Factors Predicting Quality of Nursing Care Among Registered Nurses in Myanmar: A Cross-sectional Study

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Abstract: High-quality healthcare is essential for community well-being and positive health outcomes. Healthcare settings, therefore, should deliver timely, equitable, integrated, efficient, effective, safe, and people-centered service. As in other countries, the COVID-19 pandemic and the nursing shortage crisis have impacted Myanmar's nursing care quality. A cross-sectional study was conducted to examine the predictability of nurse staffing, educational levels, work experience, nurse work environment, and job satisfaction on the quality of nursing care among 218 registered nurses from five general hospitals in the Republic of the Union of Myanmar during July and September 2022. Data were collected using the Demographic and Nurse Staffing Data Form, the Practice Environment Scale of the Nursing Work Index, the Job Satisfaction Survey, and the Good Nursing Care Scale. The data were examined using descriptive statistics and a stepwise multiple regression analysis.

Results revealed that the overall quality of nursing care as perceived by nurses was high. The significant predictors of the quality of nursing care from the highest to the lowest were nurse work environment, nurse staffing, work experience, and job satisfaction, explaining 56% of the variance in the quality of nursing care. This study provides vital evidence for creating strategies to enrich and sustain the quality of nursing care in Myanmar and possibly other countries. Nursing directors should work with the government to produce and recruit more nurses, allocate budgets for care, and create a supportive work environment for nurses to improve healthcare quality.

Keywords: General hospitals, Job satisfaction, Myanmar, Nurses, Nurse work environment, Nurse staffing, Quality of nursing care, Work experience

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Introduction

The pace of change in the healthcare industry is accelerating, which poses challenges for healthcare systems, hospitals, and providers worldwide. In addition, poor healthcare results in 5.7–8.4 million deaths annually in middle- and low-income countries, comprising up to 15% of all deaths in these nations.[1]

Therefore, conscious attention to the quality of healthcare services is necessary to provide timely, equitable, integrated, efficient, effective, safe, and

people-centered care.[1] The provision of high-quality care is crucial as it directly impacts the community's well-being and the outcomes of their health.[2]

Nurses constitute almost half of all healthcare providers worldwide.[1] They are the primary healthcare providers in hospitals, assessing patient needs, planning and delivering effective interventions, advocating for high-quality care, and ensuring patient safety.[3] However, healthcare facilities face challenges in providing high quality of nursing care (QNC).[4] Despite the pressure to deliver higher-quality care with shorter stays, nurses strive for professional excellence and provide the best possible care to their patients, often without sufficient resources and staff shortages.

Myanmar is one of 57 countries with a serious shortage of medical professionals, particularly nurses.[5] In 2019, there was an average of 1.1 nurses and midwives per 1,000 people, and hospitals in the country experienced a nursing shortage of 44.36%. This deficit was even more severe in the Mandalay region in this research setting, with a rate of 41.75%.[6] Moreover, there is a nursing shortage, with the nurse-to-patient ratio at 1:50, which is lower than the WHO recommended ratio of 1:6.[7] Due to the shortage, nurses are working hard and handling too many responsibilities. Moreover, the global COVID-19 pandemic affected the frail health systems and services in Myanmar. In January 2022, Myanmar had one of the highest mortality rates in the area, with 534,163 confirmed COVID-19 cases and 19,310 mortalities.[8] The epidemic, a shortage of resources, and the social crisis affected the health workforce management and resources needed for the health care service, eventually affecting QNC.

Previous studies in Myanmar by Myint[9] in 2010 and Maung in 2012[10] found that the QNC was at a high and moderate level, respectively. In Myint's study, professional autonomy predicted that QNC and continuing nursing education had a positive relationship with QNC in Maung's study. However, there is limited knowledge to confirm that factors such as the nurse work environment, job satisfaction, nurse staffing, educational levels, and work experience can influence QNC in Myanmar. Therefore, this study aimed to evaluate the perceived QNC of nurses in Myanmar general hospitals and determine the predictability of those factors on QNC. The research findings may serve as a valuable guide for hospital and nursing administrators to enhance the QNC.

