

NATIONAL NURSING

CORE COMPETENCY STANDARDS

TRAINING MODULES

PHILIPPINES



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Foreword



The International Labour Organization (ILO) is the United Nations' specialized agency responsible for developing and overseeing international labour standards. It is also the UN agency with a constitutional mandate to protect migrant workers including migrant health professionals and skilled workers. ILO adopts a rights-based approach to labour migration and promotes tripartite - government, employers and workers participation in migration policy. The ILO has adopted two conventions and associated recommendations focusing on migration issues. These are Migration for Employment Convention (Revised), 1949 (No. 97) Migration for Employment Recommendation (Revised), 1949 (No.86), Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), and Migrant Workers Recommendation, 1975 (No. 151).

97) Migration for Employment Recommendation (Revised), 1949 (No.86), Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), and Migrant Workers Recommendation, 1975 (No. 151).

To build bridges between ILO's standard-setting role, programmes and services for its constituents, the ILO implements projects with funding from donors worldwide and partnerships with local stakeholders. In 2011, the European Union partnered with the ILO to implement a project on the migration of skilled workers. The *ILO Decent Work Across Borders (DWAB) project: A Pilot project for Migrant Health Professionals and Skilled Workers* seeks to better understand schemes in line with circular migration of health professionals. As part of DWAB's aim to strengthen employment services for health professionals, it validated the need to conduct training courses on nursing qualification and competency frameworks and certification.

Nursing skills and competencies mastery and recognition are the prerequisite conditions for migrant nurses to be treated fairly upon employment in the Philippines and in any receiving country. To support the dissemination of the nursing core competencies to improve and uphold the quality of nursing in the country and its graduates, the ILO DWAB project partnered with the Commission on Higher Education (CHED) and the Professional Regulation Commission (PRC) to implement this subproject entitled "*Nursing Core Competencies Training for Master Trainers in Nursing Education and Practice*". This entailed the conduct of pilot training courses for nurse master trainers in key areas in Luzon, Visayas and Mindanao and the development and pilot of the training module.

Together with CHED and PRC, ILO DWAB recognizes the importance of standardizing the competencies across the Philippines to make nursing education and practice more locally relevant and internationally competitive. This subproject was designed and implemented in the best interest of the nurses themselves, the Filipino people and the many people Filipino nurses serve worldwide.

A handwritten signature in black ink, appearing to read 'L. Johnson'.

Lawrence Jeff Johnson
Director
International Labour Organization
Country Office for the Philippines

Preface



Significant advances in the nursing profession made it imperative to define the competencies, performance indicators and standards for beginning nurses in their different roles. The promulgation of the Philippine Regulation Commission-Board of Nursing (PRC-BON)'s National Nursing Core Competency Standards (NNCCS) is a response to this situation. However, for effective and efficient implementation, training programs and materials aligned with the competency standards need to be developed.

This set of training modules was prepared by expert nurses for the purpose of ensuring compliance with the NNCCS. The writers are experts from the academe, community and nursing service sectors so that situations and examples are realistic and relevant.

These modules are primarily intended for Master Trainers (Mentors) and their nurse trainees. The focus is on enhancing skills for developing competencies such as critical thinking, problem solving and decision-making in applying legal and moral principles to nursing care, management and research. Case studies and scenarios in the workplace are used to illustrate the teaching of some topics. The modules are not intended to give a comprehensive discussion of the topics. Content can be learned from the books and articles in the reference list to which mentors and trainees are directed.

As the readers go through the modules, they are encouraged to think, plan and reflect on the learning process that they should undertake and the outcomes to achieve.

The collaborative efforts of Philippine Regulation Commission-Board of Nursing (PRC-BON), Commission on Higher Education – Technical Committee for Nursing Education (CHED-TCNE), International Labour Organization (ILO) and the dedicated writing team ensure that this undertaking will contribute to the enhancement of nursing education and practice.

A handwritten signature in black ink, reading "Patricia B. Licuanan". The signature is fluid and cursive.

PATRICIA B. LICUANAN, Ph.D.
Chairperson

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Abbreviations

A

A/G Ratio – Albumin – Globulin Ratio
AACN – American Association of Critical Care Nurses
ABCDE – Airway, Breathing, Circulation, Disability, Exposure
ACLS – Advanced Cardiac Life Support
ADL – Activities of Daily Living
ADPCN – Association of Deans of Philippine Colleges of Nursing
ADR – Adverse Drug Reactions
AHA – American Heart Association
AHRQ – Agency for Healthcare Research and Quality
ANCC – American Nurses Credentialing Center
ANCOVA – Analysis Of Covariance
ANOVA – Analysis Of Variance
AO – Administrative Order
AOG – Age of Gestation
APA – American Psychological Association
APACHE – Acute Physiology and Chronic Health Evaluation
ARN – Association of Rehabilitation Nurses
ASAQ – Answer to Self-Assessment Question

B

BAM – Becoming a Mother
BCLS – Basic Cardiac Life Support
BHW – Barangay Health Worker
BLS – Basic Life Support
BP – Blood Pressure
BSN – Bachelor of Science in Nursing
BUN – Blood Urea Nitrogen

C

CBC – Complete Blood Count
CBE – Charting by Exception
CCM – Chronic Care Model
CD – Communicable Disease
CDC – Centers for Disease Control
CEO – Chief Executive Officer
CES-D – Center for Epidemiological Studies of Depression
CHED – Commission on Higher Education
CHN – Community Health Nursing
CMS – Centers for Medicare and Medicaid Services

CMO – CHED Memorandum Order
 CNM – Clinical Nurse Manager
 COPAR – Community Organizing Participatory Action Research
 COPD – Chronic Obstructive Pulmonary Disease
 CPD – Continuing Professional Development
 CPE – Continuing Professional Education
 CPR – Cardio – Pulmonary Resuscitation
 CPR – Classroom, Practicum and Reflection
 CQI – Continuous Quality Improvement
 CRED – Center for Research on the Epidemiology of Disasters

D

D&C – Dilatation and Curettage
 DAR – Data, Action, Response
 DILG – Department of Interior and Local Government
 DNR – Do Not Resuscitate
 DOH – Department of Health
 DOT – Direct Observed Therapy
 DRR – Disaster Risk Reduction
 DWAB – Decent Work Across Borders

E

ECG – Electrocardiogram
 EDD – Expected Date of Delivery
 EHR – Electronic Health Record
 EINC – Essential Intrapartum and Newborn Care
 EKG – Electrocardiogram
 EM-DAT – Emergency Events Database
 EMR – Electronic Medical Record
 ENC – Essential Newborn Care
 EPI – Expanded Program on Immunization
 EPR – Electronic Patient Record
 ER – Emergency Room
 ERB – Ethics Review Board
 EU – European Union

F

FBS – Fasting Blood Sugar
 FCC – Family-Centered Care
 FDA – Food and Drug Administration
 FEMA – Federal Emergency Management Agency
 FHSIS – Field Health Service Information System
 FIM – Function Independence Measure

G

GCS – Glasgow Coma Scale
 GNP – Gross National Product
 GO – Government Organization

GSIS – Government Service Insurance System

H

HANDS – Hands-on Automated Nursing Data System

HBMR – Home Based Mother Record

HCO – Health Care Organizations

HCW – Health Care Worker

HEP – Health Education and Health Promotion Unit

HN – Hospital Nursing

HPR – Health Promotion, Education and Communications

HQ – Headquarters

HR – Heart Rate

HRM – Human Resource Management

HIV/AIDS – Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome

HRVA – Hazard, Risk, Vulnerability Analysis

I

IASC – Inter - Agency Standing Committee

IBL – Inquiry - Based Learning

IBLA – Inquiry - Based Learning Approach

ICHRN – International Centre for Human Resources in Nursing

ICN – International Council of Nurses

ICU – Intensive Care Unit

IEC – Information, Education and Communication

IF – Implementation Facilitator

ILO – International Labour Organization

IMCI – Integrated Management of Childhood Illnesses

IMRAD – Introduction, Methodology, Results and Discussion

IOM – Institute of Medicine

ISBAR – Introduction, Situation, Background, Assessment and Recommendation

ISO – International Organization for Standardization

IV - Intravenous

J

JCAHO – Joint Commission on Accreditation of Healthcare Organizations

JCIA – Joint Commission International Accreditation

K

K-S-B – Knowledge, Skills, Behavior

L

L&M – Leadership and Management

LOE – Level of Evidence

LOI – Letter of Instruction

M

MCH – Maternal and Child Health

MCI – Mass Casualty Incident

MDGs – Millennium Development Goals
MDS – Minimum Data Set
MEWS – Modified Early Warning Score
MHPSS – Mental Health and Psychosocial Support
MMSE – Mini Mental State Examination
MOS-FS – Multi-Organ System Failure with Sepsis
MOU – Memorandum of Understanding
MRA – Maternal Role Attainment
MT – Master Trainers

N

NANDA – North American Nursing Diagnosis Association
Non-CD – Non-Communicable Disease
NGO – Non-Government Organization
NHIP – National Health Insurance Program
NIC – Nursing Interventions Classification
NIO – Nursing Interventions Outcome
NLE – Nurse Licensure Examination
NNCCS – National Nursing Core Competency Standards
NOC – Nursing Outcomes Classification
NPO – Nothing per ore
NSD – Normal Spontaneous Delivery

O

OARS – Open-ended Questions, Affirmations, Reflective Listening, and Summaries
OARSS – Older American Resources and Services Scale
OASIS – Outcome and Assessment Information Set
OR – Operating Room

P

PACIC – Patient Assessment of Care for Chronic Conditions
PATCH – Planned Approach to Community Health
PCHRD – Philippine Council for Health Research and Development
PDA – Personal Digital Assistant
PE – Physical Examination
PGCIRMS – Philadelphia Geriatric Center Instrumental Role Maintenance Scale
PHA – Philippine Hospital Association
PHN – Public Health Nurse
PIE – Plan, Intervention, Evaluation
PMA – Philippine Medical Association
PMIS – Philippine Medical Informatics Society
PNA – Philippine Nurses Association
PNEA – Philippine Nursing Education Academy
POMR – Problem – Oriented Medical Record
PPE – Positive Practice Environment
PQF – Philippine Qualification Framework
PRBON – Professional Regulatory Board of Nursing
PRC – BON – Professional Regulation Commission – Board of Nursing

