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The Implementation of Sharia Nursing Care on Patients' Knowledge, Attitudes, Behavior, and Satisfaction

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Abstract

Background: Patient satisfaction is paramount for healthcare providers, including hospitals. Sharia nursing care is a new paradigm that addresses the need for care based on sharia principles as part of the client's spiritual aspect.
Objectives: To measure the impact of implementing Sharia Nursing Care on patients' knowledge, attitudes, behavior, and satisfaction at Malingping General Hospital, Banten Province.
Methods: A quasi-experimental design with a two-group pre-test and post-test approach was conducted in the Tulip and Bougenville wards from February to July 2022, involving 20 patients. A questionnaire was used to collect data on all variables. Data were analyzed using a dependent t-test.
Results: There were differences in patients' knowledge, attitudes, behavior, and satisfaction levels before and after the implementation of Sharia Nursing Care in the intervention group. There were also differences in the control group before and after the implementation.
Conclusion: The implementation of Sharia Nursing Care had an effect on both the intervention and control groups at Malingping General Hospital.

Keywords: attitudes, behavior, knowledge, patient satisfaction, sharia nursing care

Introduction

Patient satisfaction is of utmost importance for healthcare providers, including hospitals.[1] Several factors that can affect satisfaction include traffic, demand, speed and clarity of service, facility capacity, as well as the safety and comfort of the hospital environment.[2] Nurses are the individuals who assist patients in fulfilling part or all of their activities and help them achieve independence. Nurses provide holistic care, which includes addressing the bio-psycho-socio-spiritual aspects of the patient.[3] According to the Republic of Indonesia Law No. 38 of 2014 on nursing, Article 30, point 1 explains that

nurses are tasked with and authorized to provide holistic services.[4] Sharia nursing care is a new paradigm that addresses the need for care based on sharia principles as part of the client's spiritual aspect. As a critical component of healthcare, nurses perform their professional duties to help achieve the client's stability and optimal functioning in response to the multidimensional impacts of illness, which include biological, psychological, sociocultural, and spiritual aspects. Various studies have demonstrated the public's demand for services that address these aspects.[5] According to Abdurrouf (2013), providing sharia-based services is a way to increase patient satisfaction.[6]

The results of a study conducted by Murtiningsih and Nendra Wati Zaly (2020) revealed that nearly half of the patients (41.5%) did not perform prayers during their hospital stay.[7] The findings from a preliminary study showed that the implementation of sharia nursing care was still not optimal. The Bed Occupancy Rate (BOR) in 2020 averaged 70%, and in 2021 it averaged 68%. In 2021, specifically in the Tulip and Bougenville wards, the average number of patients per month reached 134 and 133, respectively. Observations of five patients receiving care found that none of the patients performed prayers during their illness (while hospitalized). According to the satisfaction index calculation of 301 patients in September 2021, in the third trimester, the result was 89.53%. The satisfaction standard used at RSUD Malingping in 2021 was 90% or higher, as outlined in the Banten Provincial Governor Regulation No. 36 of 2017 on Minimum Service Standards. Based on the 2020 inpatient visit data, all patients (100%) were Muslim, and in 2021, almost all patients (99.8%) were Muslim. From the research results and preliminary studies, there is still limited literature on sharia nursing care in relation to patient knowledge, attitudes, behavior, and satisfaction. Therefore, this study was conducted to answer the question: What is the effect of the implementation of Sharia Nursing Care on patient knowledge, attitudes, behavior, and satisfaction at RSUD Malingping, Banten Province.

Methods

A Quasi-Experimental design using a two-group pre-test and post-test approach was conducted in the Tulip and Bougenville wards from February to July 2022 with 20 patients. A questionnaire was used to collect data on all variables, and the data were analyzed using a Dependent T-Test. This study employed a quasi-experimental research method with a pre and post-control group design, aiming to reveal cause-and-effect relationships by involving a control group alongside the treatment group.[8] The sample is a portion of the population that possesses specific characteristics.[9] The sample consisted of a selected portion of the population for research purposes.[8] The sample in this study was patients hospitalized in the Tulip and Bougenville Inpatient Wards at RSUD Malingping.