Literature Review and Conceptual Framework

Aiken's NWE-NS-OM framework guided this study,[11] which posits that the organization of a hospital can significantly impact both nurse and patient outcomes. Features of a hospital, such as nurse staffing, nurses' work environment, more autonomy, greater control, and better relationships with physicians affect QNC.[11] The nursing work environment can influence nurse outcomes such as job satisfaction, burnout, and intention to leave, ultimately impacting patient outcomes, such as QNC.[11] Additionally, the framework suggests that the qualifications of medical staff, such as their levels of education and work experience, can also impact patient outcomes.[11]

The QNC pertains to the level of excellence of care given to patients to address their spiritual, mental, social, physical, and environmental needs. This encompasses a range of factors, including the qualifications of staff, care-related activities, essential conditions for care, the physical setting, the efficacy of implementing the nursing process, and cooperation with family members.[12] Ensuring high QNC will enhance people's health and well-being. Poor nursing care has been linked to a considerable rise in adverse patient outcomes like injury, prescription errors, nosocomial infections, falls, prolonged patient stays, and a higher mortality rate.[13]

Nurse work environment refers to characteristics of an organization that control the delivery of nursing

care. There are five domains in this variable: 1) nursing involvement in hospital issues, 2) nursing foundation for QNC, 3) nursing managers' aptitude, leadership, and assistance to nurses, 4) adequate staffing and resources, and 5) collegial connections between nurses and physicians.[14] The nurse work environment enables nurses to function autonomously and to their full potential for providing high-quality nursing care. A positive nurse work environment encourages nurses to deliver high-quality nursing care.[15]

Job satisfaction refers to how nurses feel about their jobs and various job-related factors.[16] It is the degree to which people like, are satisfied with, dislike, or are dissatisfied with their job. There are nine facets involved: salary, opportunities for advancement, surveillance, additional benefits, rewards that depend on certain conditions, established protocols, colleagues, the type of work, and effective communication.[16] Nurses who are happy with their jobs perform well and provide higher-quality services. When nurses experience job satisfaction, they tend to exhibit outstanding job performance.[17] Research has shown that satisfied nurses in Canada,[18] Pakistan,[19] and Greece[20] performed better at work and offered higher-quality services. Ensuring job satisfaction among nurses is crucial to improving their performance and quality of care.[17]

Nurse staffing is the quantity of patients one nurse takes care of.[11] Previous studies revealed that nurse staffing shortage has a direct negative influence on QNC.[3,21] Inadequate nurse staffing results in the rationing of time to assess, care, and conduct treatment plan adherence.[22] Nurses may have to limit critical interventions when they are overloaded with patients, which can reduce the quality of care.[22] It is well-recognized that QNC decreases when nurses are required to care for more patients throughout a shift.[23]

Using the NWE-NS-OM model as a study framework, Koy found that nurse job satisfaction affected QNC.[3] Other studies found that a positive work environment is essential for promoting teamwork, reducing stress, and enhancing job satisfaction, which

is crucial for improving QNC.[21] Nurses who are happy with their jobs perform well on the job and provide high-quality nursing care.[18-20] In addition, adequate nurse staffing is critical for meeting patient needs, reducing medical errors, and maintaining QNC.[3] Furthermore, a nurse's educational level is determined by the type of program they have completed and by passing national licensed exams. Nurses with higher degrees perform better and deliver higher quality care.[24] With advanced education, nurses gain a deeper understanding of patient care and are equipped with the knowledge and skills necessary to provide the highest quality care possible. Also, experienced nurses improve patient care by reducing medication errors and patient falls, and can perform complex tasks and enhance the overall QNC.[24]

Study Aim

This study aimed to 1) explore the perceived QNC and 2) determine the predictability of the nurse work environment, job satisfaction, nurse staffing, educational levels, and work experience on perceived QNC among nurses in general hospitals in Myanmar.

Methods

Design: This study utilized a cross-sectional research design. Results are presented here following the STROBE Statement checklist for cross-sectional study reports.

