness and needs which emphasizes the necessity of individualized nursing care. In fact, this type of care is the key element for quality care in nursing. According to Van-Servellen (2015), cited in Yildiz (2018), individualized nursing care changes all standardized nursing procedures and activities. Actually, it adopts nursing competency with unique peculiarity for each patient condition. (Suhonen et al 2015) defined individualized nursing care as a method in which patients' personal characteristics, clinical situation, living situation and individual preferences take to account by nurses with regard to promoting their participation in decision-making from patient's point of view.

Individualized care is defined as the adjustment of nursing care according to patient's beliefs, values, emotions, thoughts, preferences, experiences and perceptions (Suhonen et al., 2014; Suhonen et al., 2015).This concept also addresses the honour, uniqueness, and integrity of the patient, and the ethical and moral values related to the consideration and protection of the patient's rights. For this reason, in addition to the healthcare providers, healthcare service recipients' decisions also have a considerable effect on the quality of care (Acaroğlu et al., 2014; Şendir et al., 2015). Patients increasingly desire to have a voice in decisions about their condition and to participate in their own care. With the goal of better analyzing patient problems, the application of patient-specific interventions and the participation in their own care, decisions is possible with the provision and maintenance of individualism in care with nurses competency (Suhonen et al., 2014; Charalabous et al., 2013). Schmidt (2014) emphasized that, patient's level of individualism is a primary factor in the determination of nursing care perception and measures of competency among the nurses.

Individualized nursing care, is related to objective and factual issues such as responsibilities, nursing interventions, nursing competency and what nurses do. Therefore, to perform this type of care, (Yildiz et al., 2018) that: nurses need to talk to their patients about his/her feeling towards illness and caring needs, give patient an opportunity to take responsibility in care based on his/her ability, Identify changes in patient's feelings, talk to patient about their concerns and fears, understand the disease effect on patient in hospital, as well as outside of hospital on their everyday life, find out about the meaning of disease to patient by talking to them, his/her daily habits and his/her family participation in care, make sure the provided instruction was understood well by patient, ask patient what he/she wants to know about his/her health state or disease, listen to individual personal preferences of patients about his/her care, help him/her to make decision and express their point of views about care, also let the patient to choose among care options and encourage patient to ask questions about his/her care.

Therefore, to perceive individualized nursing care, nurses should tailor nursing interventions for individual patient. Also they should carry out individualized nursing care by considering personal life situation such as education and culture, beliefs and traditions, habits, actions, preferences and family involvement in patient care. Sometimes patients need to talk about their individuality during patient- nurse interaction. Actually, this interaction is based on sharing information about preferences, needs and perceptions, and tailored with patient's characteristics, situations, reactions and responses to their health concerns, and physical and socio-environmental characteristics of the health care context. There is a lot of evidence emphasizing the positive effects of this type of care, which led to more appropriate treatment and better outcomes for patients, could increase self-help, reduced patient's dependency and length of hospitalization. Individualized nursing care is an important indicator for quality of nursing care; that it can increase patient satisfaction, greater awareness about health and illness, increases autonomy and health related quality of life.

In a review study by Suhonen et al, which was conducted in 2013, more than 81% of researches reported positive effects of individualized nursing care. A review of researches in the field of individualized nursing care showed that nearly all researches were conducted in European countries, while there is no research in this regard was found in Iran. Today, between provided cares in medical environments like hospital, nursing care is of more importance than others. In fact, health and improvement of patients is at stake of quality care. However, recently in all areas of health systems, emphasis is towards patient- centered care rather than quality of care and ultimately, to enhance patient's satisfaction. Unfortunately, nursing profession has major problem in Iran, such as poor quality of care and patient dissatisfaction. Researches in our country played less holistic and comprehensive attention to care concept. In fact, in most researches which have done in the country, discussion about the quality of care was general. In other words, how quality of nursing care should be considered specifically for each patient has not been considered. With failure of the present situation, may be planners could not encounter these issues and choose the right method successfully. Therefore, identifying the fact that how much patients perceive nurses' support of individualized nursing care could be a factor to enhance quality of nursing care. So, this research aimed to demonstrate point of view of

patients about nurses' support for individualized nursing care. This study is set to explore influence of nurses' degree of competence on self-reported practice of individualized nursing care in selected units of Uniosun Teaching Hospital Osogbo.

STATEMENT OF THE PROBLEMS

Current health services and health promotions in developing countries of which Nigeria is one, have been criticised in terms of quality of care provided and inadequate access to services (SANE Australia, 2012). This is because, strongly held views abound which breed incompetence in the system, rather than sound information which should exerts much influence in healthcare delivery. Yet,the aim of Health promotion is the process of enabling people to increase control over and improve their health to reach the best state of physical, mental and social well-being (World Health Organisation-WHO, 2012). The World Health Organisation (WHO, 2012) also suggested that hospitals are appropriate settings for health promotion. Furthermore, the Munich declaration (WHO, 2010) states that nurses' have a key and increasingly important role to play in society's efforts to tackle the health challenges of our time. Therefore, there is growing acceptance of practices capable of promoting development in health sector. One among these is use of individualized nursing care. Therefore it is imperative for health nurses to employ sound individualized nursing care in order to improve health outcomes (McIntosh, Conlon, Lawrie and Stanfield, 2012). This study would therefore examine influence of nurses' degree of competence on self-reported practice of individualized nursing care in selected units of Uniosun Teaching Hospital Osogbo.

OBJECTIVE OF THE STUDY

The broad objective of this study is to examine influence of nurses' degree of competence on self-reported practice of individualized nursing care in selected units of Uniosun Teaching Hospital Osogbo. Specifically the study:

- ✓ ascertains the degree of professional competence among nurses in selected units of Uniosun Teaching Hospital Osogbo.
- ✓ determines self-reported practices of individualized nursing care among nurses in selected units of Uniosun Teaching Hospital Osogbo.
- ✓ determines relationship between professional competence and practice of individualized nursng care.

RESEARCH QUESTIONS

- ✓ What is the degree of professional competence among nurses in selected units of Uniosun Teaching Hospital Osogbo?
- ✓ Do nurses adopt self-reported practices of individualized nursing care in selected units of Uniosun Teaching Hospital Osogbo?
- ✓ What is the relationship between professional competence and practice of individualized nursing care?

RESEARCH HYPOTHESES

- ✓ There is no significant relationship between degree of professional competence and self-reported practices of individualized nursing care in selected units of Uniosun Teaching Hospital Osogbo.

SIGNIFICANCE OF THE STUDY

Findings in this research will promote the practice of individualized nursing care in hospital facilities, which will help boost competency. This study will further reveal perceived factors influencing use of individualized nursing care practice which help in informed policy decision. The result will further help to provide basic information for designing structures and programmes for the practice of individualized nursing care. It will also provide evidence based information for curriculum reform, to enhance developing potential nurses inline with core principle of practice of individualized nursing care. The study would also serve as a reference material to other researchers in the field of nursing.