PSA – Prostate Specific Antigen

Q

QAP – Quality Assurance Program

QI – Quality Improvement

QOL – Quality of Life

R

RA – Republic Act

RCT – Randomized Controlled Trial

REEDA – Redness, Edema, Ecchymosis, Drainage, Approximation of Wound

RHU – Rural Health Unit

RLE – Related Learning Experience

RR – Respiratory Rate

RSVP – Reason - Story - Vital Signs - Plan

RTD – Round Table Discussion

S

SAQs – Self - Assessment Questions

SBAR – Situation Background Assessment Recommendation

SFBT – Solution - Focused Brief Therapy

SGPT – Serum Glutamic Pyruvate Transaminase

SKA – Skills, Knowledge and Attitude

SLE – Structured - Learning Experience

SOAP/IER – Subjective Data, Objective Data, Assessment, Plan/ Intervention, Evaluation, Revision

SPICES – Sleep Disorders, Problems with eating or feeding, Incontinence, Confusion, Evidence of falls, Skin Breakdown

SPO – Structure – Process - Outcome

SSS – Social Security System

START – Simple Triage and Rapid Treatment

SWOT – Strengths, Weaknesses, Opportunities and Threats

T

TB – Tuberculosis

TJC – The Joint Commission

TLA – Teaching – Learning Activity

U

UN – United Nations

UNICEF – United Nations Children's Fund

UNISDR – United Nations International Strategy for Disaster Reduction

U.S. AID – United States Agency for International Development

W

WFCCN – World Federation of Critical Care Nurses

WHMR – Woman Held Maternity Record

WHO – World Health Organization

WHO – WPR – World Health Organization Western Pacific Regional

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The completion of this project would not have been possible without the support and assistance given by the significant individuals and organizations who actively participated in this endeavour. We would like to acknowledge and express our gratitude to the following:

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Lastly, we extend our gratitude to all the Filipino nurses whose compassionate and uncompromising care towards their patients inspired us to develop this very timely project.

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INTRODUCTION

Module 1: Introduction and Course Overview

Module 2: The Roles of the Professional Nurse

Module 3: Change Management

Introduction and Course Overview

CRISTINA F. MENCINAS, BSE, MAT, MHPEd, PhD

INTRODUCTION

The implementation of the National Nursing Core Competency Standards (NNCCS) for Nursing education and practice is an exciting experience. Join us as we go through this Training Program. First, let us tell you why and how this project was planned. You will also get to know the people and groups of people who were imbued with the vision of improving, updating and standardizing Nursing education and practice through this and previous undertakings.

HISTORY OF THE NNCCS

The development of the NNCCS for nursing practice started in 2001 through the initiative of the Professional Regulation Commission - Board of Nursing (PRC-BON) which created a National Task Force for Core Competency Standards Development. The project was completed in 2005 after a series of workshops, consultations and discussions among representatives of nursing practice, nursing education and community health nursing. The project consisted of five (5) phases shown in Figure 1.1.

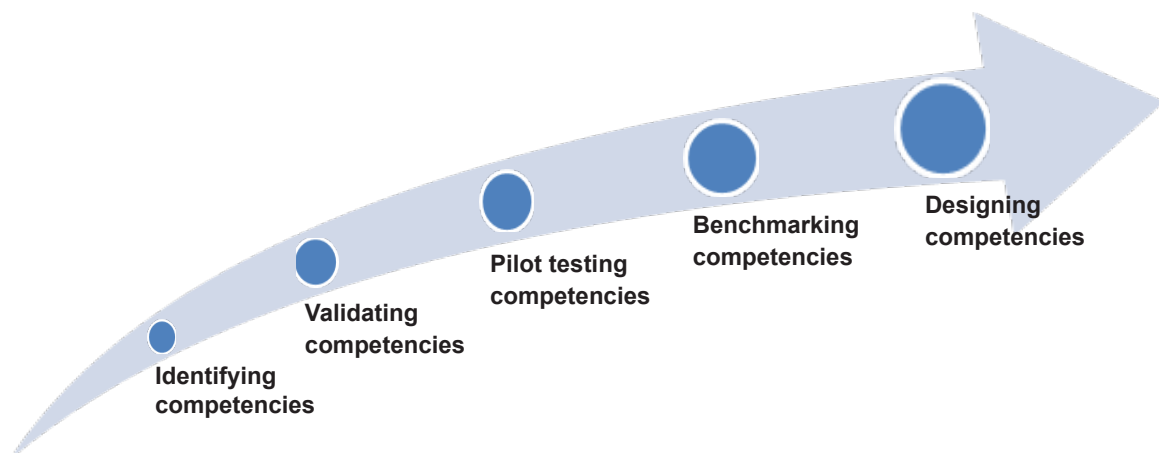


Figure 1.1 The Development Model of the Philippine Core Competency Standards for Nursing (Llanes, 2002; 2006;2009).

After four years of development, the Core Competency Standards for Nursing Practice came to fruition when the BON adapted and promulgated it in 2005. This version had eleven (11) key areas of responsibility, fifty-five (55) core competencies and one hundred fifty-one (151) performance indicators. (Llanes)

After four (4) years of implementation, the initial version was enhanced by the PRC-BON in 2009. Further refinement and validation was done and the project culminated in the publication of the 2012 NNCCS.

In the foreword of the 2012 NNCCS, Professional Regulation Commission Chair T.R. Manzala stated: “Out of this lengthy process emerged the Revised Nursing Core Competency Standards, emphasizing the three roles of the nurse: Beginning Nurses’ Role on Client Care, Beginning Nurses’ Role on Management and Leadership and Beginning Nurses’ Role in Research as well as four types of clients of the nurse. With the promulgation of the 2012 NNCCS, the succeeding stage is its implementation and evaluation in both nursing education and nursing service in all setting. This will be a collaborative activity of all partners of the PRC-BON.”

This collaboration materialized when the Commission on Higher Education (CHED) obtained a grant from the International Labour Organization (ILO). This project entitled “Nursing Core Competencies for Master Trainers in Nursing Education and Practice” is the initial step in the implementation of the 2012 NNCCS.

GOALS AND OBJECTIVES OF THE PROJECT

The PRC-BON Training Committee had earlier planned to develop a set of ready-to-use materials and a training curriculum to integrate the 2012 NNCCS into the service and academic systems. This goal blended well with the goal of the ILO project to improve Nursing Education and practice through the dissemination of materials and training of nurses. Specifically the project aims to:

1. Establish the team and system for implementing the project,
2. Develop and implement the training design and materials aligned with the revised NNCCS competencies,
3. Pilot the training course in Luzon, Visayas and Mindanao,
4. Recommend strategies to address sustainability concerns.

CONTENT OUTLINE

1. Historical Background of NNCCS
2. Commission on Higher Education (CHED) – International Labour Organization (ILO) and Professional Regulation Commission (PRC) Project
 - Goals of the Project
 - Process in development and pilot
3. Module Objectives
4. Training Workshop Objectives
5. Definition of terms
 - Framework of the Training
6. Parts of Modules
7. How to use the Modules
8. Assessment of Learning
9. References

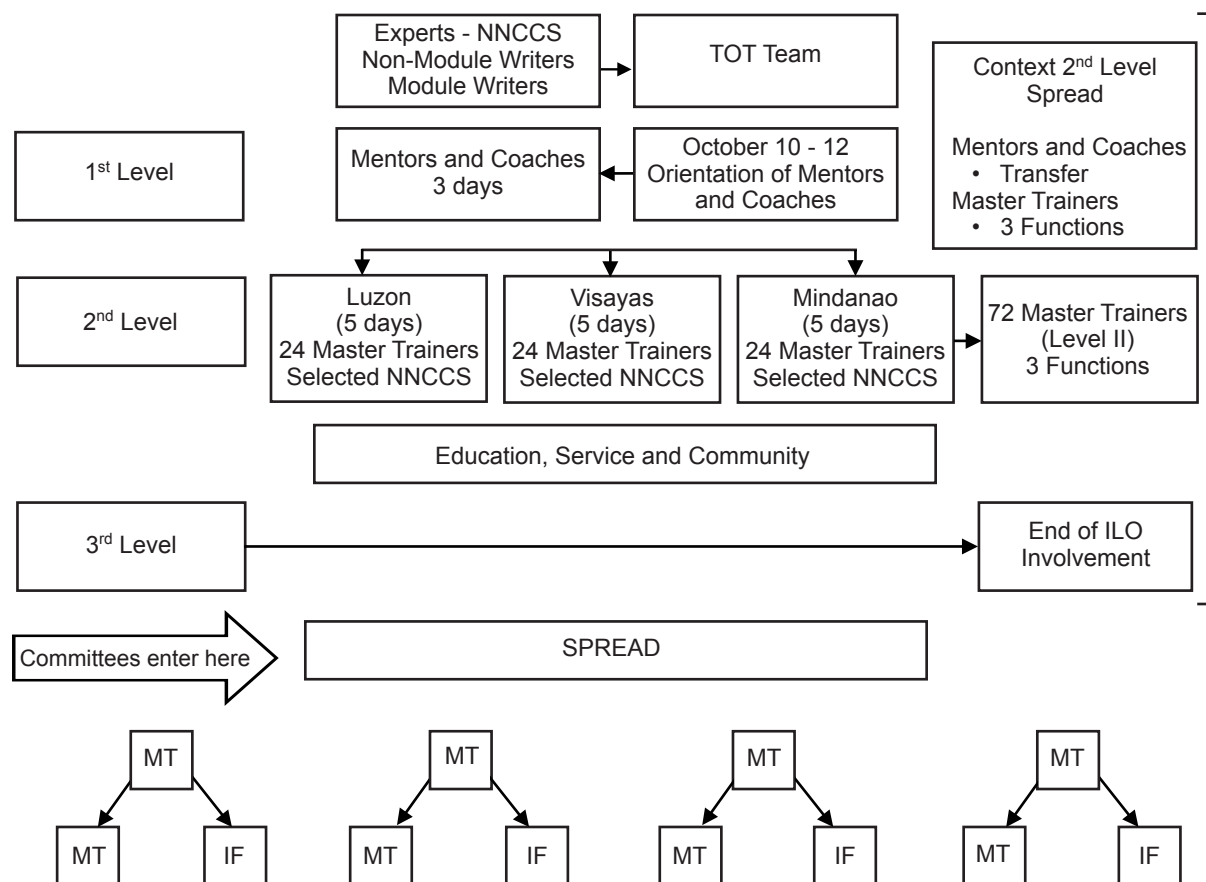


Figure 1.2 NNCCS Module Development Activity Flow (September 27, 2013)

Legend:

- NNCCS – National Nursing Core Competency Standards
- TOT – Training of Trainers
- ILO – International Labour Organization
- MT – Master Trainer
- IF – Implementation Facilitators

This figure was derived from group discussions of the following:

- Module Writers
- Professional Regulation Commission - Board of Nursing (PRC-BON)
- Commission on Higher Education - Technical Committee for Nursing Education

A series of meetings, brainstorming sessions and workshops were undertaken in the process of developing and cascading the modules. There were three (3) levels identified in the process. Experts in the field of Nursing education, service and community health who demonstrated good writing ability and commitment to the improvement of the Philippine Nursing Profession were engaged as module writers. Upon the completion of the modules, a TOT Team comprised of selected module writers, non-module writers and experts on the NNCCS was developed. In the first level of the module development, a three-day orientation program was conducted where Mentors and Coaches were oriented on how to teach the NNCCS utilizing the developed modules. Mentors and Coaches trained Master Trainers (MTs) on how to cascade and spread the NNCCS while focusing on the three (3) main functions that MTs are expected to be able to perform at the end of the training program. MTs evaluated the modules and provided valuable feedback to further refine the materials. Modules were revised based on these recommendations, formatted and published.