Population and Sample: The population was 699 registered nurses (RNs) from five general hospitals in Myanmar. The sample was calculated using the rule of thumb of 40 participants per predictor.[25] The sample, including 20% of the possible loss, was 240 RNs. Inclusion criteria were RNs who held nursing licenses from the Myanmar Nurse and Midwife Council and had at least one year of working experience in inpatient departments. Nursing administrators, managers, and nurses on leave or vacation were excluded. The

participants were proportionately chosen through stratified random sampling. Firstly, five general hospitals were randomly selected based on the bed numbers of the hospitals. Then, the sample was selected as a proportion of the unit level and then selected from each unit using random sampling (**Figure 1**).
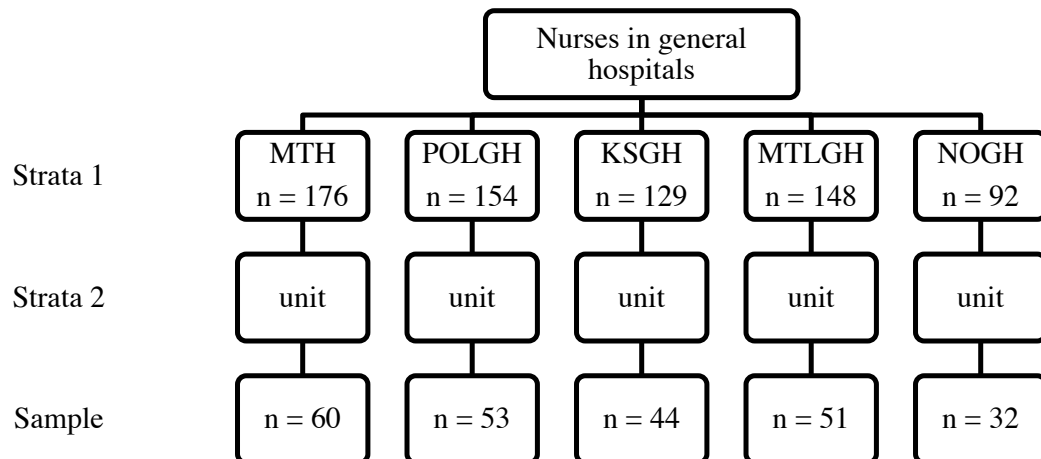

Figure 1. Stratified random sampling (n = 240)

Ethical Considerations: The guidelines outlined in the Helsinki Declaration were followed throughout this study. Ethical approval was attained from both the Research Ethics Review Committee, Faculty of Nursing, Chiang Mai University, Thailand (Approval No. 017/2022) and the Institutional Review Board, University of Public Health, Yangon, the Republic of the Union of Myanmar, UPH-IRB (2022/Research/4). Before the commencement of data collection, all participants were informed about the study's objectives, research methods, confidentiality, and anonymity. They all signed a consent form. Participants were free to decline, stop, or withdraw from the study at any time.

Instruments: The three instruments used in the study were translated from English to Myanmar by previous researchers, Zar,[26] Maung,[10] and Wai,[27] who permitted their use in this study. All instruments, except the Demographic and Nurse Staffing Data Form, were pretested with 15 RNs with traits comparable to those of the study's participants.

The Demographic and Nurse Staffing Data Form was developed by the primary investigator (PI) and includes age, gender, marital status, educational level, current job position, the total number of years working as a nurse, work experience in the current unit, the working unit, salary, and training within five years. Nurse staffing is measured using the nurse-to-patient ratio, determined by the ratio of the total number of RNs to the total number of patients in the last shift.[11]

The Practice Environment Scale of the Nursing Work Index (PES-NWI), developed by Lake,[14] was used to determine the nurse work environment. It was translated into Myanmar by Zar.[26] There are 31 items. An example item is "Adequate support services allow me to spend time with my patients." The PES-NWI has five dimensions: nursing involvement in hospital issues (9 items), nursing foundation for QNC (10 items), nursing managers' aptitude, leadership, and assistance to nurses (5 items), adequate staffing and resources (4 items), and collegial connections between nurses and physicians (3 items). The PES-NWI scores on a 4-point Likert scale: "1" = "strongly disagree" to "4" = "strongly agree." The higher the score, the more favorable the nurses perceived their work environment.

Work environments are classified as worse (< 25%), mixed (25–75%), or better (> 75%) based on the scores. The continuous scores are used for regression modeling.[28] The content validity of PES–NWI was 0.95,[14] and the Cronbach's alpha coefficient was 0.85.[26] In this study, the reliability of PES–NWI was 0.88 in the pretest and 0.96 in the actual study.