SCOPE OF THE STUDY

This study was delimited to nurses in Uniosun Teaching Hospital, Osogbo

OPERATIONAL DEFINITION OF TERMS

- ✓ Influence: is the capacity or power to effect or change how someone develops, behaves or thinks
- ✓ Nurses competence: is defined as the core ability that are required for fulfilling one's role as a nurse.
- ✓ Self reported practical: is a measure or survey relies on nurses report of their behaviors, beliefs or attitude

II. LITERATURE REVIEW

This chapter presents the review of literature related to the work, from books, Journals, Abstracts, and internet materials, under the following subheadings:

CONCEPTUAL LITERATURE REVIEW

CONCEPT OF INDIVIDUALIZED NURSING CARE

Individualized nursing care arose within social and psychological contexts in order to respond to problems in the provision of health services and to a fundamental problem and pervasive lack of knowledge (Elstein, 2014). Problems that existed in the provision of health care services included unexplained variations in clinical practice, an increase in diagnostic and therapeutic options, patient empowerment, and decision psychology (Eddy, 2013). The purpose of individualized nursing care is to move a situation on which there is incompetence to one on which there is knowledge based on something more trustworthy than opinion. The solution is to develop some sense of sufficiency and self-

capacitywhile making a treatment decision. Proponents of individualized nursing care acknowledge that a one-size fits all mentality is not the most advantageous application of this method, and so they increasingly espouse overlapping implementation strategies that target a specific group or problem (Timmermans and Mauk, 2010).

This concept also addresses the honour, uniqueness, and integrity of the patient, and the ethical and moral values related to the consideration and protection of the patient's rights. For this reason, in addition to the healthcare providers, healthcare service recipients' decisions also have a considerable effect on the quality of care (Şendir et al., 2012). Individualized care is the provision of careby attitudes such as trust, sincerity, openness, understanding and responsibility by respecting the dignity, uniqueness, individuality and integrity of each individual, taking into account their differences (Acaroglu, 2013). Individual differences in terms of health, illness and needs make individualized nursing care necessary (Suhonen et al., 2014). Focusing on the patient throughout the care process is the main reason for supporting the individualized care. According to Eddy (2013), features of individualized care individualized care includeusing an explicit, rigorous process; creating a generic product intended for application to a of patient or issue; and intending effects to move physicians and other health care providers to deliver certain types of care and away from directing care to an individual patient.

PRACTICES OF INDIVIDUALIZED NURSING CARE

It is important to consider the patient's level of individualism in order to provide the best possiblenursing care (Senarath, 2014). However, the individualization of patient care is not solely focused on the adaptation of nursing practice towards individual characteristics and the provision of patient satisfaction. It is broadly associated with the perception, experience, and feeling of the individual who has been provided with care (Acaoğlu&Şendir, 2012). In Berg's et al., (2016) study, 86% of the patients stated that individualized care was important, and 59% of the patients stated that they had received individualized care. Individualized care improves personal health and the health process, while increasing the patient's qualityof life, autonomy, and satisfaction regarding the quality of care (Lauver et al., 2012). Suhonen et al. (2013) determined in their study that the satisfaction of patients who received individualized care in nursing interventions was high. Individualized nursing care, considered as the key to quality nursing care, shapes nursing practices within the uniqueness of each patient, changing all standard nursing procedures and activities (Acaroglu et al., 2013). Individualized care affects patient satisfaction and autonomy positively by allowing patients to participate in their owncare and to make decisions on the care (Suhonen et al., 2013). This form of care, which reflects the belief of the nursing in person's valuableness and uniqueness, also contributes to patient satisfaction by increasing the quality of nursing care (Can &Acaroglu, 2015). In addition, it is stated that individualized care improves job satisfaction and motivation in nurses (Suhonen et al., 2014).

Nurses who adopt individualized care accept the uniqueness of each patient and plan and implement the care without ignoring the patient's unique characteristics (Ceylan, 2014). In a study conducted in Finland, Suhonenet al. (2013) found that nurses working in the field of mental health had a positive view of individualized care, while those working in long-term primary health care services had a negative viewpoint. In a different study carried out to determine the perceptions of individualized care of the nurses in different countries, Suhonen et al. (2014) found out that nurses' perceptions of individualized care were at good level, with differences among countries. Nurses' perceptions of individualized care were found to be affected by work duration, level of education and country differences (Idvallet al., 2012). Furthermore, Can and Acaroglu(2015) also found that nurses gave more importance to the individuality of the patients in care initiatives as their perception of professional value increased.

NURSES AND PRACTICE OF EVIDENCE-BASED PRACTICE

The practice of nursing is a science-based profession and has a body of research to guide decision making. It has been shown that practice decisions based on research improve outcomes. Nursing as a profession is tasked with utilizing scientific research to support nursing practice and decision-making. The American Nurses Association (ANA) (2013) asserts that research is an integral part of professional practice. In a policy statement the ANA (2013) depicts the role of research in practice: to refine and expand the knowledge base and science of the discipline, nurses generate and use theories and research findings that are selected on the basis of their fit with professional nursing values of health and health care, as well as their relevance to professional nursing practice".

The code of ethics for nurses (ANA, 2001), requires that the "nurse participate in the advancement of the profession through contributions to practice, education, administration and knowledge development". The accountability and responsibility for ensuring EBP is a component of healthcare, falls to the nurse and is not an optional component of practice (Rycroft-Malone, et al., 2014; Stetler, 2013; Titler, 2014). Additionally, Bonner and Sando (2013) empirically refute that nurses lack awareness or an appreciation for the necessity of research in practice. Nurses appear to have a high awareness for and appreciation for research in practice, yet are unable to engage in a dynamic evidence-based practice.

The individual nurse has been the focus of much research regarding the use of new knowledge to support decision-making in practice. This singular perspective is currently viewed as too simplistic in the complex healthcare arena where the individual nurse is balancing a variety of competing priorities (Midodzi, et al., 2012b). Evidence-based practice appears to be a system-wide activity and the focus of research is changing to reflect this understanding. The effect of the organization and nursing leadership on the staff nurse has been identified as a needed area of study for EBP (Rycroft-Malone, 2013). The focus is shifting from the individual to organizational dynamics; however, the individual nurse remains an integral part of the process.

In spite of the changing focus to context, the individual nurse remains central to the use of research at the bedside, so

an understanding of the nurse's perspective is important. Numerous studies address the individual nurse characteristics or perceptions of the use of new knowledge or EBP (Andersson, et al., 2014). This echoes findings from other studies which suggest that more experienced nurses are more likely to draw knowledge from policy and procedures, experience, and work based communications (Gerrish and Clayton, 2014).