This marks the end of the involvement of the International Labour Organization and the beginning of the third (3rd) level of the process. Spread of the NNCCS will begin thereafter. Committees are expected to be more involved in this level. Master Trainers will continue to cascade the NNCCS by training other nurses to become competent Master Trainers (MTs) and Implementation Facilitators (IFs).

OPERATIONAL DEFINITION OF TERMS

1. **Modules** are the training materials which consist of an instructional design specifying the competencies, objectives, teaching and learning activities, evaluation methods and tools for assessment of learners, with notes or teaching tips and references for trainers.
2. **Module writers** are educators and practitioners in the hospital and community settings and who demonstrate good writing ability and commitment to develop training materials.
3. **Mentors and coaches** are experts who may or may not be module writers but are well oriented on the process and goals of the NNCCS and the project. They form a training team who conducted training workshops for Master Trainers at the initial phase (SPREAD) of the Spreading and Embedding of the NNCCS. See Figure 1.3 for the initial phase which focuses on the SPREAD* of the NNCCS.
4. **Master trainers** are nurse educators who were trained by the Mentors and Coaches in the second level of training. They, in turn, will train other Master Trainers (MT) and Implementation Facilitators (IF) using the developed modules and other supplementary materials.
5. **Trainees are the Implementation Facilitators (IF) or “end users”**. They are faculty members of educational institutions, nurse practitioners and supervisors in health facilities and communities. They are the ones who are expected to apply the NNCCS in their own practice settings. They comprise the next level in the “EMBEDDING” of the NNCCS.

ROLES OF MASTER TRAINERS

As Master Trainers, your roles include:

1. Train implementation facilitators who will implement the NNCCS in their unit, department, or organization;
2. Perform site assessments and determine performance gaps;
3. Prepare, train, and provide process consultation to the unit, department, or organization implementing the NNCCS.

As Master Trainers, you have experience and knowledge of the content, but you are not expected to provide content expertise. Rather, you are expected to have expertise in raising level of awareness and inspiring other educators and practitioners to develop and align performance with the NNCCS.
You are experts in teaching and assessing your learners.

As Implementation Facilitators, your roles are:

1. Perform site assessments and determine performance gaps;
2. Prepare, train and implement the NNCCS in the unit, department or organization.

* Refer to **Figure 1.3** for better understanding of the Framework for Training. This framework and the module titles below will be better understood when you read the 2012 NNCCS with it.

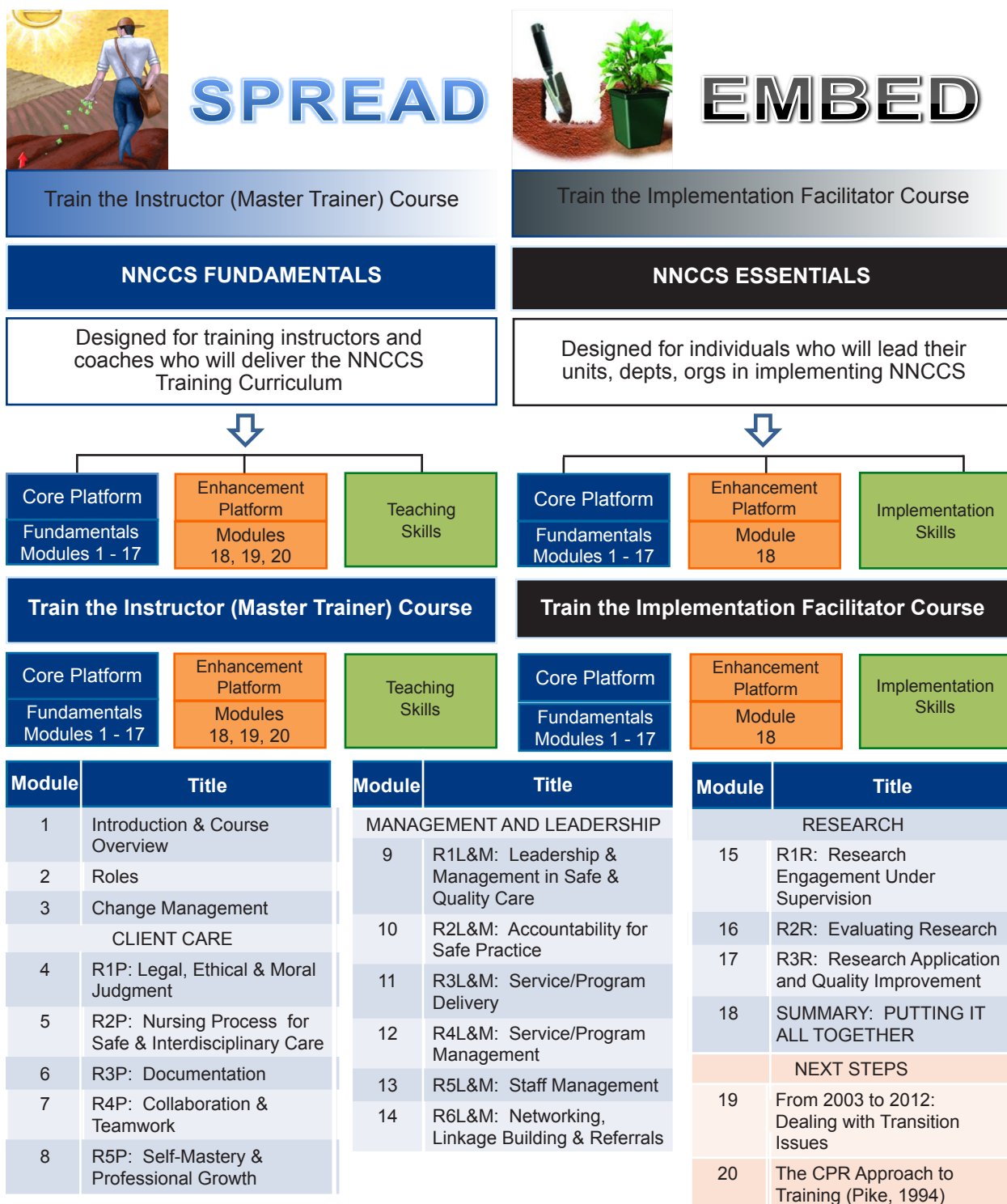


Figure 1.3. Spread and Embed Framework of the Training on the NNCCS (Borroneo, 2013)

The framework in the previous page guided the design of the training materials and training process. This framework and the module titles will be better understood if you refer to the accompanying copy of the 2012 NNCCS.

MODULE PARTS

To harmonize and achieve uniformity in the modules, the writers agreed to have the following parts for each module. This is also to help you as Master Trainers to utilize the modules and refer your learners to the appropriate parts during the training.

1. **Title** – this was derived from the competency being addressed
2. **Writer's Name**
3. An **Introduction** which describes the focus of the module, work setting, clients, coverage and core competencies from the NNCCS.
4. **Objectives** state in behavioral and measureable terms what competencies, knowledge, skills and attitudes that learners should achieve as a result of reading the module and undergoing the training.
5. **Topic outline** gives the coverage of the module and should be consistent with the objectives.
6. **Content** may be divided into sections with headings and subheadings. The teaching and learning activities such as presentations, case study, small group discussions, assigned readings, role play, review of documents/articles and abstracts are appropriate strategies indicated in the module.
7. **Cases and guide questions** are integrated in the content to enhance critical thinking skills. Illustrations, reading materials and self-assessment questions are also essential parts of the content.
8. **Application** identifies new situations where the competency is most useful. It also relates policies, research findings and other relevant information to demonstrate NNCCS.
9. **Summary** presents the highlights and reflections to recall and reinforce the major ideas and relate these to the achievement of the objectives.
10. **Self-assessment questions (SAQs)** are questions or instructions on what to do to determine if the learner achieved the objectives. SAQs are to guide you if you can teach or demonstrate the competencies.
11. **References** provide a list of documents, journal articles, research projects, books and electronic sources of materials.
12. **Assessment tools** such as checklists, rating scales, questionnaires, tests, exercises and other learning tasks are added as appendices to the modules but are to be used in determining the achievement of competencies.

HOW TO USE THE MODULES

Whenever possible, the competencies were cited in the module but it may give a better understanding of the context and content if the learners refer to a copy of the NNCCS.

As you read the module, answer the questions in the exercises and SAQs. These are the chances for you and your learners to develop critical thinking skills. In addition to understanding the content, it is important that you raise learning to higher levels such as application, analysis, synthesis and evaluation.

References are provided to guide you to additional sources of information. As we mentioned earlier, you are not expected to have expertise in the content but you are encouraged to continue learning more and be updated in the content. Self-directed and continuing education is part of our responsibilities as professionals.

As **Master Trainer**, you are reminded to: (Taken from A.O. Balabagno)

- Use an approach that accommodates the Nursing Process Framework
- Consider the work setting and needs of the client being served
- Advocate for comprehensiveness of assessment
- Give feedback to the learner based on the assessment
- Have an adequate knowledge of the topic as well as the skills in teaching and assessment

You can appreciate and understand better the Training Process and the rationale for the training when you read the modules on The Roles of the Professional Nurse by C.M. Abaquin, Change Management by F.M.E. Lorenzo and CPR (Classroom, Practicum and Reflection) Training Framework Module by A.R. Borromeo.

ASSESSMENT OF LEARNERS AS AN ESSENTIAL PART OF THE MODULE

Self-assessment questions serve the purpose of finding out what you and your learners know and are able to do. These questions should be congruent with the objectives and the content of the modules. The performance indicators in the NNCCS are useful guides in making assessment tools and methods of using them. Some modules also include checklists, tests, and other assessment tools. Outputs such as reports and answers to exercise or case studies are possible sources of evidences of learners' competencies.

