Contemporary nursing care based on Watson's theory

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ABSTRACT

The study utilized a descriptive, correlational design. A purposive criterion sampling was employed using a paper and pen questionnaire based on the theory by Jean Watson on her ten carative factors. The study attempted to answer the level of care rendered by the nurses towards their patients and if there was a noteworthy association among the level of care rendered by the nurses and the patient's demographic profile (age and gender) and nurse's profile (gender; and hospital classification). As to the Level of Care Rendered by the Nurses Towards their Patients, the computed mean reveal an interpretation of very good. Patient's profile and the level of care did not yield a significant relationship. There was a noteworthy association among the level of care and nurse's gender (p = 0.012) on the area where the nurse practices loving kindness and composure inside framework of caring awareness towards patients. The level of care and the hospital classification findings revealed significant relationship on two items (p = 0.020 and .048). The level of care in terms of the nurse assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all aspects of care; tending to both the embodied spirit and evolving spiritual emergence are better experienced by patients in government hospitals. Based on the findings Cebuano nurses were very good in their nursing care towards their patients.

Keywords: *contemporary nursing care, Jean Watson, Theory of Human Caring, carative factors, level of care*

I. INTRODUCTION

All over the world, healthcare practitioners are exposing themselves to the risk of dehumanizing patient care. Sometimes, they become like robots, a programmed machine, unattached, and depersonal with their lives, work and relationship. A daily practice that helps transcends them from a position where nursing is viewed as "just a job", to that of a fulfilling vocation or profession. Just like change, it is the only thing that is constant. Over time, nursing care has evolved as technology does. One very big question in the present times is: Are patient's still getting the nursing care that they are supposed to receive?

Nurses must exert a conscious effort to preserve caring as the core of nursing profession within their clinical and/or research practice. Ideally, Jean Watson's Caring Theory (1979) can

be viewed as pivotal to this objective. It embodies the prototype of what an idyllic nurse should be. Watson mentioned that the key essentials of her theory are the: (1) carative features; (2) transpersonal caring affiliation; and (3) the caring incident or moment. She believes that the practice of caring is the most essential idea of nursing. It is the unifying focus for practice (Vanguard Health Systems, 2010).

The intention of the research is to construct a superior thought and application of the theory of Jean Watson to the recent nursing care. Based on a reflection of the researchers' experiences last year, the one of the researchers for instance, has assumed the role of a patient for a time. It was observed that the nurse-client relationship has greatly changed. Over time the nurse-client interaction has diminished and nurses are plainly just doing their job and not feeling for their patients. This situation correlated to the importance of Watson's Caring Theory and preserving human dignity. Giving courage to patient when their position is gloomy can be moderately overpowering and a sense of contentment to fill the emptiness of the one who cares and satisfaction to the one being cared for. It is also the intention of the researchers to determine if nursing care has really changed over time and up to what extent is the change with Watson's Theory as a baseline.

Fundamentally, reawakening and reliving Watson's Caring Theory is a tribute to nurses to find meaning in their work. A drive that donates to the manner they realize themselves jobwise. Caring permits nurses to labor with a sense of desire rather than a responsibility. Nurses must admit reality and accept challenge to change patient's perception regarding current nurse-patient approach.

The Researchers were very confident that this undertaking will be a fruitful one. With the Researchers determination, experience in research and perseverance, this research is going to bring out a relevant finding on caring. The study attempted to answer the level of care rendered by the nurses towards their patients and if there was a noteworthy association among the level of care rendered by the nurses and the patient's demographic profile (age and gender) and nurse's profile (gender; and hospital classification).

The study is anchored on the theory of human caring proposed by an American nursing scholar Dr. Jean Watson, (1979). The Theory of Human Caring highlights the humanistic facets of nursing in mixture with methodical knowledge. Watson intended the theory to transport importance and emphasis to nursing as a different health profession.

> *"Caring as an essential field in nursing conveys physical acts but embraces the mind-body-spirit as it reclaims the embodied spirit as its focus of attention". In further writings, nursing was defined by her as "a human science of people and human health-illness that are mediated by professional, personal, scientific, esthetics, and ethical human care transactions" (Octaviano & Balita, 2008).*

Watson mentioned in her theory the carative factors, the transpersonal caring relationship, caring occasion or the caring moments, and the seven basic assumptions as the main features of her theory. Watson visions the carative features as a leader for the central of nursing. She customs the word carative to compare with conservative medicine's curative features. Her carative features endeavor to "honor human dimensions of nursing work and the inner life world and the subjective experiences of the people we serve" (Tomey, 2008).