Limited education on research and EBP has been assumed or explicitly described in studies as a barrier to EBP activities. A finding that prevailed throughout the literature was that the more education (Bonner and Sando, 2013) or research classes (Rycroft-Malone, et al., 2014a) that the nurse received, the greater the impact on EBP behaviors. However, Rycroft-Malone et al., (2014) refer to this as *skilling up* the nurse and found that education as a single intervention to promote the use of evidence by the clinical nurse was ineffective.

Bonner and Sando (2012) found little evidence regarding the nurse's awareness of research and how much of it is actually used in practice. Does reflect the finding that Andersson et al. (2012) reported regarding the clinician's self -perception of professionalism. Research that includes the educational background of the clinician and nurse leader is needed for correlational studies with EBP as the dependent variable. Experience, like education, would be easily assumed to have a positive impact on research utilization behaviors, but Andersson et al., (2012) found that with increased competence and experience of the nurse, positive attitudes and behaviors about the use of research decrease. Gerrish and Clayton (2014) suggest that nurses prefer to call on experiential knowledge and work-based information (i.e., policy and procedures) to inform practice. It was also found that other sourcesof nursing knowledge were correlated with organizational transfer of new knowledge (i.e., health care reports), instead of research use (Leiter, Day, Harvie and Shaughnessy, 2012). In a study by the American Academy of Nursing it was found that out of 1,097 registered nurses more than half held negative beliefs about the use of research by their colleagues and did not feel competent in EBP (Pravikoff, Tanner and Pierce, 2012).

The ability to critique research is viewed as a barrier by the nurse (Hutchinson and Johnston, 2014) in that the researcher's toolkit (methodology, questions, outcomes, and goals) appears to be irrelevant to the nurse and his/her task at hand. Evidence based practice has been found to be impacted not only by organizational context and nursing management, but also by education (Bonner and Sando, 2014). Many of these identified variables may find positive or negative correlations to leadership behaviors and requires more investigation. It has been found that education, role, abilities, and awareness of research impacts staff nurses' beliefs about EBP. The bedside nurse is a strategic point of practice where empirical knowledge is required to ensure the best outcomes for patients. The pendulum of understanding is now swinging toward the contextual environment in which the staff nurse resides. It is with caution that we do not focus solely on contextual factors to the exclusion of the individual nurse as he/she remains central to EBP.

FACTORS MILITATING AGAINST PRACTICE OF INDIVIDUALIZED NURSING CARE

A study by Laal (2013), which investigated factors affecting patients' perceptions of nursing care, determined that age, gender, educational level, marital status, duration of hospital stay and surgical interventions affected perceptions of nursing care. The variation of patients' experiences, expectations and problems necessitates the consideration of patient perception in the individualization of care and increasing the patient's satisfaction of nursing care. Barriers, such as lack of time, lack of staff, lack of clarity in the documentation process, and perceived lack of interest and/or lack of need for documentation, were also evidenced in the literature (Asamani, Amenorpe, Babanawo and Ofei,2013). Bjorvell et al. (2013) found that over 70% of nurseparticipants believed that they had insufficient time to properly document, which they attributed to their perceptions of limitations of work organization and environment. There are many barriers to successful adoption of individualized care in the workplace. They fall into three categories: the individual, the organization and the environment.

THE INDIVIDUAL

A critical element in individualized care practice is the competence of the nurse elders. Caine and Kenrick (2012) suggest that because many nurse elders lack advanced academic skills themselves, they may be apprehensive about fostering a highly skilled and analytical nursing workforce. Nurse elders and nurses may be locked into an "old school" mentality in which nursing is seen primarily as a practical rather than a cognitive activity, and where nurses adhere to procedures and standards that are reinforced and rewarded by the organization.

Kondratieff, a Russian economist, argued that we are currently living in an era that values the commodity of knowledge (Muir Gray, 2014). Nursing is expected to operate within this commodity. As nursing continues to struggle with task efficiency, the transformation of our practice into one of knowledge workers applying evidence-based research is proving a challenge. The responsibility for utilizing individualized care lies solely with nurses at the bedside. It is speculated that, in an effort to support nurses in a more complex work environment, may make too few demands on them and unknowingly limit the potential for better patient outcomes. In addition, the majority of nurses have not been taught how to use research within the context of practice (Crane, 2014). Added to this is the research–practice gap that exists in the nursing profession. Research and individualized care practice are valued by academics, whereas the "real world" of death and dying and caring for patients and their families is more highly valued by bedside nurses. Nurses in the clinical setting have little knowledge of the individualized care process and its application to practice and limited ability to critically appraise research. Moreover, there is a belief that most nursing practice is routine, so why search for new evidence. Nurses often manage heavy workloads as a result of the nursing shortage. This situation frequently leaves them too exhausted to advocate for changes that could strengthen the

quality of care they provide (Falk Rafael, 2014). Exhaustion plays a considerable role not only in hampering nurses' ability to practise in the manner they would like, but in providing consistently safe nursing care. The "lofty" idea of evidenced practice then becomes an even further distant goal.

THE ORGANIZATION

Limited access to library resources (Newman et al. 2013) and lack of knowledge of how to navigate complex databases are major barriers to locating and utilizing evidence in practice. Added to this difficulty is the high cost of corporate licences to access these databases. Lack of access to computers on nursing units also poses significant constraints. Staggering patient workloads and the nursing shortage pose notable limitations on nurses' time. Missed breaks and frequent overtime are a direct result of resource constraints, making it difficult for nurses to attend research-related activities (Newman et al. 2012). Consequently, minimal time is spent on an "esoteric" activity such as learning about and implementing evidence-based practice.

Funding reductions within healthcare organizations have severely limited opportunities for skill development that allows nurses to update their knowledge base regularly (Newman et al. 2013). Lack of training and knowledge often lead to low levels of receptivity and willingness to participate in the change to individualized care.

Till date, individualized care has not been seen as a priority for healthcare organizations, as the political interests of the facility often influence how resources are distributed (Newman et al. 2012). For example, financial constraints and the recruitment and retention of staff are but two issues impinging upon management's agenda. Moreover, the loss of the clinical nurse specialist role in many hospitals further confirms the shift from an emphasis on patient care to financial priorities.

THE ENVIRONMENT

The culture of nursing practice is embedded in the wider socio-cultural, political and economic forces of society. Healthcare reform in the 1990s led to massive cutbacks of nursing positions across the country as a direct result of government interventions. For this reason, we need to be cognizant that nursing is one player among many at the macro level. Most importantly, the Canadian federal and provincial governments have created positions for senior nurse executives to spear-head and increase nurses' input into health and nursing policies. Consequently, nursing's voice is becoming consistently more influential in shaping the direction of healthcare.