The Job Satisfaction Survey (JSS) developed by Spector[16] was used to assess job satisfaction. Wai[27] translated the JSS to Myanmar. It comprises 36 items with nine dimensions (four items in each dimension): salary, opportunities for advancement, surveillance, additional benefits, rewards that depend on certain conditions, established protocols, colleagues, the type of work, and effective communication. Responses are on a 6-point Likert scale ("1" = "strongly disagree" to "6" = "strongly agree"). An item example is "I feel I am being paid a fair amount for the work I do." The scores range from 36 to 216, and a greater score correlates with a higher degree of job satisfaction. The cut point of 36–108 (0–40%) is determined as a low, 109–144 (41–60%) as moderate, and 145–216 (> 60%) as high job satisfaction.[16] The CVI of the JSS was 0.95,[16] and the Cronbach's alpha was 0.84.[27] The reliability of the JSS in the pretest was 0.91 and 0.90 in the actual study.

The Good Nursing Care Scale (GNCS), developed by Leino–Kilpi,[12] was used to evaluate QNC and was translated into Myanmar by Maung.[10] It consists of 58 items with six dimensions: the qualifications of staff (7 items), care–related activities (19 items), essential conditions for care (8 items), the physical setting (2 items), the efficacy of implementing the nursing process (10 items), and cooperation with family members (12 items). An example item is "I show a sincere interest in my patients' well–being." Each item is rated on a 7–point Likert scale. The scale ranges from 0 (do not know) to 6 (always), with the other values being 1 (never), 2 (very rarely), 3 (rarely), 4 (often), and 5 (very often). The scores range from 0 to 348, with a higher score indicating a higher level of QNC. The cut point is classified as high (233–348),

moderate (117–232), and low (0–116) and the CVI of GNCS was 0.92.[12] The Cronbach's alpha coefficient of GNCS was 0.88.[10] The reliability of GNCS in this study was 0.98 in the pretest and 0.94 in the actual study.

Data Collection: This was done from July to September 2022. Data were collected using a questionnaire package that contained study information, including participant rights, a consent form, and questionnaires, and a marked return envelope with a coding number. Two RNs from each hospital who expressed research interest were invited as research coordinators, and the PI explained the research objectives and benefits to the coordinators assisted with data collection. Questionnaires were distributed, completed, and returned to the PI. They were informed that the questionnaires took 30 minutes to complete, with a request to return these within two weeks to the coordinators, who in turn forwarded them to the PI.

Data Analysis: After completion, 96.25% of the questionnaires were returned, and 95.00% were used for data analysis (three questionnaires were incomplete). Descriptive and inferential statistics were generated using the Statistical Package for the Social Sciences (SPSS) software version 13.0 at a significance level of 0.05. Frequency, percentage, mean, median, range, and standard deviation were used for all variables. Before predicting QNC, the assumptions of normality of distribution, linearity, multicollinearity, and homoscedasticity were assessed. The p-value obtained from the Kolmogorov–Smirnov test was greater than 0.05, which indicated that the normality assumption was met. The linearity assumption was also met, as evidenced by the straight diagonal line on the Q-Q plot. The residuals on the normal scatter plot were rectangularly distributed, meeting the assumption for homoscedasticity. The VIF values ranged from 1.05 to 1.6, and tolerance values ranged from 0.62 to 0.95, indicating no multicollinearity.[29] The study utilized stepwise regression analysis to examine the factors affecting QNC, where potential explanatory variables

were iteratively added and removed and then tested for statistical significance.

Results

Most participants (98.62%) were female, with a mean age of 31.73 years. Nearly 62.00% of the nurses, were single, and 64.22% had a diploma education. Staff nurses accounted for 61.47% and nearly 75.00% of nurses had a total work experience of > 5 years. More than half (64.68%) had not attended any training in the last five years, while 72.48% got a salary of 205,001–230,000 Kyats (97.58–109.48 USD). In terms of nurse staffing, 32.11% of RNs were responsible for taking care of more than ten patients, which results in higher workloads (**Table 1**).