In summary, the carative features are composed of ten elements. First is the creation of humanistic and altruistic scheme of values. Second is the instilling faith and hope. Third is the refinement of thoughtfulness to self and others. Fourth is the creation of helping, trusting and human caring connection. Fifth is the advancement and recognition of the manifestation of affirmative and undesirable feelings. Sixth is the systematic usage of artistic

problem-solving caring method. Seventh is the advancement of transpersonal teaching and learning. Eighth is the providing for a helpful, shielding and curative mental, physical, societal and spiritual atmosphere. Ninth is the support with fulfillment of human needs? And lastly, the allowance for existential and phenomenological spiritual powers (Marriner-Tomey, 2010).

With the dynamism of the nursing profession and the desire to improve the standards of care, Watson's carative factors evolved into *caritas* processes which possess a greater spiritual dimension with mixed love and care (Marriner-Tomey, 2010).

The subsequent are translations of the carative factors hooked on clinical *caritas* processes; first, accept unselfish values and run-through loving kindness with self and others. Second, instilling belief and optimism and honor others. Third, be thoughtful to self and others by cultivation of personal beliefs as well as practices. Fourth, improve helping-trusting-caring affiliation. Fifth, encourage and consent affirmative and undesirable feelings as you can genuinely listen to an alternative story. Sixth, use artistic scientific problem-solving means for caring and decision making. Seventh, share teaching and learning that answers the individual needs and understanding approaches. Eighth, make a healing atmosphere for physical and spiritual human needs. Ninth, assist with basic physical, emotional, and spiritual human needs. And lastly being exposed to unknown and permit miracles to arrive (Marriner-Tomey, 2010).

Her second element, the transpersonal caring relationship labels in what way a nurse go past an unprejudiced valuation and shows more concern toward the subjective and deeper meaning of the client towards the his/her own healthcare situations. It lives up to its goal of shielding, improving and conserving the person's self-esteem, totality and inner synchronization (Marriner-Tomey, 2010).

The third concept defines what a caring occasion really is. Watson expressed that, caring incident is instant (crucial pointing space and time) when a nurse and person arise together in such a way that a moment for a mortal loving is generated (Watson, 1999). Not basically an objective for the favored for, Watson asserts that the nurse has to be cognizant of her private mindfulness and trustworthy existence when in a caring instant with the client. The circumstance develops "transpersonal" when it tolerates for the existence of the essence of both. Then, the incident of the instant inflates the borders of candidness that has the aptitude to inflate human competencies" (Marriner-Tomey, 2010).

Watson suggests seven expectations about the discipline of caring. The essential expectations of caring can be efficiently established and practiced only interpersonally. Caring comprises of carative features that produces the gratification of definite human needs, effective caring encourages health and personal or family development. Caring retorts admit the person not only as he/she is now but as what he/she may turn out to be. A caring atmosphere is one that suggests the expansion of possibilities while permitting the person to select the best act for himself/herself at a given time. Caring is more "healthogenic" than curing. A discipline of caring is harmonizing to the discipline of curing and the practice of caring is vital to nursing (Duqette & Cara, 2000).

The applications of Watson's Theory of human caring approves the professional individuality within a framework where humanistic ideals are regularly interrogated and tested (Duqette & Cara, 2000).

It is explained that men become ill twice as frequently as women, though women incline to be extra worried about their healthiness. It is however not conclusive that those men always seek admission. This finding affirms the findings of the inaugural 2008 Deloitte Survey of Health Care Consumers (2008). A comprehensive online poll of more than 3,000 participants, revealed substantive differences in how women and men select, finance and manage their own health care. The survey results for men indicate they are less likely to be admitted to a hospital for treatments. The survey further revealed that women are more

likely to be admitted to hospital for treatments. This will explain why there are more women hospitalized which concurs the result of the study.

The international code of ethics for nurses reaffirms that nurses give health services and care to the person, families and the community and synchronize such services with linked groups unrestricted by oldness, gender, skin color, belief, cultural origin, disease/disability or sickness, nationality, political inclination, race, or socioeconomic status (Marriner-Tomey, 2010). More similarly with the study it was found out that the quality of nursing care is unaffected by the age or gender of the patient. It comes to show that nurses in the study are nondiscriminatory.