You should answer the questions then check your answers or ask your trainer to discuss the answers. Feedback or information that you get from the answers to the SAQs or comments from your trainer or supervisor will lead to improvement of performance. Improvement will likely happen if feedback and suggestions are accepted by the learner and chances to practice are provided. You are also encouraged to reflect on the process to understand it better and to approximate the given standards.

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The Roles of the Professional Nurse

CARMENCITA M. ABAQUIN, RN, PhD

INTRODUCTION

Welcome to this introductory module on “The Roles of the Professional Nurse in Nursing Practice.” I believe that all of us who are going to utilize the 2012 National Nursing Core Competency Standards (NNCCS) should know the various phases, processes and activities involved in its development. In line with this, let me share with you a brief history of the development of the 2012 NNCCS.

In 2005, the Professional Regulatory Board of Nursing (PRBON) Resolution no. 112 Series of 2005 adopted and promulgated the Core Competency Standards of Nursing Practice in the Philippines. As mandated, the Professional Regulatory Board of Nursing ensured, through a monitoring and evaluation scheme, that the core competency standards were implemented and utilized effectively in nursing education, in the development of test questions for the Nurse Licensure Examination (NLE), and in nursing service as a basis for orientation, training and performance appraisal.

Through the years of implementation, global and local developments in health and professional nursing prompted the PRBON to conduct a “revisiting” of the Core Competency Standards of Nursing Practice in the Philippines. In 2009, the PRBON created the Task force on Nursing Core Competencies Revisiting Project in collaboration with the Commission on Higher Education - Technical Committee on Nursing Education and selected nursing leaders from the various nursing professional organizations with the **primary goal of determining the relevance of the current nursing core competencies to expected roles of the nurse and to its current and future work setting.**

MODULE OBJECTIVES

After going through the module, you, as the Master Trainer, will be able to:

1. Describe the various phases involved in the development of the 2012 National Nursing Core Competency Standards (NNCCS).
2. Discuss the conceptual framework of the 2012 NNCCS including the three distinct roles of the nurse, responsibilities per roles and the competencies and performance indicators for each responsibility in the care of the four types of clients.

The process of revisiting the core competency standards involved the following **ten (10) key phases**. Please pay particular attention on the activities undertaken in each phase.

Table 2.1 Ten Key Phases Involved in the Process of Revisiting the Core Competency Standards

PHASES	DESCRIPTION
I A (Feb. 2010) Work setting scenario inputs and analysis	<p>Resource persons were invited to discuss global, regional and local health scenarios, impact of nursing in achieving health care goals, in the light of global and local health care situations and the health human resource master plan as well as the local health care industry.</p> <p>After the work setting scenario inputs and analysis the group had workshops to undertake the following:</p> <ul style="list-style-type: none"> • creation of health and health care scenarios affecting the nursing profession (current, 5 years and 10 years projection); • identification of their roles and the responsibilities needed to perform each role.
I B (April 2010) Benchmarking of Nursing Core Competencies	<ul style="list-style-type: none"> • Committees were formed to undertake benchmarking of nursing core competency standards of selected countries. • The output was consolidated and presented to the nursing body.
II Field Validation studies of role and responsibilities and benchmarking of core competencies with other countries II A, B, and C (June 2010, Nov.2010, & Feb.2011) Presentation of field validation studies of the identified nurses' roles and responsibilities.	<ul style="list-style-type: none"> • Several Field Validation studies of the identified nurses' roles were undertaken by nursing partners in hospital (government; private, tertiary, secondary); community (urban and rural) settings using either of the following methodologies: Focus-group Discussion, Participant Observation, Modified Delphi, and Clinical Exemplar. • Validation strategies of the specified responsibilities and tasks for each roles were likewise undertaken. • These were presented to the nursing community in several fora.
III A Integrative review of outputs from the validation strategies and SKA Analysis	<ul style="list-style-type: none"> • Hospital and community research teams were formed to undertake Integrative review of outputs from the validation strategies and do SKA Analysis. • Workshops were undertaken to do the following for each task: <ul style="list-style-type: none"> • specify the skills needed to perform each task, • identify the knowledge needed to perform each skill, • list the values and attributes needed to perform the skills.
III B These include: Consolidation of Parts I and II and Phase III A Outputs and Content Validity Determination and Identification of Roles	<ul style="list-style-type: none"> • Consolidation and presentation of outputs by the Research Teams (Community based Research Team and Hospital based Research Team) • Identification of the Nurses Roles: <ul style="list-style-type: none"> • Beginning Practitioner Role • Beginning Manager-Leader Role • Beginning Researcher Roles

PHASES	DESCRIPTION
	<ul style="list-style-type: none"> • Identification of the various clients of the nurse: <ul style="list-style-type: none"> • Individual with varying age group, gender and health-illness status • Family – well and at risk • Population groups • Community • Then merging of the outputs of the two research teams was done.
<p>III C (August 24, 2011) Initial Presentation of Core Competency List</p>	<p>Presentation of Nursing Core Competency List to the BON and Partners.</p>
<p>IV A (Sept. - Oct. 2011) Consensual Validation of Core Competencies <u>Zamboanga, Iloilo, and Baguio</u></p>	<ul style="list-style-type: none"> • Consensual Validation tool was developed to ensure relevance, importance and clarity of the statement. • Create with BON and Partners the scenario and work plan on expanding the consensual validation team represented by nurse leaders and colleagues as stakeholders in Luzon, Visayas and Mindanao, to review/ evaluate the revised core competency list. • Data Processing, Analysis and Preparation of Full Report on the Results of the Expanded Consensual Validation on the revised core competencies
<p>IV B (Oct - Nov. 2011) Presentation of Consolidated Outputs of the Consensual Validation and the Statistical Implications</p>	<p>Presentation of the Consolidated outputs of the consensual validation and the statistical implications to the research teams to determine needed modifications.</p>
<p>IV C (Nov. – Dec. 2011) Finalization of Outputs by the Formatting Team</p>	<p>Presentation of the Results to the Expanded Consensual Validation Teams to prepare work plan for conducting and facilitating Public Hearings.</p>
<p>V (Jan. - Feb. 2012) Conduct of Public hearing <u>Cebu, Davao, Baguio, & NCR</u></p>	<ul style="list-style-type: none"> • Teams for the Public Hearing were organized in collaboration with our nursing partners in the various regions. • Suggestions for changes in the statement of roles, responsibilities, competencies and performance indicators were considered. • The three identified nurses' roles were rephrased: <ul style="list-style-type: none"> • Beginning nurse's role on client care • Beginning nurse's role on management and leadership • Beginning nurse's role on research

PHASES	DESCRIPTION
<p>VI Promulgation of the revised and modified Nursing Core Competency Standards</p>	<p>After the consolidation of the outputs of the public hearing, Resolution was submitted by the PRBON to the PRC for the promulgation of the revised nursing core competency standards (June 2012)</p> <p>Resolution 24 Series of 2012 was approved on July 27, 2012 amending Board Resolution No 112 Series of 2005 and adopting the 2012 National Nursing Core Competency Standards (2012 NNCCS)</p>
<p>VII Printing of the 2012 National Nursing Core Competency Standards (2012 NNCCS)</p>	<p>Printing of the 2012 NNCCS was done and this is found in the BON website.</p>
<p>VIII A Training for the Implementation of the 2012 National Nursing Core Competency Standards</p>	<ul style="list-style-type: none"> Initial Planning of the Implementation was done including the formation of various committees. <ul style="list-style-type: none"> Oversight and steering – with the PRBON in charge Program and Design Committee Selection Committee Logistics Committee Information and Media Relations Committee Evaluation Committee Program and design of the implementation was presented and approved by the Implementation Team PRBON organized two programs to update the nursing community of the recent developments that can impact the implementation of 2012 NNCCS <ul style="list-style-type: none"> Philippine Qualifications Framework ASEAN Qualifications Reference Framework
<p>VIII B (until Dec. 2013) ILO Funded Initial Implementation of 2012 NNCCS through CHED TCNE</p>	<ul style="list-style-type: none"> ILO Funded the initial phase of the implementation phase that included: <ul style="list-style-type: none"> Formation of the Committee Module development and pilot testing of the modules and evaluation of the Master Trainer and Implementation Facilitator Program Design
<p>VIII C Training of Trainors for Mainstreaming of the 2012 NNCCS (Spreading and Imbedding) Target 2014</p>	<p>This phase will include</p> <ul style="list-style-type: none"> Modification of the program design based on the pilot testing Activating the various implementation committees Establishing the program design for spreading and imbedding 2012 NNCCS in nursing education and service (hospital and community)
<p>IX Evaluation of the effectiveness of the 2012 National Nursing Core Competency Standards (Target 2015-2018)</p>	<p>The evaluation phase will include both education and service.</p>

A competency based framework and a creation paradigm were utilized in planning the revision. (Please see Figure 2.1 for the Competency Based Framework.). This ensures a systematic approach in developing competence in nursing practice.