Table 1. Demographic characteristics of participants (n = 218)

Demographic characteristics	Frequency	Percentage
Age (years) (M = 31.73, SD = 7.53, Min = 21, Max = 50)		
21–30	112	51.38
31–40	77	35.32
41–50	29	13.30
Gender		
Male	3	1.38
Female	215	98.62
Marital status		
Single	135	61.93
Married	82	37.61
Divorced	1	0.46
Educational level		
Diploma in nursing	140	64.22
Bachelor's degree in nursing and higher	78	35.78
Current job position		
Trained nurse	84	38.53
Staff nurse	134	61.47
Work experience (M = 8. 83, SD = 5.14, Min = 1, Max = 24)		
≤ 5 years	59	27.06
6–10 years	89	40.82
11–15 years	46	21.11
16–20 years	19	8.72
≥ 21 years	5	2.29
Number of years working in the current unit (M = 1.07, SD = 0.31, Min = 0.08, Max= 20)		
< 5 years	205	94.03
6–10 years	10	4.59
> 10 years	3	1.38
Working Unit		
Medical unit	42	19.27
Surgical unit	39	17.89
Orthopedic unit	11	5.04
Obstetrics and gynecology unit	20	9.17

Table 1. Demographic characteristics of participants (n = 218) (Cont.)

Demographic characteristics	Frequency	Percentage
Pediatric unit	27	12.39
Urological and hemodialysis unit	10	4.59
Eye, ear, nose, and throat unit	12	5.50
Psychiatric unit	8	3.67
COVID unit	22	10.09
Intensive care unit and coronary care unit	7	3.22
Compound unit including medical, surgical, and orthopedic patients	20	9.17
Salary per month (Myanmar Kyat MMK) [a]		
180,000-205,000 Kyats (85.68-97.58 USD)	60	27.52
205,001-230,000 Kyats (97.58-109.48 USD)	158	72.48
Training within 5 years		
No	141	64.68
Yes[b]	77	35.32
Nurse to patient ratio (M = 1:9.33, SD = 6.54, Min = 1:1, Max= 1:31)		
1:< 10	148	67.89
1:11-1:20	54	24.77
1:21-1:30	14	6.42
1:31	2	0.92

Note. [a] Approximately 2100 Myanmar Kyat MMK equals 1 USD

[b] Topic of short training and 9-month specialty program: emergency nursing care, cardiopulmonary resuscitation training, preoperative and postoperative care, nursing care for coma patients, obstetric emergency care, intensive care training, gastrointestinal scope training, and hemodialysis training

Table 2 indicates that the overall QNC was high (M = 291.95, SD = 28.57). All variables except educational level were associated with perceived QNC, with the nurse work environment being the highest (.73). As shown in **Table 3**, the variables were put in the model step by step, with the strongest association variable (the nurse work environment) first, followed by nursing staff, working experiences, and job satisfaction to predict QNC. All four factors were significantly predictive and explained 56.00% of the variance in the QNC, with the nurse work environment being the strongest predictor.

Table 2. Correlation matrix of study variable (n = 218)

Variables	Mean	SD	Level	1	2	3	4	5
1. Quality of nursing care	291.95	28.57	High	1.00				
2. Educational level				-.048	1.00			
3. Work experience	8.83	5.14		.259**	.239**	1.00		
4. Nurse staffing	9.15	6.38		.378**	-.043	-.052	1.00	
5. Job satisfaction	121.39	24.63	Moderate	.426**	-.148**	.007	-.156*	1.00
6. Nurse work environment	90.21	17.67	Mixed	.734**	-.088	.146*	-.407*	.493**

Note. **$p < 0.01$, *$p < 0.05$

Table 3. Multiple regression analysis of factors predicting quality of nursing care (n = 218)

Independent variables	B	SE	β	t	p-value	R^2	Adjusted R^2
1. Constant		7.3		26.17	< .001	.48	.48
1. Nurse work environment	1.12	.08	.69	14.08	< .001		
2. Constant		8.75		24.43	< .001	.52	.52
1. Nurse work environment	.97	.08	.6	11.58	< .001		
2. Nurse staffing	−1.00	.23	−.22	−4.33	< .001		
3. Constant		8.66		24.10	< .001	.55	.54
1. Nurse work environment	.94	.08	.58	11.38	< .001		
2. Nurse staffing	−.99	.23	−.22	−4.37	< .001		
3. Work experience	.89	.26	.26	3.43	< .001		
4. Constant	202.19	9.18		21.82	< .001	.56	.55
1. Nurse work environment	.82	.09	.51	8.79	< .001		
2. Nurse staffing	−1.04	.23	−.23	−4.57	< .001		
3. Work experience	.97	.26	.18	3.64	< .001		
4. Job satisfaction	.15	.06	.13	2.50	.01		

Note. R =.75, R^2 = .56, Adjusted R^2 = .55, SE = 9.43, Overall F $(4, 213)$ = 67.34, p < .001

Discussion

In this study, we found that Myanmar RNs perceived the overall QNC to be high. The significant predictors of RNs' perceived QNC, from the highest to the lowest, were the nurse work environment, nursing staff, working experiences, and job satisfaction.