The Philippines has been a primer in providing manpower—nurses in the United States. Primarily for the very reason that Filipino nurses have been known to have commitment towards their vocation/profession. Nurses from the Philippines are not only compassionate but they are also hardworking and trustworthy. These are the essential qualities that health care institutions are searching for in nurses. With the demands for nurses in the United States, there is no cause not to carry on hiring nurses from overseas (Abbariao, 2008).

Filipino nurses are no doubt one of the best health care providers globally. Filipinos culturally genuinely care about people (Davis, 2010). Filipino nurses have been known to be hardworking. A warm and caring worker, who is intensely devoted and steadfast to his/her work (Philippine Overseas Employment Administration, 2005). Filipino nurses are exceptional for they acquire quality knowledge, a respectable and assisting heart and a very hardworking personality. These traits cannot be taught nor be acquired through schooling or by plainly studying in a state of the art facility or institutions. This explains why nurses in the Philippines are world class professionals (Sikat ang Pinoy, 2010).

Filipino nurses would pursue assistance from these government hospitals since fees are not collected. Private hospitals are situated in key cities all over the nation with tertiary hospitals that are up-to-date in medical technologies. On the other hand, private hospitals are further costly (Allianz Worldwide Care, 2011). The study revealed that there were more patients admitted in the public hospital than in private. This is so because private hospitals in the Philippines are more expensive compared to government hospitals. Thus, people would opt to avail the services in the government hospitals.

Comparing private hospitals to public hospitals, the former have a greater average value of total assets: more items of costly medical facilities, more manpower, and more doctors (regulatory for hospital beds, urban position, insurance system, and university association). Public and private hospitals statistically enjoy similar total staffing. However, private hospitals have proportionally greater support staff and minimal medical professionals. Mortality rates for non-government, non-profit and for-profit hospitals are statistically the same from those of government hospitals of same size, accreditation level and patient mix (Eggleston, Lu, Li, Wang, Yang & Zhang, 2009).

Both private and public health care facilities are present in the Philippines. Majority of public hospitals deliver quality healthcare equally similar to the way private hospitals deliver. The only difference is basically in the availability of facilities. Many of the public hospitals in the Philippines are not furnished with the newest machineries in medicine. However, majority of the Filipinos go to these hospitals because charges are for free (Castro, 2009).

The outcomes gave an impression of the standpoints of Bangladeshi patients on the superiority of service in three kinds of hospitals. The superiority of service in private hospitals scored better than that in the public hospitals, hospital matters which are tangible like cleanliness, utilities and drug availability. In general, the overall quality of service was better in the foreign hospitals compared to that in the private hospitals in Bangladesh in all factors, even the 'perceived cost' factor (Siddiqui & Khandaker, 2007).

Disadvantages include increased number of workload, less supplies and equipment making their practice in demand but at the same time making them very resourceful. Fewer budgets to purchase supplies affect the quality of care provided by government nurses (Nursetogether, 2008).

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II. THE STUDY

The study utilized a quantitative, non-experimental, correlational design. The study was conducted within the vicinity of Cebu, namely: Vicente Sotto Memorial Medical Center and Vicente Gullas Memorial Hospital, both classified as Tertiary Hospitals in Cebu City, Philippines, accredited by Philhealth. The respondents of the study were those who have been recently hospitalized individuals and were admitted for two weeks and more from the bracket of adolescent group (12 years old to 18 years old) up to late adulthood or the maturity period (65 years old and above).The sampling technique that was used in the study was purposive criterion sampling.

The research instrument used was a paper and pen questionnaire. The researcher-made questionnaire was based on the theory by Jean Watson on her ten carative factors which were content validated. The questionnaire was made up of two parts. Part one would deal about the profile of the respondents, while part two would deal with the level of nursing care received by the respondents. Since the study was Cebu-based, an expert was consulted to translate the questionnaire into the language spoken by Cebuanos—Bisaya.

Content validation of the tool was made and respondents were identified from the different hospitals in Cebu. Questionnaires were distributed to the respondents that lasted for three weeks (January 2011). Descriptive statistical treatment was used to interpret and analyze the data gathered. As an output of the study, a guide to patient care was proposed. Statistical treatments used in the study were frequency distribution and simple percentage. Weighted mean was also used to determine the perceptions and functional ability of the respondents. Chi Square, test of independence was used to determine the association among the client and nurse profile as against the level of nursing care received by the patients. Cramer's V was used to test the strength of correlations.