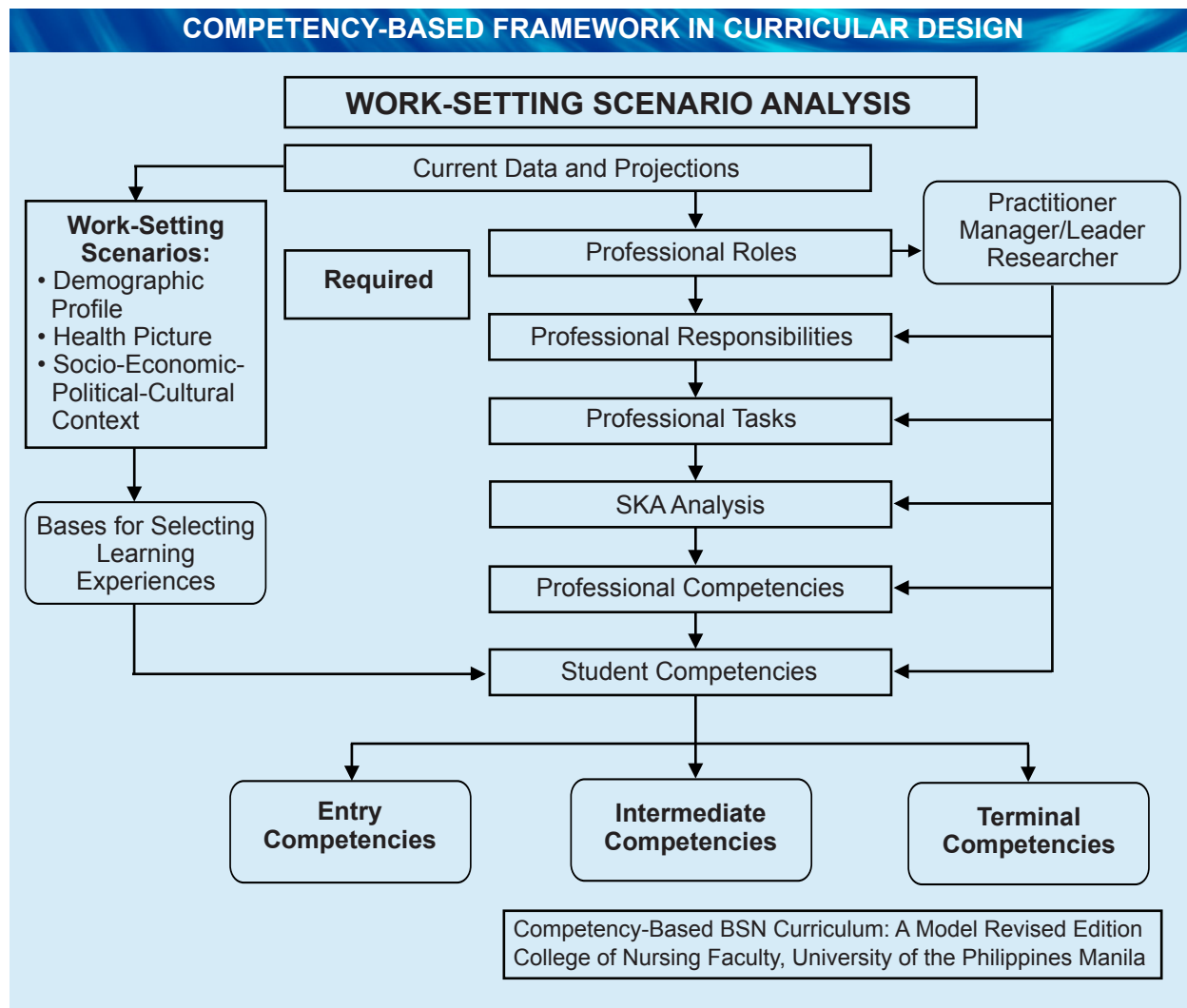


Figure 2.1. Competency-Based Framework in Curricular Design

The 2012 National Nursing Core Competency Standards (2012 NNCCS) will serve as a guide for the development of the following:

- Basic Nursing Education Program in the Philippines through the Commission on Higher Education (CHED).
- Competency-based NLE Test Framework as the basis for the development of course syllabi and test questions for “entry level” nursing practice in the Philippine Nurse Licensure Examination.
- Standards of the Professional Nursing Practice in various settings in the Philippines.
- National Career Progression Program (NCPP) for nursing practice in the Philippines.
- Any or related evaluation tools in various practice settings in the Philippines.

2012 NATIONAL NURSING CORE COMPETENCY STANDARDS (2012 NNCCS)

The various roles of the nurse including their responsibilities will be discussed in the various modules. Please pay particular attention on the commonalities and uniqueness of the manner by which the roles and responsibilities are presented depending on the setting as well as the health-illness status of the clients. The various competencies and performance indicators are spelled out to serve as guide in the development of our plan of care.

For The Beginning Nurses' Role On Client Care, there are 5 responsibilities:

I. BEGINNING NURSE'S ROLE ON CLIENT CARE

RESPONSIBILITY		COMPETENCIES
1:	Practices in accordance with legal principles and the code of ethics in making personal and professional judgment.	5
2:	Utilizes the nursing process in the interdisciplinary care of clients that empowers the clients and promotes safe quality care.	7
3:	Maintains complete, accurate and up to date recording and reporting system.	3
4:	Establishes collaborative relationship with colleagues and other members of the team to enhance nursing and other health care services.	2
5:	Promotes professional and personal growth and development.	4
TOTAL		21

II. BEGINNING NURSE'S ROLE ON MANAGEMENT AND LEADERSHIP

RESPONSIBILITY		COMPETENCIES
1:	Demonstrates management and leadership skills to provide safe and quality care	4
2:	Demonstrates accountability for safe nursing practice.	3
3:	Demonstrates management and leadership skills to deliver health programs and services effectively to specific client groups in the community settings.	2
4:	Manages a community/village based health facility/component of a health program or a nursing service.	9
5:	Demonstrates ability to lead and supervise nursing support staff.	8
6:	Utilizes appropriate mechanism for networking, linkage building and referrals.	4
TOTAL		30

III. BEGINNING NURSE'S ROLE ON RESEARCH

RESPONSIBILITY		COMPETENCIES
1:	Engages in nursing or health related research with or under the supervision of an experienced researcher.	4
2:	Evaluates research study/report utilizing guidelines in the conduct of a written research critique.	4
3:	Applies the research process in improving client care in partnership with a quality improvement/quality assurance/nursing audit team.	4
TOTAL		12

MODULE OBJECTIVES AS TRAINING OUTCOMES

1. Describe the three roles of a beginning nurse
2. Explain the roles as they impact the delivery of safe and high quality care
3. Discuss outcomes when these roles are performed poorly

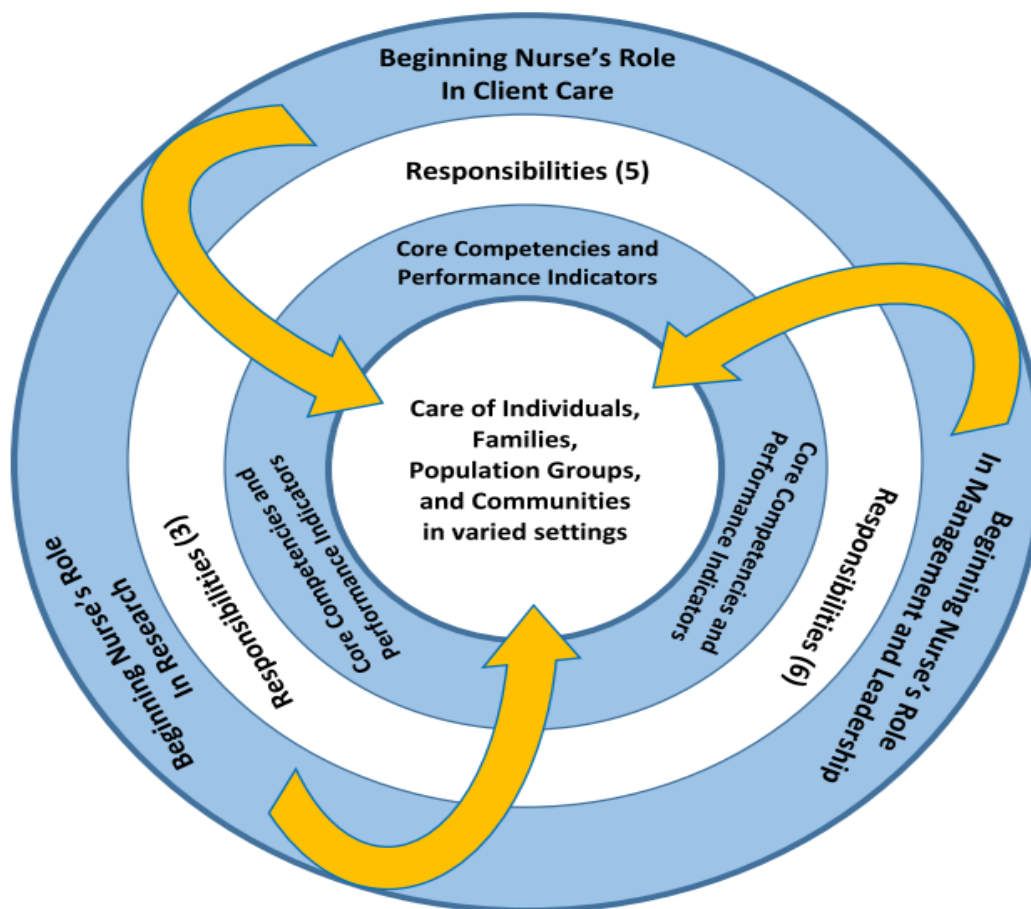


Figure 2.2. Conceptual Framework of the 2012 National Nursing Core Competency Standards

DESCRIPTION

Work-setting scenario on local, regional and global health industry demands was determined after having conducted assessments, benchmarking studies and application of the competency-based framework and creation paradigm. This sets the stage for the “beginning” professional nursing competencies for the care of clients especially performed in 3 distinct and clear **ROLES**: the Beginning Nurse Role on Client Care; Beginning Nurse Role on Management and Leadership and Beginning Nurse Role on Research. These roles set expected patterns of behavior for the professional nurse in society, performed within clearly established and universally accepted processes – the NURSING PROCESS.

In each of these roles are **RESPONSIBILITIES**. These are obligations explicitly carrying the authority afforded by the state to every duly licensed professional nurse. It spells out very peculiar mandate in terms of expected performances in order to decide and act based on scientific evidences as well as ethico-spiritual and legal basis for nursing care.

These are translated in what are to be recognized as **CORE COMPETENCIES** referred to as technical capacities needed for doing the tasks and roles of every Filipino Professional Nurse. **PERFORMANCE INDICATORS** are spelled out for each competencies to serve as guide in evaluating effectiveness of competencies and this can ensure clients’ safety.

At the innermost circle is the *raison d’être* (reason for being as nurses). These consists of individuals, families, population groups and community as clients. They are the recipients of holistic health care provided by nurses in any work setting.

Organized and put together, these now serve as the conceptual framework of the 2012 National Nursing Core Competency Standards for the Nursing Practice in the Philippines.

SUMMARY

In order for you to develop better insights on the 2012 NNCCS, details of the various phases of the development of the 2012 NNCCS was presented.

Likewise the competency based framework was presented to give you a systematic way of developing competence in nursing practice both in education and service.

The Conceptual Framework of the 2012 NNCCS and its description will help you appreciate that the competencies expected of the nurse are derived from the needs of the industry or the work place and the type of clients of the nurse.

Again please pay particular attention on assessment and interventions that are unique for each of the clients as well as the performance indicators for each of the competencies to better evaluate the effectiveness of the care given to your clients.

Change Management

FELY MARILYN E. LORENZO, RN, DrPh

INTRODUCTION

The only constant aspect of organizations is change. Change is necessary to adapt to the changing environment. Organizations must modify themselves all the time. Even large organizations must find ways to act like small, flexible organizations. Change management is critical to achieve and sustain competitiveness and responsiveness.

As Philippine nursing sector prepares to disseminate the 2012 National Nursing Core Competency Standards (NNCCS), Master Trainers need to be made aware of the change process and how it can be harnessed to bring about effective adoption and utilization of the new standards by the academe, practitioners and organizations where nurses work.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define Change and Innovation
2. Identify and discuss the process of Change
3. Describe the actions required to set the stage for organizational change
4. Identify ways to empower individuals to change
5. Begin planning how to teach others about National Nursing Core Competency Standards

TOPIC OUTLINE

1. Change and Innovation
2. Process of Change
3. Types of Change
4. Managing and leading organizational change
5. Guidelines to empower individuals to change
6. Planning how to teach others about National Nursing Core Competency Standards

MODULE CONTENT

WHAT IS CHANGE/INNOVATION?