The combination of the seriousness of COVID-19 cases and the overwhelming quantity of infections resulted in an immense strain on healthcare systems. Hospitals became inundated with patients requiring urgent care, leading to some regions experiencing high COVID-19 mortality rates due to medical personnel and equipment shortages.[30] In Myanmar, the health sector continues to encounter obstacles in addressing the COVID-19 pandemic. These include a shortage of human resources, technical difficulties in managing data, delays or underreporting in hard-to-reach regions, inadequate coordination among various stakeholders, concerns regarding vaccine safety in the community, and uneven demand for vaccines in rural and urban areas and conflict zones.[31] Many continue to deliver high-quality patient care despite increased workloads and stress. Although the pandemic and nursing shortage have presented numerous challenges for nurses, they have shown incredible resilience and adaptability to the pandemic by adopting new protocols, technologies, and care practices. Therefore, it is evident that the QNC has increased.[32]

In this study, the nurse work environment significantly and strongly predicted QNC. Nurses in general hospitals actively contribute to decision-making processes and policy development by serving on quality assurance and infection control committees.[33] Nurses can help manage the unit by organizing shifts, ensuring access to medication, linen, and cleaning supplies, and delegating tasks among the staff.[34] Collaboration between physicians and nurses leads to better patient outcomes and increases QNC. A healthier nurse work environment results in higher-quality patient care and improved job performance.[35] Therefore, the nurse work environment has a definite impact on QNC. The results of studies conducted in Portugal[36] and Chile[37] indicated that nurses' work environment positively influences QNC. Previous

findings in China and Mongolia also support our conclusion that the nurse work environment positively influences QNC.[4]

Nurse staffing negatively predicted QNC. It is well-recognized that QNC decreases when nurses have to care for more patients throughout a shift.[11] In hospitals, it is crucial to maintain a balanced nurse-to-patient ratio because an inappropriate ratio might result in lower patient care quality.[38] Overall, the study's findings are consistent with those of earlier investigations, which found that a nurse shortage negatively affects QNC.[22,35]

Work experience predicted QNC in this study. Nurses with more extended experience performed more complex jobs than those with less experience. An expert nurse with comprehensive knowledge and vital experience can recognize a patient's situation and promptly take the necessary measures, actions, and priorities.[24] The results of this study are supported by other findings that reveal that the lack of experience of nurses harms QNC. Nurses with good experience have a decreased rate of medication errors.[39] Thus, inexperienced nursing staff can negatively impact QNC.[39]

As job satisfaction increases, so does QNC. In Myanmar, nurses have tools such as a Messenger or Viber group as well as the group meeting which helps them to effectively communicate about care. These improve job satisfaction. When nurses feel satisfied with their work, they will show excellent job performance and increase the quality of their services.[27] A happy RN concentrates more on the patient and makes fewer medication mistakes, which leads to higher quality nursing care. Because of this, job satisfaction is considered a crucial factor that significantly impacts the ability to deliver excellent QNC.[40] Research conducted in Canada,[18] Pakistan,[19] and Greece[20] has demonstrated that nurses who derive job satisfaction from their work are more likely to achieve exceptional job performance and provide higher-quality services. Therefore, it is imperative to prioritize the satisfaction of nurses in order to enhance the QNC they provide.[17] The finding of this study was also supported by Zar, that employees' job satisfaction in the healthcare industry will lead to good hospital outcomes by providing quality nursing care to patients.[26]

Limitations

In this research, a cross-sectional study design was used to examine the level of QNC and the factors predicting QNC, including the nurse work environment, job satisfaction, nurse staffing, educational levels, and work experience among nurses. However, this study only focused on nurses' perceptions regarding QNC, which may pose a bias. Therefore, the perception of QNC by patients and clinical outcomes should be studied. In addition, general hospitals were the only ones included in this study, so further studies should be conducted at other levels of hospitals, including specialty hospitals.