The overwhelming number of changes that occurred as a result of healthcare reform frequently led to high levels of unpredictability in the workplace, leaving nurses weary and less able to cope with further changes to their practice (Baumann et al. 2013). In an environment where nurses have performed in an exemplary fashion with diminishing resources, it is difficult for them to fathom making yet another change. Healthcare reform has created a shift in the power balance away from professionalism towards management. Rodgers (2014) describes a "culture of managerialism" whereby nurse managers and nurses have different agendas. The shift in nurse managers' responsibilities has moved them away from providing clinical expertise to focusing solely on managerial functions, thus leaving little room for experimentation and implementation of research findings.

PRACTICE OF INDIVIDUALIZED NURSING CARE AND PATIENT SATISFACTION

To understand the practice of individualized nursing care, there was need to understand what quality is from a health perspective. According to World Health Organization (WHO, 2013) quality has been defined as the process of meeting the needs and expectations of patients and health service staff. The WHO, (2013), identified effectiveness, efficiency, accessibility; acceptability/patient-centeredness, equitability and safety as dimensions that help to define quality. The health care services should be effective in such a way that is adherent to individualized nursing care which results in improved health outcomes for individuals. The health care services should be accessible in terms of being timely and be provided in a setting where skills and resources are appropriate to aid practice of individualized nursing care. The WHO (2013), emphasized that the practice of individualized nursing care should be employed so as to be patient centered in which it takes into account the preferences and aspirations of individual service users.

Since nursing care makes one of the major components of health care service in a hospital, it is necessary that, they put before them the welfare of patient such that, would aid quick recovery. According to Virginia Henderson definition, nursing is the unique function of the nurse to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible (Lewis, et.al, 2013).

Many studies done on individualized nursing care revealed that, it is important to consider the patients' satisfaction with the care (Debono&Travaglia, 2014). Patients become more satisfied if their needs are met. As health professionals, nurses are accountable for quality and systematic improvement of nursing practice (Burhans, &Alligood, 2015). Adoption of individualized nursing care ensures patients' need fulfillment and therapeutic effectiveness mediated through selective focusing (Burhans, &Alligood, 2014). Individualized nursing care in Thailand was perceived as one that met individual patients' physical, psychological and extra needs. The nurses who were providing individualized nursing care were perceived to have good attitude and professional manners, showed kindness, trust and honesty as well as clinical competence (Zhao & Akkadechanunt, 2014). Individualized nursing care ensure patients understanding was perceived as quality care. A study in China revealed that patients perceived individualized nursing care when as nice attitude towards them and caring for them (Zhao &Akkadechanunt, 2014). Teaching diseases and nursing related knowledge to individual patient and providing care as needed promptly was also perceived as individualized

nursing care by patients (Zhao &Akkadechanunt, 2014). It was observed that individualized nursing care demands that we pay attention to the needs of patients and clients and use methods that have been tested to be safe, affordable and reduce deaths, illness and disability and health care workers are expected to practice according to set standards. Individualized nursing care satisfies the needs and expectations of patients. Patients are likely to care more about the communication, listening, kindness and responsiveness of their nurses (Burhans, & Alligood, 2013). Therefore, assessment of individualized nursing care from patients' perspective has been operationalised as patient satisfaction (Rafii, et.al, 2015).

EMPIRICAL REVIEW

Eylem et al., (2015) determine the perception of individualized care, satisfaction with nursing care levels and the relationship between them. The sample for this study, which was planned as descriptive and cross-sectional, was constituted of 425 patients who were staying at the internal medicine and surgical clinics of a university hospital in Turkey. Data was collected using 'Patient Information Form', 'Individualized Care Scale' and 'Satisfaction with Nursing Scale'. The mean age of the patients was 57.70±14.51 years, the average duration of hospital stay was 11.03±10.15days and 52.9% of the patients were staying at internal medicine clinics. The patients' realization of nursing care (3.65±0.82), perception of the individualism in nursing care (3.88±0.69) and satisfaction with nursing care (71.41±17.63) scores were found to be above average. A positive correlation was found between satisfaction with nursing care and perception of individualized care ($p<.001$). Patients are aware of individualized care, and individualized care increases the level of patients' satisfaction with nursing services. It is important that nurses provide specific and individualized care for their patients.

Yildiz et al., (2018) evaluate nurses' perceptions of individualized care. The population of this descriptive and cross-sectional study consisted of nurses working in intensive care, surgery and internal medicine services of a state hospital and the sample group consisted of 97 nurses who agreed to participate in the study. Research data were collected with the "Introductory Information Form" and the "Individualized Care Scale-A-Nurse Version". The data obtained were evaluated using the arithmetic mean, standard deviation, frequency, percentage distribution, t test and variance analysis in the SPSS 22.0 package program. The total item score average of nurses' Individualized Care Scale-A-Nurse Version is 3.75±0.74.Subscale item score averages were 3.95±0.75 for the Clinical Status subscale, 3.37±0.95 for the Personal Life status subscale, and 3.94±0.95 for the Decision-Making Control subscale. Individualized Care Scale mean scores in nurses working in internal clinics and having between 21-30 years of experience in clinical practice were higher, and the difference was significant ($p <0.05$). It was found that nurses' perceptions of individualized care were better, those in internal clinics and those with more years of experience in internal clinics were more concerned with the individuality of the patient.

Yeong Woo, Yu Lee and San Tam (2017) examine impact of advanced practice nursing role on quality of care, clinical outcomes, patient satisfaction, and cost in the emergency and critical care settings: a systematic review. A comprehensive and systematic search of nine electronic databases and a hand-search of two key journals from 2006 to 2016 were conducted to identify studies evaluating the impact of advanced practice nursing in the emergency and critical care settings. Two authors were involved selecting the studies based on the inclusion criteria. Out of the original search yield of 12,061 studies, 15 studies were chosen for appraisal of methodological quality by two independent authors and subsequently included for analysis. Data was extracted using standardized tools. Finding revealed that, Narrative synthesis was undertaken to summarize and report the findings. This review demonstrates that the involvement of nurses in advanced practice in emergency and critical care improves the length of stay, time to consultation/treatment, mortality, patient satisfaction, and cost savings. In conclusion, Capitalizing on nurses in advanced practice to increase patients' access to emergency and critical care is appealing. This review suggests that the implementation of advanced practice nursing roles in the emergency and critical care settings improves patient outcomes. The transformation of healthcare delivery through effective utilization of the workforce may alleviate the impending rise in demand for health services. Nevertheless, it is necessary to first prepare a receptive context to effect sustainable change.

Nakate et al., (2014). In a mixed methods intervention study, determine knowledge and attitudes of nurses towards documentation, including an evaluation of nurses' response to a designed nursing documentation form. Forty participants were selected through convenience sampling from six wards of a Ugandan health institution. The study intervention involved teaching nurses the importance of documentation and using of the trial documentation tool. Pre and post testing and open-ended questionnaires were used in data collection. On both pre and post-tests, most participants strongly agreed that nursing notes were meaningful and necessary for legal protection, as well as a nursing priority. Most participants strongly disagreed that there was familiarity with policies on nursing documentation, and that an uninterrupted environment for care documentation existed. Although participants' knowledge about documentation improved by 20% following the intervention, there was no significant change in attitudes toward documentation. Participants consistently reflected on documentation as an important practice, but highlighted contextual constraints limiting implementation and quality of documentation. The study findings have implications for pre and post-service training, documentation policies, and organizational.