III. RESULT AND DISCUSSION

The following were the pertinent findings of the study:

As to the profile of the respondents, majority of the respondents belong to the young adult group or the 19 – 40 years old with a 55 percent sharing in the total population. As to the gender, there were 51 females at 51 percent and 49 males at 49 percent. As to the nurses' profile and hospital classification, there were 59 female nurses who took care of the respondents while there were 41 male nurses who attended the patients. The number shows that there were more female nurses employed in different hospitals than male nurses. There were 65 respondents from the government hospital and 35 respondents from the private hospital.

The respective means of the areas covered on the ten carative factors revealed an interpretation of very good. The data imply that Filipino nurses are very good when it comes to taking care of patients. This is consistent with the statement published that the Philippines is one of the sources of manpower—nurses for the United States. For the very reason, nurses coming from the Philippines possess the character of being steadfast to their vocation. Aside from being compassionate, they are also diligent and trustworthy – which are the key qualities that health care institutions are considering for in nurses (Abbariao, 2008).

Table 1. Level of Care Rendered by Nurses Towards their Clients, N=100.

Question	Mean	Interpretation
The nurse practices loving compassion and composure within context of caring consciousness towards patients.	**3.93**	**Very Good**
The nurse is genuinely present-day, and enabling and satisfying the profound faith structure and independent life realm of oneself and the client.	**3.74**	**Very Good**
The nurse cultivates own spiritual acts and transpersonal self, going past ego self, opens with kindness and compassion.	**3.80**	**Very Good**
The nurse develops and sustains a helping and trusting, genuine caring association.	**3.75**	**Very Good**
Being available to, and helpful of, the communication of affirmative and undesirable feelings as a link with a profounder spirit of ego and the client.	**3.67**	**Very Good**
Inventive usage of self and all methods of knowing as fragment of the caring course; to participate in the art of caring and healing acts.	**3.91**	**Very Good**
Participating in authentic teaching and learning experience that joins to union of being and meaning, trying to halt inside others' casings of position.	**3.61**	**Very Good**
Creating healing environment at all levels (physical as well as non-physical), subtle environment of energy and awareness, whereby totality, attractiveness, coziness, self-esteem, and peacetime are enhanced.	**3.55**	**Very Good**
Supporting with simple needs, with a deliberate caring awareness, ordering "human care essentials", which enhance placement of mind, body, spirit, totality, and unison of being in all parts of care; nursing to both the personified spirit and changing spiritual development.	**3.81**	**Very Good**
Open and attends to spiritual and mysterious and existential magnitudes of own life and death; soul repair for self and the client.	**3.54**	**Very Good**
TOTAL GRAND MEAN	**3.731**	**Very Good**

On the next table, all the p-values were greater than 0.05 and therefore to be interpreted as not significant which means also that the null hypothesis was not to be rejected. It implies that age has no bearing to the level of care received by the respondents from the nurses. This furthermore implies that no matter what the gender of the patient is, the level of care rendered by the nurse does not change. Significantly, this would also imply that nurses working in the

hospitals do not look at gender as a hindrance in providing quality nursing care when utilizing the ten carative factors. It is to be noted that the international Code of Ethics intended for nurses reaffirms that nurses give services to the person, families and the community and harmonize services with linked groups regardless of oldness, skin color, belief, cultural origin, disease/disability or sickness, sex, nationality, political inclination, race or socioeconomic status (Marriner-Tomey, 2010). On the relationship between the level of care and the nurses' gender, item one has a p value of 0.012 which was less than 0.05 it means that there was a noteworthy association among

Table 2. Relationship Between the Level of Care and the Patient`s Age, N=100.