Conclusion and Implications for Nursing and Health Policy

Our study adds to the body of knowledge regarding the high perception of the QNC among nurses in Myanmar. Also, the results support the NWE-NS-OM model proposed by Aiken et al.[11] that the significant predictors of the QNC were nurse work environment, nurse staffing, work experience, and job satisfaction, which explain 56.0% of the variance in the QNC. Thus, hospital and nursing administrators should formulate strategies to maintain a positive work environment. To improve the quality of care, nursing directors should work with the government to produce and recruit more nurses and find the budget and resources needed to provide care. At the hospital level, nursing directors need to improve the nurse environment and job satisfaction by involving nurses in improving

care and supporting and assisting them in their work. They also should maintain QNC by lowering the nurse-to-patient ratio, raising employee satisfaction, promoting and enhancing nurses' competencies, and reducing nurses' workload to increase patient care time and decrease wait times. Additionally, administrators should prioritize adherence to guidelines and standards of care and try to create satisfactory work conditions for nurses by supporting their physical, psychological, social, and spiritual needs within affordable resources.

Acknowledgments

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ปัจจัยทำนายคุณภาพการดูแลทางการพยาบาลของพยาบาลในสาธารณรัฐแห่งสหภาพเมียนมา: การศึกษาแบบภาคตัดขวาง

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บทคัดย่อ: คุณภาพการดูแลที่สูงมีความสำคัญต่อสุขภาวะที่ดีของชุมชนและผลลัพธ์ทางบวกทางด้านสุขภาพ องค์กรสุขภาพจึงควรให้บริการที่ทันท่วงที เสมอภาค บูรณาการ มีประสิทธิภาพ ประสิทธิผล ปลอดภัย และบริการโดยมีประชาชนเป็นศูนย์กลาง เช่นเดียวกับหลายประเทศ การระบาดใหญ่ของโควิด-19 และปัญหาการขาดแคลนพยาบาล ได้ส่งผลต่อคุณภาพการดูแลในสาธารณรัฐแห่งสหภาพเมียนมา การศึกษาแบบภาคตัดขวางนี้มุ่งศึกษาปัจจัยทำนายคุณภาพการดูแลทางการพยาบาล ได้แก่ การจัดอัตรากำลังทางการพยาบาล ระดับการศึกษา ประสบการณ์การทำงาน สิ่งแวดล้อมในการปฏิบัติการพยาบาล และความพึงพอใจในงานในพยาบาล 218 คนจากโรงพยาบาลทั่วไป 5 แห่ง สาธารณรัฐแห่งสหภาพเมียนมาระหว่างเดือนกรกฎาคมถึงกันยายน 2565 รวบรวมข้อมูลโดยใช้แบบรวบรวมข้อมูลส่วนบุคคลและอัตรากำลัง แบบวัดสิ่งแวดล้อมในการปฏิบัติการพยาบาลของดัชนีงานพยาบาล แบบสำรวจความพึงพอใจในงาน และแบบวัดการพยาบาลที่ดี วิเคราะห์ข้อมูลโดยใช้สถิติพรรณนาและการวิเคราะห์การถดถอยพหุคูณแบบขั้นตอน

ผลการศึกษาพบว่าคุณภาพการดูแลทางการพยาบาลโดยรวมตามการรับรู้ของพยาบาลอยู่ในระดับสูง สิ่งแวดล้อมในการปฏิบัติการพยาบาล การจัดอัตรากำลังทางการพยาบาล ประสบการณ์การทำงาน และความพึงพอใจในงานร่วมทำนายคุณภาพการดูแลทางการพยาบาลได้ร้อยละ 56.00 ผลการศึกษานี้ให้ข้อมูลที่สำคัญในการกำหนดกลยุทธ์เพื่อเพิ่มพูนและคงไว้ซึ่งคุณภาพการดูแลทางการพยาบาลในสาธารณรัฐแห่งสหภาพเมียนมา หัวหน้าพยาบาลควรทำงานร่วมกับรัฐบาลในการผลิตและสรรหาพยาบาลเพิ่มขึ้น จัดสรรงบประมาณ และสนับสนุนสิ่งแวดล้อมในงานเพื่อปรับปรุงคุณภาพการดูแลทางการพยาบาล

คำสำคัญ: โรงพยาบาลทั่วไป ความพึงพอใจในงาน สาธารณรัฐแห่งสหภาพเมียนมา พยาบาล สิ่งแวดล้อมในการปฏิบัติการพยาบาล การจัดอัตรากำลังทางการพยาบาล คุณภาพการดูแลทางการพยาบาล ประสบการณ์การทำงาน

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