THEORETICAL MODEL

DREYFUS MODEL OF SKILL ACQUISITION

The theory underlying factors that affect clinical training of nursing students in nursing schools is the Dreyfus model of skill acquisition as developed by Benner (2004). This model contains a systematically planned process for teaching

students to acquire the required clinical skills for nursing practices.

The Dreyfus model of skill acquisition is a model of how students acquire nursing skills through formal instruction and practical experiences. It has originally five steps such as novice stage, advanced beginner, competent stage, proficiency stage and expert stage.

- ✓ *NOVICES' STAGE:* This being the first step, orientations and instructions on the subject matter are given to the students. Rigid adherence to taught rules, plans of actions, procedures of doing things are advocated by the trainer. The students have no sense of responsibility beyond following the rules and procedures exactly. In this stage, good orientation and practical demonstrations of nursing skills by a professional is advocated.
- ✓ *ADVANCED BEGINNERS:* With the teacher's drilling of instructions, demonstrating and students practicing procedures with adequate equipment and adequate supervision of students, students leave the former stage. Here individual students develop organizing principles to quickly access the particular rules or procedures that are relevant to the specific task at hand. Students also have limited situational perception and treat all aspect of work separately with equal importance. Students' participation in practicing the things they have been taught help them to understand the nursing skills involved well.
- ✓ *COMPETENT STAGE:* With much exposure and practice, training becomes more concrete. Students now are engaged in active decision making in choosing a course of action, e.g. coping with crowded activities, accumulation of information, some perception of actions in relation to goals, deliberate planning execution of action under supervision and can formulate and carry out routines.
- ✓ *PROFICIENT STAGE:* With active participation in clinical experiences, students have learnt some nursing skills. Also with much clinical nursing practice, individual student nurse develops intuition to guide his/her decisions and develops the ability to formulate nursing plans according to the profession. Candidate now has holistic view of situations, can prioritize important aspects of activities, perceives deviations from the normal pattern and employs maxims for guidance with meanings that adapt to the situation at hand.
- ✓ *EXPERT STAGE:* Candidates here transcend reliance on rules, guidelines and maxims. They have intuitive grasp of situations based on deep, tacit understanding. They have vision of what is possible and use analytical approaches in new situations or in cases of problems.

APPLICATION OF DREYFUS'S SKILL ACQUISITION MODEL

The Dreyfus skill acquisition model as propounded by Benner (2004) can be utilized to explain nursing competency and use of individualized care. This training theory views each student and their stages of performance uniquely and helps the teachers/ supervisors to attend to their needs individually and appropriately. It aims at upgrading students from novice to expert nurses by identifying the training needs at each stage and drilling the students to acquire those needed skills before stepping forward to the next stage. In the model of study, the dependent variables are the stages of skill acquisition which are novice stage, advanced beginner, competent stage, proficient and expert stage. The intervening variables are the study variables which include factors of adequate teachers/supervisors, equipment, techniques/measures used for training and attitude towards training.

The intervening variables are the factors that may affect clinical training of nursing students either positively or negatively depending on the adequacy of the intervening variables. The independent variable is the clinical training offered to nursing students which involves skill acquisition that manifests in the quality of nursing care rendered by students.

The model shows that adequacy and competency of the intervening variables using the five stages approach of the model will affect clinical training of nursing students. This is because at each stage, the students will be drilled properly on the skills to be learnt before moving up to the next stage. In other words, it is hypothesized that with experienced supervisors using appropriate equipment with right training techniques and students being interested in clinical experiences, students will acquire adequate and appropriate nursing skills necessary for practice. Also, lack or inappropriateness in any of the intervening variables or lack of proper utilization of the stages of the model will result to poor acquisition of the necessary nursing skills thereby leading to poor clinical nursing practice. The model also showed that acquisition of nursing skill is a continuous process that never ends but needs regular updating in order to remain relevant and proficient in nursing profession.

III. RESEARCH METHODOLOGY

This aspect of the research study discuss the research design, research setting, population, sample determination, sampling techniques, research instruments, pilot study, validity and reliability of instruments, method of data collection, ethical consideration and method of data analysis.

RESEARCH DESIGN

A non-experimental descriptive design will be adopted for the study. This approach aimed at observing, describing and documenting the characteristic of phenomena under the study. This design is considered appropriate for this study because it allows to provide answers to the questions of who, what, when, where, associated with a particular research problem. Also, Descriptive research is used to obtain information concerning the current status of the phenomena and to describe "what exists" with respect to variables or conditions in a situation.

RESEARCH SETTING

This research was conducted in UNIOSUN Teaching Hospital which is situated in Idi Seke Osogbo. The institution was one of the state Teaching Hospital in Nigeria organized in the year 1997 by the Oyo State and Osun government to be a

teaching clinical arm for students of nursing, medicine and medical laboratory department. It consists of male surgical, female surgical, male medical, female medical, eye, male orthopedic, pediatric medical and surgical wards, there are about 135 non-medical staff in the hospital is made up of 14 departments. The hospital provides in and outpatient services including national health insurance scheme services, public/community health care services and immunization.

TARGET POPULATION

The target populations for this study include, male and female Nurses at Osun State University Teaching Hospital, Osogbo, Osun State.

SAMPLE SIZE DETERMINATION

The sample size of this research was calculated using Taro Yamane formula. The calculation formula of Taro Yamane is represented as follows:

$$n=\frac{N}{1+N(e)^2}$$

Where: n = sample size required
1 = constant
N = number of people in the population
e = level of precision
N = 350
e= 0.05
n = 350/1+327(0.05)^2
n=350/1+350(0.0025)
n=350/1+0.8775
n=350/1.8775
n = 186.5

Therefore, the sample size that will be use in this study is 187

SAMPLING TECHNIQUE

The study adopted Stage I Units, Stage II Wards, Stage III Nurses in the selected wards. Firstly, four department and wards were purposively selected, these include, inpatients, accidental and emergencies department and male and female medical wards. The need to adopt these sections of the hospital is based to the fact that, nurses are much in these departments and wards. Secondly, the adopted convenience sampling techniques to select respondents. The study also uses, Convenience sampling techniques due to the busy schedule of nurses.

INSTRUMENT FOR DATA COLLECTION

In order to have a comprehensive and reliable source of information, self-structured questionnaire was used in this study and administered to respondents. The questionnaire is divided into three sections. section A consist of background information about the respondents; while

Section B contained structured questions/statements that points to obtaining information about degree professional of competence among nurses.