“Change is the only constant.” – Heraclitus, Greek philosopher

In any organization and in all of life, the only constant is change itself. Hence, in any work setting especially in health care, change has to be managed and led effectively.

Organizational change is a generic concept that constitutes any modification in operations, structure or goals of the organization. It is also adoption of a new idea (e.g. standards) or behavior by a group or organization. **Organizational innovation** is perceived to be new to an organization, work group or individual. It is also adoption of an idea (standards) or behavior that is new to the organization's industry, market or general environment. All innovation is considered change but not all change is innovation (Shortell and Kaluzny, 2001).

The introduction of the 2012 National Nursing Core Competency Standards (NNCCS) will bring about significant change within the whole nursing sector and within nursing units where the standards will be utilized to ensure quality nursing change.

The process of introducing the NNCCS effectively will necessarily go through several stages. These stages include:

1. **Awareness of the need for change** – This is the initial stage of the change process where individuals realize that there is a discrepancy or gap between what they are currently doing and what they should be doing. This awareness may be stimulated internally by expectations of organizational participants or it may also be driven externally by community or regulatory pressures affecting the performance of the organization.
2. **Identification of potential change strategies or solutions to the discrepancy or gap.** This stage involves an attempt to address the discrepancies or performance gaps identified in the first stage. This may occur at various levels within the organization, and the critical challenge is to ensure that the identified solutions are quickly moved to implementation.
3. **Implementation** involves actual operations of the change within the organization at the specific work unit levels.
4. **Institutionalization** involves the integration of the change into ongoing activities and the prevailing culture of the organization. It is observed that while many changes are implemented, only few are successfully internalized within the organization. This is an important stage that will ensure sustainability and successful change efforts if done well (Shortell and Kaluzny, 2002, Daft, 1995).

The aforementioned stages of the change process are interactive in nature in that Institutionalization is contingent on implementation, implementation is affected by identification and identification is dependent on awareness.

The process is also affected by a complex set of interacting factors. The prevailing organizational structure and processes, such as the degree of organizational complexity and formalization as well as levels of communication, coordination and availability of resources, all influence whether a change or innovation prospers through the different stages of the change process.

Change is a continuous and interactive process. The internal organizational environment is dynamic and evolving within which the organization functions. Changes are institutionalized and require continual assessment. Subsequent awareness of any discrepancy between what the individual or organization is currently doing vis-à-vis what it should be doing should stimulate the process once again.

TYPES OF CHANGE

Health services organizations may undergo different types of change namely technical; product or service change; administrative, structural, or strategy change; or human resources change. Some individuals and organizations are able to better handle some types of change than others. Managers of change need to understand the types of changes, their interactions, and the factors which influence the successful implementation and institutionalization of the various types of change (Shortell and Kaluzny, 2002).

Technical Change is about changing the basic modalities that organizations use to deliver health services. This change may involve modifications in the practice patterns of nurses, changes in the flow of patients into or through the health facility, change in job assignments and responsibilities of professionals within the health care organization or change which results in the purchase of new equipment to provide existing services. For example, purchase of a new intravenous (IV) drip counter may change the speed by which nurses manage IV lines.

Product or Service Change is concerned with the introduction of new products or services in the health care facility. Teaching hospitals may provide new evidence in modalities of pain management that may prompt other health care facilities to utilize these new modalities that will improve patient care.

Administrative, Structural or Strategy Change consists of changes in the managerial or administrative activities of the health care organization. These may involve changes in organizational structure, human resource policies, organizational strategy, use of integrating mechanisms within the institution, management and clinical information systems, and financial systems. For example, many government hospitals now have private hospital components such as Philhealth beds or wards that are utilized to subsidize the care of charity or service in patients.

Human Resource Change may constitute efforts to influence attitudes, behaviors, skills and values of employees. For example, new standards such as NNCCS may specify new behaviors expected of beginning nurses in practice to conform to the new standards.

The types of change are not mutually exclusive and effective management of change may require considerable insight into the type of change and appropriate strategies to facilitate the change process.

MANAGING AND LEADING ORGANIZATIONAL CHANGE

There are many theories and approaches about how to accomplish change. Many originate with leadership and change management guru, John Kotter. A professor at Harvard Business School and world-renowned change expert, Kotter introduced his eight-step change process in his 1995 book, "Leading Change." These are summarized in the following section and related to nursing organizational changes when feasible. Practical guidelines on how to accomplish each step are also discussed.

Step 1: Create Urgency

For change to happen, it helps if the whole organization really wants it. Develop a sense of urgency around the need for change. This may help you spark the initial motivation to get things moving.

This isn't simply a matter of showing people statistics of medication errors or patient accidents or talking about improving health facility performance. Open an honest and convincing dialogue about what's happening in the nursing and health care industries and trends your competitors or other health care organizations (HCOs) are exhibiting and why there is a need for change. If many people start talking about the change you propose, the urgency can build and feed on itself.

Guidelines:

- Identify potential threats, and develop scenarios showing what could happen in the future.
- Examine opportunities that should be, or could be, exploited.
- Start honest discussions, and give dynamic and convincing reasons to get people talking and thinking.
- Request support from clients/patients, outside stakeholders and nursing sector movers and shakers to strengthen your argument.

It should be noted that Kotter suggests that for change to be successful, 75 percent of an organization's management needs to “buy into” the change. In other words, one has to work really hard on Step 1, and spend significant time and energy building urgency, before moving onto the next steps. His advice is not to panic and jump in too fast because you don't want to risk further short-term losses – if you act without proper preparation, you could be in for a very difficult change process.

Step 2: Form a Powerful Coalition

Convince people that change is necessary. This often takes strong leadership and visible support from key people within your organization. Managing change isn't enough – you have to lead it. You can find effective change leaders throughout your organization – they don't necessarily follow the traditional company hierarchy. To lead change, you need to bring together a coalition, or team, of influential people whose power comes from a variety of sources, including job title, status, expertise, and political importance.

Once formed, your “change coalition” needs to work as a team, continuing to build urgency and momentum around the need for change.

Guidelines:

- Identify the true leaders in your organization.
- Ask for an emotional commitment from these key people.
- Work on team building within your change coalition.
- Check your team for weak areas, and ensure that you have a good mix of people from different departments and different levels within your company.

Step 3: Create a Vision for Change

When one first starts thinking about change, there will probably be many great ideas and solutions floating around. Link these concepts to an overall vision that people can grasp easily and remember. A clear vision can help everyone understand why you're asking them to do something. When people see for themselves what you're trying to achieve, then the directives they're given tend to make more sense.

Guidelines:

- Determine the values that are central to the change.
- Develop a short summary (one or two sentences) that captures what you “see” as the future of your organization. Usually this is your change vision statement.
- Create a strategy to execute that vision. Ensure that your change coalition can describe the vision in five minutes or less. Don't just call special meetings to communicate your vision. Instead, talk about it every chance you get. Use the vision daily to make decisions and solve problems. When you keep it fresh on everyone's minds, they'll remember it and respond to it. It is also important to “walk the talk.” What you do is far more important – and believable – than what you say. Demonstrate the kind of behavior that you want from others.
- Practice your “vision speech” often.

Step 4: Communicate the Vision

What one does with your vision after you create it will determine your success. Your message will probably have strong competition from other day-to-day communications within the company, so you need to communicate it frequently and powerfully, and embed it within everything that you do.

Guidelines:

- Talk often about your change vision.
- Openly and honestly address peoples' concerns and anxieties.
- Apply your vision to all aspects of operations – from training to performance reviews. Tie everything back to the vision.
- Lead by example.

Step 5: Remove Obstacles

By now, you've been talking about your vision and building buy-in from all levels of the organization. Hopefully, your staff wants to get busy and achieve the benefits that you've been promoting.

But is anyone resisting the change? And are there processes or structures that are getting in the way of accomplishing change?

Put in place the structure for change, and continually check for barriers to it. Removing obstacles can empower the people you need to execute your vision, and it can help the change move forward.

Guidelines:

- Identify, or hire, change leaders whose main roles are to deliver the change.
- Look at your organizational structure, job descriptions, and performance and compensation systems to ensure they're in line with your vision.
- Recognize and reward people for making change happen.
- Identify people who are resisting the change, and help them see what's needed.
- Take action to quickly remove barriers (human or otherwise).

Step 6: Create Short-term Wins

Nothing motivates more than success. Give your company a taste of victory early in the change process. Within a short time frame (this could be a month or a year, depending on the type of change), you'll want to have results that your staff can see. Without this, critics and negative thinkers might hurt your progress. Create short-term targets – not just one long-term goal. You want each smaller target to be achievable, with little room for failure. Your change team may have to work very hard to come up with these targets, but each "win" that you produce can further motivate the entire staff.

Guidelines:

- Look for sure-fire projects that you can implement without help from any strong critics of the change.
- Don't choose early targets that are expensive. You want to be able to justify the investment in each project.
- Thoroughly analyze the potential pros and cons of your targets. If you don't succeed with an early goal, it can hurt your entire change initiative.
- Reward the people who help you meet the targets.

Step 7: Build on the Change

Kotter argues that many change projects fail because victory is declared too early. Real change runs deep. Quick wins are only the beginning of what needs to be done to achieve long-term change.

Launching one new product using a new system is great. But if you can launch 10 products, that means the new system is working. To reach that 10th success, you need to keep looking for improvements.

Each success provides an opportunity to build on what went right and identify what you can improve.

Guidelines:

- After every win, analyze what went right and what needs improving.
- Set goals to continue building on the momentum you've achieved.
- Learn about kaizen, or CQI, the idea of continuous improvement.
- Keep ideas fresh by bringing in new change agents and leaders for your change coalition.

Step 8: Anchor the Changes in Organizational Culture

Finally, to make any change stick, it should become part of the core of your organization. Your corporate culture often determines what gets done, so the values behind your vision must show in day-to-day work.

Make continuous efforts to ensure that the change is seen in every aspect of your organization. This will help give that change a solid place in your organization's culture.

It's also important that your company's leaders continue to support the change. This includes existing staff and new leaders who are brought in. If you lose the support of these people, you might end up back where you started.