In this study, data collection began with the researcher submitting a research introduction letter to the university, followed by applying for research permission at RSUD Malingping with an introduction letter from the university. After receiving the research permit, the researcher provided Sharia Nursing Care training to the nurses working in the Tulip ward as the intervention group. The next step involved identifying respondents as the research sample. The researcher explained the purpose of the study to the respondents and requested their consent to participate. Data collection then proceeded by conducting a pre-test, followed by administering nursing care and a post-test for the intervention group. In contrast, the control group only underwent pre- and post-tests.

This study was conducted after ethical review and approval. The researcher completed administrative procedures related to the research permit by seeking approval from the director of RSUD Malingping. The study adhered to ethical principles, including Beneficence (the principle of doing good) and Nonmaleficence (doing no harm), Fidelity (keeping promises) and Responsibility, Integrity (consistency), Justice, and Respect for People's Rights and Dignity.[10] Univariate analysis examines the frequency or average value of a variable.[11] Univariate analysis aims to describe the characteristics of each variable in

a study.[12] Data processing is done by using the mean and standard deviation of all variables, followed by analyzing demographic data for all respondent characteristics. Bivariate analysis is used to determine the significant relationship between two variables and can also be used to identify significant differences between two or more sample groups.[12]

Results

Table 1. Frequency Distribution Based on Respondent Characteristics

Respondent Characteristics	Group			
	Intervention		Control	
	Frequency	%	Frequency	%
Age				
36-45	3	30	2	20
> 45	7	70	8	80
Marital Status				
Single	2	20	1	10
Married	8	80	9	90
Gender				
Male	8	80	8	80
Female	2	20	2	20
Education				
No formal education	2	20	1	10
Elementary school or equivalent	8	80	9	90
Occupation				
Private sector	2	20	3	30
Laborer	8	80	7	70
Insurance				
BPJS	10	100	10	100
Income				
Below minimum wage	10	100	10	100
Previous Hospitalization				
1 time	8	80	7	70
2 times	2	20	3	30
Number of Caregivers				
1 person	7	70	6	60
> 1 person	3	30	4	40

Based on the characteristics, most respondents in the intervention group were over 45 years old (70%), married (80%), male (80%), and had elementary-level education or its equivalent (80%). In the control group, most respondents were also over 45 years old (80%), married (90%), male (80%), and had elementary-level education or its equivalent (90%).

In the intervention group, the majority worked as laborers (80%), all were covered by BPJS insurance (100%) and had an income below the regional minimum wage (100%). Most had been hospitalized once in the past two years (80%) and were accompanied by one person (70%). Similarly, in the control group, most worked as laborers (70%), all were covered by BPJS (100%), had an income below the regional minimum wage (100%), had been hospitalized once in the past two years (70%), and were accompanied by one person (60%).

Table 2. Distribution of knowledge, attitude, behavior, and patient satisfaction before and after the implementation of Sharia nursing care in the intervention group

Variabel	Mean	SD	SE	P-value	N
Knowledge					
Pre-Test	12.20	1.033	0.327	0.000	10
Post-Test	16.30	1.252	0.396		
Attitude					
Pre-Test	39.50	1.650	0.522	0.000	10
Post-Test	45.00	1.414	0.447		
Behavior					
Pre-Test	3.80	0.789	0.249	0.000	10
Post-Test	6.50	0.972	0.307		
Satisfaction					
Pre-Test	95.00	2.625	0.830	0.000	10
Post-Test	103.30	2.751	0.870		

This table presents the mean, standard deviation (SD), standard error (SE), and p-value of the variables measured (knowledge, attitude, behavior, and patient satisfaction) in the intervention group before and after the implementation of Sharia-based nursing care. Each variable shows significant improvement, as indicated by the p-value of 0.000 for all tests.

Table 3. Distribution of Knowledge, Attitude, Behavior, and Patient Satisfaction Before

Variabel	Mean	SD	SE	P-value	N
Knowledge					
Pre-Test	12.30	1.059	0.335	0.434	10
Post-Test	12.60	1.430	0.452		
Attitude					
Pre-Test	39.70	1.636	0.517	0.020	10
Post-Test	41.60	1.955	0.618		
Behavior					
Pre-Test	3.90	0.738	0.233	0.024	10
Post-Test	4.50	0.527	0.167		
Satisfaction					
Pre-Test	96.00	2.261	0.715	0.032	10
Post-Test	97.80	1.932	0.611		

Based on Table 3, the average knowledge did not increase significantly with a P-value of 0.434. However, for the variables of attitude, behavior, and satisfaction, there was an increase, with statistical testing yielding a P-value < 0.05. It can be concluded that only three variables—attitude, behavior, and satisfaction—showed differences before and after measurement in the control group.