Section C contained structured questions/statements that points to obtaining information about practice of individualized nursing care.

VALIDITY OF THE INSTRUMENT

Face and Content validity were ensured before proceeding to the field. This was carried out to ensure the items capture the needed data. The original items drawn were critically examined by the researcher's supervisor. All the corrections made were taken into consideration while drawing the final items for the questionnaire.

RELIABILITY OF THE INSTRUMENT

In order to ensure that the research instrument maintains consistency in measuring what it intends to, a Pilot study of 10 nurses from State Hospital Asubiaro will be carried out. The questionnaire was administered to the selected Nurses at once and Cronbach Alpha was used to test the consistency of the instrument. The study will indicate the reliability of the instrument.

DATA COLLECTION METHOD

Data was collected by the researcher from respondents in selected wards and departments in the hospital. The nurses were asked to complete the questionnaire according to how each items applies to them without bias or prejudice after which all correspondents responded accordingly. The research questionnaires were finally returned and analyzed.

METHOD OF DATA ANALYSIS

After the questionnaires was received, the data extracted will be treated as raw data using descriptive statistics like percentages and frequency count data will be analysed. Hypotheses was tested using inferential statistics such as line arregression analysis at 0.05 level of significance.

ETHNICAL CONSIDERATION

A letter of introduction for permission to carry out the research was collected from the researcher's head of department and given to the ethical committee of Osun State University Teaching Hospital, Osogbo, Osun Statefor necessary approval before it was finally taken to each ward where the respondents were assured of confidentiality and the questionnaires were administered under free will and not compulsion.

IV. DATA ANALYSIS AND INTERPRETATION

The responses to the question contained in the questionnaires were analyzed using Descriptive statistics. This was presented using, frequency tables and percentages.

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Demographic Characteristics

Items	Frequency	Percentage
Highest Educational Attainment		
RN and equivalent	88	48.4
BSc.	72	39.6
MSc	22	12.0
Wards		
Medical Wards	27	14.8
Surgical Wards	24	13.2
Orthopaedic	28	15.4
Emergency	23	12.6
SCBU	17	9.3
Ante natal	21	11.5
Paediatric. Medical	22	12.1
Paediatric Surgical	20	11.0
Year of experience		
0-5	52	28.6
6-10	8	4.4
11-15	121	66.5
16 years and above	1	0.5
Bed space of the ward		
17	69	37.9
20	47	25.8
21	44	24.2
22	22	12.1
Average number of nurses per shift		
1-2	115	63.2
3-4	66	36.3
5 and above	1	0.5

Table 4.1: Demographic Characteristics

Table 4.1 above present distribution of respondent by demographic characteristics. Age results revealed that, 9.9% were 20-29 years old, 47.8% were 30-39 years old, 33.0% were 40-49%, while 9.3% were 50 years and above. For sex, 9.9% were male, while 87.1% were female. For Educational attainment, 48.4% had RN and equivalence, 39.6% had BSc, while 12.0% had MSc. Also 14.8% were selected from medical wards, 13.2% were selected from surgical ward, 15.4% were selected from Orthopaedic, 12.6% were from Emergency, 9.3% were from SCBU, 11.5% were from Ante natal, 12.1% were from Ped. Medical while 11.0% were from Ped. Surgical. On Year of experience, 28.6% have worked for 0-5 year, 4.4% have worked for 6-10 Year, 66.5% have worked for 11-15 Year, while .5% has worked for 16 Years and above. On bed space, 37.9% of the respondents are stationed in a ward with 17 bed space, 25.8% are stationed in a ward with 20 bed space, 24.2% are stationed in a ward with 21 bed space, while 12.1% are stationed in a ward with 22 bed space. Based on average number of nurses per shift 63.2% represent 1-2 nurses, 36.3% went for 3-4 per shift, while .5% represent 5 and above

ANSWER TO RESEARCH QUESTIONS

RESEARCH QUESTIONS ONE: Degree of competency

	F(%)			
Items	**A**	**U**	**O**	**N**
Independently apply the nursing process	130(71.4)	44(24.2)	7(3.8)	1(0.5)
How often do you attend conference	1(0.5)	52(28.6)	121(66.5)	8(4.4)
Follow up on patient's conditions after examinations and treatments	49(26.9)	125(68.7)	7(3.8)	1(0.5)
Provide patients and relatives with support to enhance participation in patient care	37(20.3)	90(49.5)	55(30.2)	0(0.0)
How often are you updated about new technologies?	48(26.4)	18(9.9)	115(63.2)	1(0.5)
Interact with other professionals in care pathways?	85(46.7)	49(26.9)	40(22.0)	8(4.3)
Teach, supervise and assess students	102(56.0)	69(37.9)	10(5.5)	1(0.5)
How often do you upgrade your learning skills?	56(30.8)	117(64.3)	5(2.7)	4(2.2)
How often are you updated about new medical conditions?	74(40.7)	76(41.8)	21(11.5)	11(6.0)
Comply with current legislation and routines?	81(44.5)	68(37.4)	31(17.0)	2(1.1)
Show respect for patient autonomy, integrity and dignity?	35(19.2)	59(32.4)	60(33.0)	28(15.4)

Table 4.2: Frequency distribution of the respondents showing degree of competency

Table 4.2.1 presents frequency distribution of the respondents' showing degree of competency. Result revealed that, majority (A= 71.4%; U= 24.2%) independently apply the nursing process, while a few (O=3.8%; N=.5%) don't usually or never. A few (A= .5%; U= 28.6%) do attend conference, while majority (O=66.5%; N=4.4%) usually or never attend conference. Majority (A= 26.9%; U= 68.7%) follow up on patient's conditions after examinations and treatments, while a few (O=3.8%; N=.5%) either don't usually or never. Majority (A= 20.3%; U= 49.5%) provide patients and relatives with support to enhance participation in patient care, while a few (O=30.2%; N= 0.0%) don't usually or never. A few (A= 26.4%; U= 9.9%) regularly get updated about new technologies, while majority (O=63.2%; N=.5%) either don't usually or never. majority (A= 46.7%; U= 26.9%) interacted with other professionals in care pathways, while a few (O=22.0%; N=4.3%) don't usually or never .majority (A= 56.0%; U= 37.9%) Teach, supervise and assess students, while a few (O=5.5%; N=.5%) don't usually or never.

majority (A= 30.8%; U= 64.3%) often do upgrade them learning skills, while a few (O=2.7%; N=2.2%) don't usually or never.

majority (A= 40.7%; U= 41.8%) often get updated about new medical conditions, while a few (O=11.5%; N=6.0%) don't usually or never.

majority (A= 44.5%; U= 37.4%) comply with current legislation and routines, while a few (O=17.0%; N=1.1%) don't usually or never.

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majority (A= 19.2%; U= 32.4%) do show respect for patient autonomy, integrity and dignity, while a few (O=33.0%; N= 15.4%) don't usually or never.