Question	Chi Value	p-value	Interpretation	Decision	Cramer's V Value	Strength
The nurse practices loving kindness and composure inside framework of caring awareness towards patients.	180.487	.881	Not Significant	***Do not reject Ho***	.672	—
The nurse is genuinely present-day, and enabling and satisfying the profound faith structure and independent life realm of oneself and the client.	172.615	.946	Not Significant	***Do not reject Ho***	.657	—
The nurse cultivates own spiritual acts and transpersonal self, going past ego self, opens with kindness and compassion.	196.702	.630	Not Significant	***Do not reject Ho***	.701	—
The nurse develops and sustains a helping and trusting, genuine caring association.	191.327	.728	Not Significant	***Do not reject Ho***	.692	—
Being available to, and helpful of, the communication of affirmative and undesirable feelings as a link with a profounder spirit of ego and the client.	206.464	.439	Not Significant	***Do not reject Ho***	.718	—
Inventive usage of self and all methods of knowing as fragment of the caring course; to participate in the art of caring and healing acts.	165.966	.976	Not Significant	***Do not reject Ho***	.644	—
Participating in authentic teaching and learning experience that joins to union of being and meaning, trying to halt inside others' casings of position.	175.099	.929	Not Significant	***Do not reject Ho***	.662	—
Creating healing environment at all levels (physical as well as non-physical), subtle environment of energy and awareness, whereby totality, attractiveness, coziness, self-esteem, and peacetime are enhanced.	217.271	.249	Not Significant	***Do not reject Ho***	.737	—
Supporting with simple needs, with a deliberate caring awareness, ordering "human care essentials", which enhance placement of mind, body, spirit, totality, and unison of being in all parts of care; nursing to both the personified spirit and changing spiritual development.	153.987	.462	Not Significant	***Do not reject Ho***	.716	—
Open and attends to spiritual and mysterious and existential magnitudes of own life and death; soul repair for self and the client.	203.921	.488	Not Significant	***Do not reject Ho***	.714	—

Table 3. Relationship Between the Level of Care and the Patient`s Gender. N=100.

Question	Chi Value	p-value	Interpretation	Decision	Cramer's V	Strength
The nurse practices loving kindness and equanimity within context of caring consciousness towards patients.	2.645	.619	***Not Significant***	Do not reject Ho	.163	-
The nurse is authentically present, and enabling and sustaining the deep belief system and subjective life world of self and the one-being-cared-for.	5.108	.276	***Not Significant***	Do not reject Ho	.226	-
The nurse cultivates one's own spiritual practices and transpersonal self, going beyond ego self, opens to others with sensitivity and compassion.	2.649	.618	***Not Significant***	Do not reject Ho	.163	-
The nurse develops and sustains a helping-trusting, authentic caring relationship.	2.242	.691	***Not Significant***	Do not reject Ho	.150	-
Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for.	4.087	.394	***Not Significant***	Do not reject Ho	.202	-
Creative use of self and all ways of knowing as part of the caring process; to engage in artistry of caring-healing practices.	5.070	.280	***Not Significant***	Do not reject Ho	.225	-
Engaging in genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within others' frames of reference.	2.955	.565	***Not Significant***	Do not reject Ho	.172	-
Creating healing environment at all levels (physical as well as non-physical), subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.	5.698	.223	***Not Significant***	Do not reject Ho	.239	-
Assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all aspects of care; tending to both the embodied spirit and evolving spiritual emergence.	1.823	.610	***Not Significant***	Do not reject Ho	.135	-
Open and attends to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one-being-cared-for.	5.102	.277	***Not Significant***	Do not reject Ho	.226	-

@0.05 significance level

Table 4. Relationship Between the Level of Care and the Nurse's Gender. N=100.

Question	Chi Value	p-value	Interpretation	Decision	Cramer's V Value	Strength
The nurse practices loving kindness and equanimity within context of caring consciousness towards patients.	12.807	.012	***Significant***	Do not Accept Ho	.358	***Very Strong***
The nurse is authentically present, and enabling and sustaining the deep belief system and subjective life world of self and the one-being-cared-for.	3.059	.548	***Not Significant***	Do not reject Ho	.175	-
The nurse cultivates one's own spiritual practices and transpersonal self, going beyond ego self, opens to others with sensitivity and compassion.	3.659	.454	***Not Significant***	Do not reject Ho	.191	-
The nurse develops and sustains a helping-trusting, authentic caring relationship.	4.280	.369	***Not Significant***	Do not reject Ho	.207	-
Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for.	2.966	.564	***Not Significant***	Do not Accept Ho	.172	-
Creative use of self and all ways of knowing as part of the caring process; to engage in artistry of caring-healing practices.	2.872	.579	***Not Significant***	Do not reject Ho	.169	-
Engaging in genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within others' frames of reference.	4.622	.328	***Not Significant***	Do not reject Ho	.215	-
Creating healing environment at all levels (physical as well as non-physical), subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.	2.477	.649	***Not Significant***	Do not reject Ho	.157	-
Assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all aspects of care; tending to both the embodied spirit and evolving spiritual emergence.	2.359	.501	***Not Significant***	Do not reject Ho	.154	-
Open and attends to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one-being-cared-for.	6.933	.139	***Not Significant***	Do not reject Ho	.263	-

@0.05 significance level

Table 5. Relationship Between the Level of Care and the Hospital Classification. N=100.