Guidelines:

- Talk about progress every chance you get. Tell success stories about the change process, and repeat other stories that you hear.
- Include the change ideals and values when hiring and training new staff.
- Publicly recognize key members of your original change coalition, and make sure the rest of the staff – new and old – remember their contributions.
- Create plans to replace key leaders of change as they move on. This will help ensure that their legacy is not lost or forgotten.

KEY POINTS

You have to work hard to change an organization successfully. When you plan carefully and build the proper foundation, implementing change can be much easier, and you'll improve the chances of success. If you're too impatient, and if you expect too many results too soon, your plans for change are more likely to fail.

Create a sense of urgency, recruit powerful change leaders, build a vision and effectively communicate it, remove obstacles, create quick wins, and build on your momentum. If you do these things, you can help make the change part of your organizational culture. That's when you can declare a true victory. Then sit back and enjoy the change that you have envisioned so long ago.

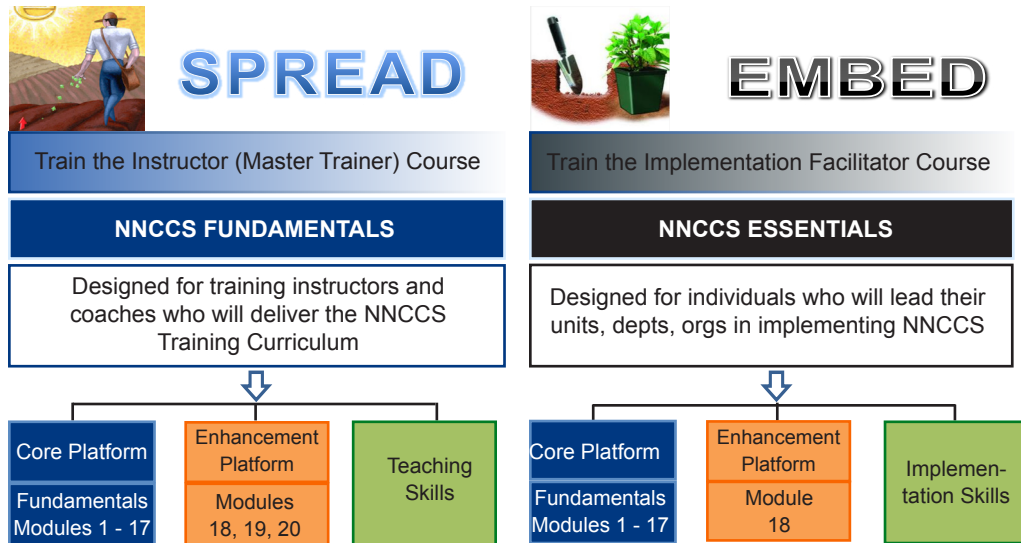


Figure 3.1 Spread and Embed Aspects of NNCCS process of Change (Borromeo, 2013)

DISCUSSION QUESTIONS

1. What are the types of change that the NNCCS development in each health care setting requires i.e, academe, community and practice?
2. How would you go about introducing and sustaining change?
3. What are the usual challenges or barriers that one would usually encounter in instituting change?

APPLICATION

- Planning for Change at the Institutional Level

REFERENCES

- Daft, R.L. (1995). *Organizational Theory and Design*. (5th Edition). MN: West Publishing Company.
- Rogers, E.M. (1982). *Diffusion of Innovations*. (3rd Edition). New York: The Free Press.
- Shortell, S.M. & Kaluzny, A.D. (2000). *Health Care Management: Organization Design and Behavior*. (4th Edition). Albany, NY: Delmar Thomson Learning.

BEGINNING NURSE'S ROLE ON CLIENT CARE

- Module 4 : Practicing Legal and Ethical Principles towards Personal and Professional Judgment
- Module 5.1: Nursing Care of Children
- Module 5.2: Care of Childbearing Women
- Module 5.3: Health Promotion
- Module 5.4: Teaching the Care of the Chronically Ill Adult Patient
- Module 5.5: Care of the Acutely Ill Adult Client
- Module 5.6: Rehabilitation Nursing of Adult and Older Persons
- Module 5.7: Care of Clients with Problems on Psychosocial Adaptation/Adjustment
- Module 5.8: Care of the Older Person
- Module 5.9: Levels of Clientele in Community Health Nursing Practice: Family, Specific Population Groups and Community
- Module 5.10: Emergency and Disaster Management
- Module 6: Documentation, Recording and Reporting System
- Module 7: Collaboration and Teamwork
- Module 8: Self-Mastery and Professional Growth

Practicing Legal and Ethical Principles Towards Personal and Professional Judgment

REMEDIOS L. FERNANDEZ, RN, PhD

INTRODUCTION

We are experiencing rapid technological advancement in many areas of society even in the health care system. More than ever nurses face legal, cultural and ethical dilemmas that need to be resolved. The increasing dependence on technology, longer life span and higher medical cost, coupled with increasing complexity, demand that nurses recognize situations with ethical, legal and moral implications.

Ethical issues have always affected the role of the professional nurse. The American Nurses Association defines nursing as “The diagnosis and treatment of human responses to health and illness”. The definition supports the claim that nurses must be actively involved in the decision-making process regarding ethical and legal concerns surrounding health care and human responses.

Although technical advances and diminished resources have been instrumental in raising numerous ethical questions and controversies in the country, nurses should not ignore the many routine situations that involve ethical and legal considerations. Some of the most common issues faced by nurses today include confidentiality, refusing care, end of life concerns, advance directives and genetics.

This module includes examples and suggestions in the teaching/learning strategy in the teaching of Responsibility 1 of the “Beginning Nurse’s Role on Client Care” with emphasis on the development of decision-making skills and/or reflective thinking and life-long learning.

MODULE OBJECTIVES

After going through the module, you, the master trainer, will be able to:

1. Recognize the ethico-legal considerations when providing safe and professional nursing care based on the performance indicators specified in the National Nursing Core competency Standards (NNCCS).
2. Select appropriately learning activities that will enable the learners to implement the NNCCS on the legal/ethical principles in making personal and professional judgment.
3. Apply guidelines, frameworks and laws/ code of ethics and relevant frameworks in the care of clients.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills on the legal/ethical principles in making personal and professional judgment.
5. Utilize appropriate methods and tools in assessing the achievement of specified competencies of

- the NNCCS in applying legal and ethical principles in the care of clients.
6. State policies and actions necessary to facilitate implementation of the NNCCS on practicing legal and ethical principles towards personal and professional judgment.

CRITICAL THINKING IN INQUIRY-BASED APPROACH TO NNCCS

Development of critical thinking skills demands varied teaching-learning methodologies. Varied references are suggested at the end of this module which can be of help to the trainers.

For further reading on critical thinking in Inquiry-based Approach to NNCCS, you are advised to read A. Borromeo's explanation in Module 5.4 - Teaching the Care of the Chronically Ill Adult Patient. Critical Thinking is an effective strategy that uses cases as you will see in this module.

LEGAL PRINCIPLES AND THE CODE OF ETHICS IN MAKING PERSONAL AND PROFESSIONAL JUDGMENT

Safe and quality human care anchored on the ethico-legal requisites of nursing practice defines the discipline of the Art and Science of the profession (Maglaya, 2013). One of the primary functions of the Board of Nursing is to protect the public from unqualified persons to practice the profession of nursing or for practitioners to pose potential harm to a patient through unsafe practices. Through such mechanisms as, but not limited to, the Philippine Nursing Act of 2002, the NNCCS, The Code of Ethics of 2004, and The Standards for Safe Nursing Practice, the Board of Nursing is able to ensure a degree of public safety where nursing care is involved.

When a nurse violates the Nursing Practice Act, the Standards of Care or the Code of Ethics, the Board of Nursing has the authority to discipline the nurse who is not acting in a professional manner. It is in this regard that it is incumbent upon every nurse to develop critical thinking skills in the performance of nursing functions and responsibilities in the light of ethical, legal and moral mandates of the profession.

Table 4.1	NNCCS on Legal Principles and the Code of Ethics in Making Personal and Professional Judgment	
Responsibility 4	Practices in Accordance with Legal Principles and the Code of Ethics in Making Personal and Professional Judgment	
COMPETENCIES		PERFORMANCE INDICATORS
1.1. Adheres to ethico-legal considerations when providing safe, quality and professional nursing care.		<ol style="list-style-type: none"> 1. Specifies the ethico-legal bases for providing safe, quality and professional nursing care. 2. Makes professional decisions within ethical and legal parameters. 3. Use institutional, community and scholarly resources to address ethical and legal concerns in nursing practice. 4. Applies legal and ethical principles to advocate for human and societal well-being and preferences. 5. Clarifies unclear or questionable orders, decisions or action made by other inter-professional health care team members.

COMPETENCIES	PERFORMANCE INDICATORS
1.2. Applies ethical reasoning and decision making process to address situations of ethical distress and moral dilemma.	1. Executes the ethical reasoning process used in arriving at decisions to address situations of ethical distress and moral dilemma.
1.3. Adheres to established norms of conduct based on the Philippine Nursing Law and other legal, regulatory and institutional requirements relevant to safe nursing practice.	<ol style="list-style-type: none"> 1. Articulates clearly the scope and standards of nursing practice. 2. Shows evidence of legal requirements in the practice nursing , (i.e. current professional license). 3. Acts in accordance with the terms of contract of employment and other rules and regulations. 4. Articulates the vision, mission and values of the institution where one belongs.
1.4. Protects clients rights based on "Patient's Bill of Rights and Obligations".	<ol style="list-style-type: none"> 1. Advocates for client's rights. 2. Evaluates client's understanding of health care rights. 3. Implements strategies/interventions to protect client's rights guided by the "Patient's Bill of Rights and Obligations". 4. Ensures that the client acknowledges that he/she is accountable for his obligations.
1.5. Implements strategies/policies related to informed consent as it applies in multiple contexts.	<ol style="list-style-type: none"> 1. Demonstrates an understanding of informed consent as it applies in multiple contexts. 2. Validates with client if informed consent is clear, complete, taken wholly voluntarily, and signed by legally competent representative. 3. Obtains the client's signature on the informed consent taking into consideration ethico-legal principles. 4. Acts as a witness to the signing of the informed consent. 5. Questions the informed consent process when the requirements are not met.

1. NNCCS ON ETHICO-LEGAL CONSIDERATIONS WHEN PROVIDING SAFE, AND PROFESSIONAL NURSING CARE

To effectively teach this topic, it is required that you must have a good grasp and understanding of the following:

1. RA 9173 otherwise known as the Philippine Nursing Act of 2002
2. Board of Nursing Resolution No. 220 S. 2004 Implementing Rules and Regulations of RA 9173
3. ICN Code of Ethics
4. Legal/Aspects in the Practice of Nursing
5. The Bill of Rights of Patients

You should prepare for an interactive class discussion and be ready with an outline of key points for projection using computer or overhead projector (OHP) with ready questions to involve students in active participation. In the discussion of Patient's Bill of Rights and legal aspects in the practice of nursing be sure to utilize group

learning activities using actual case studies involving ethico-legal cases commonly encountered by nurses.