RESEARCH QUESTIONS TWO: What is the practice of individual nursing care?

Items	F(%) A	U	O	N
Do you have adequate knowledge about illness and treatments of each individual patient?	77(42.3)	66(27.5)	28(15.4)	11(6.0)
Do you avoid distraction while attending to individual patient?	75(41.2)	56(30.2)	31(17.0)	21(11.5)
Do you ensure privacy of individual patients?	71(39.0)	53(29.1)	40(22.0)	18(9.9)
Do you allow patients to voice out their opinion?	76(41.8)	73(40.1)	28(15.4)	5(2.7)
Do you health educate patients about every care	44(24.2)	56(30.8)	50(27.5)	32(17.5)
Do you respect patient's relative and encourage their visits?	72(39.6)	47(25.8)	34(18.7)	29(15.9)
Do you Identify objectives of care which reflect patient centred goals?	64(35.2)	76(41.8)	30(16.5)	12(6.6)
Do you plan care activities using available resources and in accordance with your organisation's policies?	71(39.0)	69(37.9)	38(20.9)	4(2.2)
Do you select interventions appropriate to a patient's problem?	54(29.7)	93(51.1)	21(11.5)	14(7.7)
Do you implement appropriate interventions independently?	51(28.0)	107(58.8)	13(7.1)	11(6.0)
Do you accurately assess a patients' resources and their potential to continue the plan of care at home if necessary?	53(29.1)	90(49.4)	23(12.6)	16(8.8)
Do you carryout discharge plan effectively?	66(36.2)	51(28.0)	42(23.1)	23(12.6)
Do you plan care activities using available resources and in accordance with your organisation's policies?	58(31.9)	71(39.0)	37(20.3)	16(8.8)
Do you develop an appropriate plan of care?	69(37.9)	85(46.7)	27(14.8)	1(0.5)
Do you select and prepare appropriate resources required for procedure?	60(33.0)	81(34.5)	30(16.5)	11(6.0)
Do you adequately explain to patients what various procedures involve for them?	55(30.2)	98(53.9)	30(16.5)	29(15.9)
Do you Implement appropriate interventions in collaboration with other carers?	68(37.4)	64(35.2)	50(27.5)	0(0.0)
Do you perform clinical procedures safely as part of a treatment plan (eg catheterisation)?	96(52.7)	47(25.8)	39(21.4)	0(0.0)
Do you effectively update the plan of care to meet a patient's individual needs?	63(34.6)	72(39.6)	47(25.8)	0(0.0)
Do you adapt therapeutic interventions appropriately to meet patient's needs?	119(65.4)	61(33.5)	1(0.5)	1(0.5)
Do you evaluate a patients' social environment accurately?	44(24.1)	77(42.3)	37(20.3)	24(13.2)
Do you accurately identify health problems in a patient's home environment?	35(19.2)	50(27.5)	62(34.1)	35(19.2)
	19.2	27.5	34.1	19.2
Do you accurately assess the effectiveness of preventive health care measures?	50(27.5)	67(36.8)	51(28.0)	14(7.7)
Do you provide efficient care in emergency situations?	108(59.9)	64(35.1)	9(4.9)	1(0.5)
Do you adequately meet patients' personal hygiene needs?	39(21.4)	103(56.6)	40(22.0)	0(0.0)
Do you demonstrate skills with regard to the appropriate administration of medicines?	104(57.2)	46(25.3)	31(17.0)	1(0.5)
Do you implement therapeutic measures for a patient who is in pain?	85(46.7)	49(26.9)	40(22.0)	8(4.3)
Do you manage palliative care appropriately for a terminally ill patient?	102(56.0)	69(37.9)	10(5.5)	1(0.5)
Do you provide sensitive care for a patient who is grieving?	56(30.8)	117(64.3)	5(2.7)	4(2.2)

Table 4.3: Frequency Distribution of the respondents showing practice of individual nursing care

The above table revealed that, majority (A= 42.3%; U= 27.5%) do have adequate knowledge about illness and treatments of each individual patient, while a few (O=15.4%; N= 6.0%) don't usually or never. A few (A= 41.2%; U= 30.2%) do avoid distraction while attending to individual patient, while majority (O= 17.0%; N= 11.5%) usually or never attend conference. Majority (A= 39.0%; U= 29.1%) do ensure privacy of individual patients?, while a few (O=22.0%; N= 9.9%) either don't usually or never . Majority (A= 41.8%; U= 40.1%) do allow patients to voice out their opinion?, while a few (O=15.4%; N= 2.7%) don't usually or never . A few (A= 24.2%; U= 30.8%) do health educate patients about every care , while majority (O=27.5%; N= 17.5%) either don't usually or never . majority (A= 39.6%; U= 25.8%) do respect patient's relative and encourage their visits, while a few (O=18.7%; N=15.9%) don't usually or never. majority (A= 35.2%; U= 41.8%) do Identify objectives of care which reflect patient centred goals, while a few (O=16.5%; N= 6.6%) don't usually or never .majority (A= 39.0%; U= 37.9%) do plan care activities using available resources and in accordance with your organisation's policies, while a few (O=20.9%; N=2.2%) don't usually or never .majority (A= 29.7%; U= 51.1%) do select interventions appropriate to a patient's problem, while a few (O=11.5%; N=7.7%) don't usually or never .majority (A= 28.0%; U= 58.8%) do implement appropriate interventions independently, while a few (O=7.1%; N=6.0%) don't usually or never .majority (A= 29.1%; U= 49.4%) do accurately assess a patients' resources and their potential to continue the plan of care at home if necessary?, while a few (O=12.6%; N= 8.8%) don't usually or never.

Majority (A= 36.2%; U= 28.0%) do carryout discharge plan effectively, while a few (O=23.1%; N=8.8%) either don't usually or never.

Majority (A= 31.9%; U= 39.0%) do plan care activities using available resources and in accordance with your organisation's policies, while a few (O=20.3%; N= 8.8%) don't usually or never.

A few (A= 37.9%; U= 46.7%) do develop an appropriate plan of care, while majority (O=14.8%; N= .5%) either don't usually or never.

Majority (A= 33.0%; U= 34.5%) do select and prepare appropriate resources required for procedure, while a few (O=16.5%; N=6.0%) don't usually or never.

Majority (A= 30.2%; U= 53.9%) do adequately explain to patients what various procedures involve for the, while a few (O=16.5%; N=15.9%) don't usually or never.

Majority (A= 37.4%; U= 35.2%) do implement appropriate interventions in collaboration with other carers, while a few (O=27.5%; N=0.0%) don't usually or never.

Majority (A= 52.7%; U= 25.8%) do perform clinical procedures safely as part of a treatment plan (eg catheterisation), while a few (O=21.4%; N=0.0%) don't usually or never.