Discussion

This study shows that age is one of the important factors affecting patient satisfaction and individual knowledge levels regarding health services, particularly in nursing care. The majority of respondents in both the intervention group (70%) and the control group (80%) were over 45 years old, indicating a dominant distribution among older adults. This age factor correlates with physical, psychological, and social maturity, which influences the process of receiving information and perceptions of the quality of services provided. Previous research has also indicated that age is a demographic factor that can influence

patient satisfaction levels regarding services. Furthermore, Maslow's hierarchy of needs theory explains that individuals, whether young or adult, have a need for good interpersonal relationships, which can impact satisfaction in healthcare interactions.[13] Mature age may contribute to increased knowledge related to nursing services, as individuals tend to have broader experiences with healthcare as they age.[14]

In addition to age, variables such as marital status, gender, education level, type of occupation, and income also influence patient satisfaction with health services. The majority of respondents in this study were married (80% in the intervention group and 90% in the control group), male (80% in both groups), had a low level of education (elementary school or equivalent), worked as laborers, and had incomes below the Regional Minimum Wage (UMK). Marital status can affect patients' perceptions of social support and interactions in healthcare, as married individuals tend to receive greater support from their families. Furthermore, a low level of education and low-paying jobs can impact respondents' ability to understand the medical information provided, potentially reducing satisfaction with health services. All respondents in this study utilized BPJS insurance, emphasizing the importance of access to social insurance in facilitating healthcare for low-income groups.

Moreover, this study shows significant differences in the levels of knowledge, attitudes, behaviors, and patient satisfaction before and after the implementation of the sharia nursing care intervention in the intervention group at RSUD Malingping. For the knowledge variable, there was a significant increase, with an average pre-test knowledge score of 12.20 and a post-test score of 16.30 (p-value 0.000). This indicates that the sharia nursing care intervention is effective in improving patient knowledge. This increase in knowledge aligns with the theory that health education provided through interventions impacts the enhancement of patient understanding and knowledge.[14]

In addition to knowledge, there was also a significant increase in the attitude variable, with an average pre-test score of 39.50 and a post-test score of 45.00 (p-value 0.000). This improvement in attitudes indicates that sharia-based nursing care contributes to the formation of positive patient attitudes towards the services received. Previous research has also shown that spiritual nursing care, including sharia, can strengthen interpersonal relationships that support patient satisfaction and comfort during the care process.[15] For the behavior variable, there was a significant difference with an average pre-test score of 3.80 and a post-test score of 6.50 (p-value 0.000). This increase in behavior suggests that the implementation of sharia nursing care not only enhances knowledge and attitudes but also influences patient behavior towards the services provided. This supports the theory that behavior change is a result of changes in knowledge and attitudes influenced by the health education or interventions provided.[16]

The level of patient satisfaction also increased significantly after the intervention, with an average pre-test score of 95.00 and a post-test score of 103.03 (p-value 0.000). This improvement is consistent with previous findings that indicate the implementation of sharia nursing care can significantly enhance patient satisfaction.[17] This underscores the importance of applying sharia principles in healthcare services to boost patient satisfaction, especially in hospitals with an Islamic service base. The implications of this study suggest that the application of sharia nursing care can significantly improve knowledge, attitudes, behaviors, and patient satisfaction, supporting efforts to enhance the quality of services in hospitals. Thus, hospitals that implement sharia nursing principles have the potential to increase patient satisfaction and improve their service reputation. Furthermore, these implications also highlight the importance of training for healthcare personnel to understand and apply sharia principles to provide services that meet patients' spiritual needs, making it a potential service model for other hospitals, particularly in predominantly Muslim communities.

Conclusion

Based on the research results, it can be concluded that the implementation of Sharia nursing care significantly improves patients' knowledge, attitude, behavior, and satisfaction. This intervention has proven effective in enhancing the quality of patient experience, with clear positive changes observed between the conditions before and after the intervention. Therefore, Sharia-based nursing care can be implemented as a strategic approach to improving the quality of health services, particularly for populations that require a spiritually and religiously based approach.

Conflict of Interest Declaration

The research has no conflict of interest.

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