Question	Chi Value	P Value	Interpretation	Decision	Cramer's V Value	Strength
The nurse practices loving kindness and equanimity within context of caring consciousness towards patients.	11.656	.020	Significant	***Do not accept Ho***	.341	***Very Strong***
The nurse is authentically present, and enabling and sustaining the deep belief system and subjective life world of self and the one-being-cared-for.	1.686	.793	Not Significant	***Do not reject Ho***	.130	-
The nurse cultivates one's own spiritual practices and transpersonal self, going beyond ego self, opens to others with sensitivity and compassion.	1.745	.783	Not Significant	***Do not reject Ho***	.132	-
The nurse develops and sustains a helping-trusting, authentic caring relationship.	4.912	.296	Not Significant	***Do not reject Ho***	.222	-
Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for.	2.184	.702	Not Significant	***Do not reject Ho***	.148	-
Creative use of self and all ways of knowing as part of the caring process; to engage in artistry of caring-healing practices.	1.687	.793	Not Significant	***Do not reject Ho***	.130	-
Engaging in genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within others' frames of reference.	4.035	.401	Not Significant	***Do not reject Ho***	.201	-
Creating healing environment at all levels (physical as well as non-physical), subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.	5.843	.211	Not Significant	***Do not reject Ho***	.242	-
Assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all aspects of care; tending to both the embodied spirit and evolving spiritual emergence.	7.924	.048	Significant	***Do not accept Ho***	.281	***Very Strong***
Open and attends to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one-being-cared-for.	2.779	.596	Not Significant	***Do not reject Ho***	.167	-

@0.05 significance level

the level of care and the patient's demographic profile regarding the nurse's gender on the area where the nurse practices loving kindness and composure inside framework of caring awareness towards patients. While in items 2 to 10 all the p-values were greater than 0.05 which was interpreted as having no significant relationship between the level of care in questions 2 to 10 and the nurse's gender. The male gender is better in terms of providing loving kindness and composure inside the framework of caring awareness. On the relationship between the level of care and the hospital classification findings revealed that both items 1 and 9 have a significant relationship with the hospital classification. Consequently for both items the Cramer's V values established a strong relationship. Collectively all the remaining items have an interpretation of having no significant relationship despite bearing a Cramer's V value that had a strength of either moderate or strong relationship because the chi value failed to establish a significant relationship. The level of care in terms of the nurse assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all aspects of care; tending to both the embodied spirit and evolving spiritual emergence are better experienced by patients in government hospitals. The significant and strong relationship established between the hospital classification and the level of care implies that one is better over the other. Upon determination of the mean scores both hospital classification, it revealed that private hospitals and on item 1 is greater than that of the government hospitals.

This data imply that the level of care in terms of the nurse practicing loving kindness and composure inside the framework of caring awareness towards patients in private hospitals is better compared to government hospitals.

IV. CONCLUSION

Utilizing the Watsonian paradigm, Filipino Nurses were able to practice loving compassion and composure within the context of caring consciousness towards patients. They are genuinely present-day, and enabling and satisfying the independent life realm of oneself and the client. They are able to improve one's spiritual practices and deal clients with sympathy and compassion. Further, they were able to exhibit at all times and supports both negative and positive feelings of the one being-cared-for. Moreover, the art of caring-healing practices with the use of therapeutic self are practiced by nurses. The nurse develops and sustains a helping, trusting and genuine caring association. They are also able to exhibit inventive usage of self and all methods of knowing as fragment of the caring and healing course. They also participate in authentic teaching and learning experience that joins the union of being and meaning, trying to halt inside others' casings of position. Other capabilities of the nurses includes: (1) creating a healing environment at all levels (physical as well as non-physical) - subtle environment of energy and awareness, whereby totality, attractiveness, coziness, self-esteem, and peacetime are enhanced; (2) supporting with simple needs - a deliberate caring awareness, ordering "human care essentials" which enhance placement of mind, body, spirit, totality and unison of being in all parts of care; (3) nursing to both the personified spirit and changing spiritual development; and lastly (4) to spiritual, mysterious and existential magnitudes of own life and death - soul repair for self and the client.

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