Majority (A= 34.6%; U= 39.6%) do effectively update the plan of care to meet a patient's individual needs, while a few (O=25.8%; N=0.0%) don't usually or never.

Majority (A= 65.4%; U= 33.5%) do adapt therapeutic interventions appropriately to meet patient's needs, while a few (O=.5%; N= .5%) don't usually or never.

Majority (A= 24.1%; U= 42.3%) do evaluate a patients' social environment accurately, while a few (O=20.3%; N= 13.2%) either don't usually or never.

Majority (A= 19.2%; U= 27.5%) do accurately identify health problems in a patient's home environment, while a few (O=34.1%; N= 19.2%) don't usually or never.

A few (A= 27.5%; U= 36.8%) do accurately assess the effectiveness of preventive health care measures, while majority (O=28.0%; N=7.7%) either don't usually or never.

majority (A= 59.9%; U= 35.1%) do provide efficient care in emergency situations, while a few (O=4.9%; N=.5%) don't usually or never.

majority (A= 21.4%; U= 56.6%) do adequately meet patients' personal hygiene needs, while a few (O=22.0%; N=0.0%) don't usually or never.

majority (A= 57.2%; U= 25.3%) do you demonstrate skills with regard to the appropriate administration of medicines, while a few (O=17.0%; N= .5%) don't usually or never.

majority (A= 46.7%; U= 26.9%) do implement therapeutic measures for a patient who is in pain, while a few (O=22.0%; N=4.3%) don't usually or never.

majority (A= 56.0%; U= 37.9%) do manage palliative care appropriately for a terminally ill patient, while a few (O=5.5%; N= .5%) don't usually or never.

Majority (A= 30.8%; U= 64.3%) do provide sensitive care for a patient who is grieving, while a few (O=2.7%; N= 2.2%) either don't usually or never.

TESTING OF RESEARCH HYPOTHESES

$H_0$1: There is no significant relationship between degree of competence and practice of individual nursing care.

	N	Mean	SD	df	r	Decision
Degree of competence	182	2.88	0.73	180	0.609	0.002
Practice of individual nursing care	182	2.61	0.91			

Table 4.3.1: Relationship between degree of competence and practice of individual nursing care

Reject H_0if P-value, is < or = 0.05; upheld if otherwise.

Table 4.3.1 Above presents the Relationship between degree of competence and practice of individual nursing care. Result revealed that, there is a significant relationship between degree of competence and practice of individual nursing care [r= .609; p=0.002].. This implies that, the null hypothesis which states that, there is no significant relationship between degree of competence and practice of individual nursing care is hereby rejected. While the alternative was upheld. Therefore, there is a significant relationship between degree of competence and practice of individual nursing care.

V. DISCUSSION, SUMMARY, CONCLUSION AND RECOMENDATION

DISCUSSION OF FINDING

DISCUSSION ON DEMOGRAPHIC CHARACTERISTICS

Findings revealed that, majority of the respondents were age 30 years upwards. This implies that, most of them are matured. More so, most are female and had at least RN and its equivalence. Majority were Yoruba, probably because the research is conducted in a Yoruba territory. Both Christianity and islam are well represented in the study. Wards selected include, medical, surgical, orthopedic, emergency, SCBU, antenatal, pediatric among others. Findings also shows that majority are well experience, and most wards has between 17-21 bed space.

DEGREE OF COMPETENCY

The findings revealed that, degree of competence among the respondents is high. This is evidence in the results presented in table 4.2.1 which shows that, respondents independently apply nursing process, follow up on patient's conditions after examinations and treatments, Provide patients and relatives with support to enhance participation in patient care among other. Findings agrees with Nakate et al., (2014) found that, Although participants' knowledge about documentation improved by 20% following the intervention, there was no significant change in attitudes toward documentation.

PRACTICE OF INDIVIDUAL NURSING CARE

Findings also revealed that, majority of the respondents reported good individualized nursing care. This is evidence in

the report presented in table 4.2.2 which show that, majority adequate knowledge about illness and treatments of each individual patient, avoid distraction while attending to individual patient, ensure privacy of individual patients, allow patients to voice out their opinion, health educate patients about every care among other. Findings corroborate Yildiz et al., (2018). It was found that nurses' perceptions of individualized care were better.

Yeong Wooet al., (2017)This review demonstrates that the involvement of nurses in advanced practice in emergency and critical care improves the length of stay, time to consultation/treatment, mortality, patient satisfaction, and cost savings.

RELATIONSHIP BETWEEN DEGREE OF COMPETENCE AND PRACTICE OF INDIVIDUAL NURSING CARE

More findings revealed that, there is a significant relationship between degree of competence and practice of individual nursing care. There is no significant relationship between degree of competence and practice of individual nursing care. This implies that, as competence become good, practice of individual nursing care becomes good also. Findings support.

Eylem et al., (2015) where they found that, patients are aware of individualized care, and individualized care increases the level of patients' satisfaction with nursing services.

IMPLICATION OF THE STUDY TO NURSING PRACTICE

Nurse plays a crucial role in preventing infection among the burned patients. Therefore, maximum degree of competency is needed to the quality of nursing care. There is always a need for well-qualified nurses to improve client health outcomes, so it is the goal to recruit and retain competent nurses and train them towards appropriate good individualized nursing care in the clinical setting. Therefore measures should be taken to strengthen nursing, updating and upgrading to strength competency.

LIMITATION

This study experiences time constraint. Moreso, respondents were afraid to complete the instrument, especially when it has to do with their jobs. However, after several trial, they complied.

SUMMARY

This research examined influence of nurses degree of competence on self-reported practice of individualized nursing care in selected units of Uniosun Teaching Hospital Osogbo. A descriptive design with a qualitative approach was applied to explore the nurses degree of competence onself-reported practice of individualized nursing care. This study was conducted among nurses of UNIOSUN Teaching Hospital Osogbo, using TaroYemane (1967) sampling model to justify the sufficiency of the sample size, a total number of 187 respondents were arrived. The Study obtained data from the field using a structured questionnaire. The instrument was administered one on one basis. Respondents completed the instrument and clarification was made by there searcher who was available on areas that proves difficult to the respondents. Data collection process lasted for five days. Data were collated, sorted and processed into excel spread sheet. The processed data were analysed using SPSS edition 22 .Demographic data and research questions were analysed infrequencies(f), percentages. The hypothesis was tested using one-way ANOVA.

CONCLUSION

Degree of competence among the respondents is high.

This study concluded that, majority of the respondents reported are competent and have good individualized nursing care. The study also concluded that, there is a significant relationship between degree of competence and practice of individual nursing care.

RECOMMENDATION

Based on the findings of this study, the following recommendations were made:

- ✓ There is need for re-training of nurses to enhance competency.
- ✓ More nurses need to be employed into the systems
- ✓ Often times Nurses should be encouraged to participate in various seminars and work shops that will help boost competency.

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