In teaching the above topic, you must use effective presentation skills. Effective presentation skills are just as important as careful planning. No matter what setting you are in, when delivering information, use questioning techniques. Well-designed visual aid such as flip charts, transparencies, and videotapes make your presentation more effective.

When possible, you should ask questions during a presentation. You can use a variety of questioning techniques to help students develop problem solving skills, check their understanding and engage them in learning.

Sample Questions to be asked in discussing the code of Ethics for Nurse are as follows but not limited to:

1. Class, why do you think it is important to have a Code of Ethics?
2. Stated in the Preamble are assumptions, principles and precepts about health and the responsibilities of the nurse in the practice of the profession. What does our constitution say about health? What is the implication of this to nursing?

2. NNCCS ON APPLYING ETHICAL REASONING AND DECISION-MAKING PROCESS

The Ethical Decision – Making Algorithm found on page 236 of Critical Thinking in Nursing: Cognitive Skill Workbook by Lipe and Beasley (2004) may be used in confronting ethical and moral dilemma. You may also access this model through the web resource found in the reference list of this module.

1. Introduce the model step by step and discuss each phase:

Decision making starts with an assessment phase. (Use a case study for discussion using the suggested model).

1.1. Assessment

- The decision maker must gather all appropriate information to determine those facts that have the most bearing on the situation.

1.2. Analysis

- Determine the values that are in conflict
- Generate multiple alternatives which should be analyzed and ranked based on correctness.

1.3. Plan

- Choose the best option or combination of options that provide for priority needs and achieve the desired outcome

1.4. Implementation

- Follow up through the chain of command is essential

1.5. Evaluation

- There are other ethical decision-making models available that you can use and practice with students.

Web Resources

Bioethical Decision-Making Model can be found in the following sources:

National Open University of Nigeria. (2008). Nursing Ethics and Jurisprudence. *In National Open University of Nigeria*. Available at http://www.nou.edu.ng/NOUN_OCL/pdf/pdf2/NSS%20320%202.pdf.

Thompson, J.B. (2004). A Human Rights Framework for Midwifery Care. *Journal of Midwifery and Women's Health*, 49, 175-181. Available at <http://www.azdhs.net/als/midwife/documents/reports/resources/thompson-et-al.pdf>.

3. NNCCS ON ESTABLISHED NORMS OF CONDUCT BASED ON LEGAL REGULATORY AND INSTITUTIONAL REQUIREMENTS

In meeting this particular competency you can use the vision/mission and values of a particular institution(s) as a starting point. Discussion can revolve around the services that are offered in order to meet the vision/mission of the institution. In analyzing the values, draw ideas from the students as to practices both in the hospital and school that nurture the development and support the identified values. The mission/vision and values in the Philippine Nursing Roadmap 2030 can be introduced at this time to give meaning and importance why the nurse must be cognizant of the mission/vision and values of the institution be it a school or university and/or hospital.

Very important in the development of the above competency is a thorough discussion of the Philippine Nursing Law, the scope of nursing practice as defined and the requirements and other provisions thereof.

Because of rampant practice of contractualization and job order practices, you should discuss thoroughly contract of employment and other relevant rules and regulations as in the Magna Carta for Public Health Workers, for example. Other topics to be included in your presentation should include the following:

1. WHO Patient Safety Curriculum Guide (*See Annex C*)
2. BON Resolution No. 110, S. 1998 on the Adoption of a Guide to Evaluate Compliance with the Standards of Safe Nursing Practice. (*See Annex D*)
3. The Philippine Nursing Law
4. RA 9262 Violence Against Women and Children
5. RA 7877 Anti-Sexual Harassment at Work (*See Annex E*)
6. Occupational Safety and Health Guidelines
7. Law on Blood-Borne Diseases
8. Advance Directive Guidelines
9. Organ Donation Act
10. Bill of Rights under the Philippine Constitution of 1987

4. NNCCS ON PROTECTING CLIENTS RIGHTS BASED ON PATIENTS BILL OF RIGHTS AND OBLIGATIONS

In discussing the Patient's Bill of Rights, it is best to start the topic with the Bill of Rights as provided by the Philippine Constitution of 1987. The Philippines has not adopted a Patient's Bill of Rights but the United States has one and is a very good reference to use in this aspect. The following books are suggested for this:

1. Legal, Ethical and Political Issues in Nursing , Tonia Dandy Aiken F. A. Davis Co., 2nd edition 2004
2. Any Fundamentals of Nursing Textbook (Chapter on Legal and Ethical Issues on Nursing)
3. American Hospital Association Patient Care Partnership
4. Venzon, Lydia, Professional Nursing in the Philippines, 2010
5. Patient's Rights (PhilHealth)
6. Philippine Medical Association Patient's Rights and Obligations (*See Annex F*)

5. NNCCS ON STRATEGIES/POLICIES RELATED TO INFORMED CONSENT/ASCENT AS IT APPLIES IN MULTIPLE CONTEXT

The roles and responsibilities of the patient and the health care provider have changed through the years and in different cultures. In some cultures, decisions regarding "what is best" for the patient have been relegated to doctors who are believed to know what is best for the patient. Recent developments however, accept the rights of patients in making health care decisions. The following legal terms should be discussed

clearly:

- 5.1. ethical and legal elements of autonomy
- 5.2. maleficence
- 5.3. beneficence
- 5.4. ethical and legal elements of informed consent
- 5.5. roles and responsibilities of the nurse in informed consent

One of the effective teaching strategies that you can use in teaching this competency is the use of case studies. A case study is a learning activity that uses realistic scenarios focusing on a specific issue, topic or problem. Students typically read, study and react to the case study individually or in small groups. It is best that you use case studies involving ethico-legal cases that actually happened in the respective hospitals and community that you are working and/or affiliated with. The purpose of this part of the module is the utilization of critical-thinking skills on the part of the trainees and/or students using relevant case study.

The much publicized Terri Schiavo case, in addition to the following case study, maybe presented to the class for discussion (Burkhardt & Nathaniel, Ethics Issues in Contemporary Nursing, 3rd edition pp. 282-283).

Case Presentation

Case Study:

A number of ethical issues regarding end of life care decision usually occurs in the absence of advanced directives and/or living will. Advanced directives and living will is not a common practice in the Philippines as in the following case:

AF, 63 years old, was rushed to the Philippine Heart Center because of chest pain at 7: 00 PM. He was suspected to have myocardial infarction and was given morphine for the pain. From the emergency room (ER) he was finally moved to a regular room at eleven o'clock in the evening.

Two years prior to his admission in the Heart Center, he was operated for prostatectomy because of Prostrate Cancer. His bone scan showed that cancer has metastasized to his bone. Because his Prostate-Specific Antigen (PSA) was abnormally high, his medication for some time included testosterone. His wife talked to the children that if anything happens for the worst, she would opt for a Do Not Resuscitate (DNR). Six weeks after the operation, linear accelerator was prescribed for six week. As a side effect, he had low hemoglobin that often necessitates blood transfusion. He was in and out of the hospital several times for this reason and was just discharged from the hospital a day before when he complained of chest pain thus bringing him to the Philippine Heart Center.

The evening after his admission was uneventful when at 6:00 AM, he appeared to be pale and looked alarming. The wife called all the children to come to the hospital at once. Code blue was called, cardiopulmonary resuscitation (CPR) was initiated and intubation was done to no avail.

Questions:

1. What ethical issues have you identified in the above case?
2. What values and beliefs about the case have you identified?
3. What could have been different if requirement of DNR was consummated?
4. What are the current hospital practices for DNR?

In conclusion, nursing is a profession that deals with the most personal and private aspects of people's lives. As nursing practitioners, we are faced with ethical, legal and moral issues that affect the profession and more so with human life as well. We take part in health care decision-making groups, in the community down to the smallest barangay; we participate in policy-making bodies in national task forces, committees and organizational boards. It is imperative therefore that early in the life of a nurse as a student, she is aware of the ethical, legal and moral implications of her decisions. These decisions are at the very heart of our beliefs regarding the patient as an individual person with rights and privileges. This day to day reality compels every nurse to cautiously deliberate every decision involving client care.

APPLICATION

Legal principles and code of ethics are embedded in all aspects of nursing care. Knowledge about them helps the nurse in one's decision-making skills. They guide the nurse in one's personal and professional conduct in and outside the workplace. Observing legal and ethical principles in the practice of nursing will influence quality of nursing care rendered, thus contributing to patient's satisfaction about nurses and nursing care.

SELF-ASSESSMENT QUESTIONS (SAQ)

1. Name important ethico-legal considerations when providing safe and professional nursing care.
2. How can the ethical principles best be taught to enhance their application in making personal and professional judgment as a nurse?
3. What laws/guidelines/code of ethics are important and applicable in providing safe, quality nursing care.
4. What teaching-learning strategies can best be used for learners to apply ethical-decision making skills?
5. Cite an evaluation tool that you can use in order to determine development of critical thinking skills in the care of client.

ANSWERS TO SELF-ASSESSMENT QUESTIONS (ASAQ)

1. Ethico legal considerations in providing safe and professional nursing care.
 - 1.1. R. A. 9173 otherwise know as the Philippine Nursing Act of 2002
 - 1.2. Board of Nursing Resolution No. 220, S. 2004 Adopting the code of Ethics for Nurses in the Philippines
 - 1.3. The Bill of Rights of Patients
 - 1.4. Legal Aspects in the Practice of Nursing
2. Ethical principles in the practice of nursing can best be taught utilizing:
 - 2.1. Group learning activities
 - 2.2. Interactive class discussion
 - 2.3. Use of case studies
3. Laws/guidelines/code of ethics that are important and applicable in providing safe and quality nursing care?
 - 3.1. WHO Patient Safety Curriculum Guide
 - 3.2. Available Standards of Nursing Practice in the Philippines
 - 3.3. Nursing Board Resolution # 110 S. 1998. A Guide to Evaluate Compliance with the Standards for Safe Nursing Practice
 - 3.4. The 2012 National Nursing Core Competency Standards

4. Teaching-learning Strategies in applying ethical decision-making skills
Utilize ethical decision-making models either by Lipe & Beasley, 2004 or Thompson and Thompson Model and Cassells and Redman Model (Berman and Synder, Fundamentals of Nursing, 8-9th edition p. 89)
5. Evaluation tool that can be used in order to determine development of critical thinking skills in the care of patients.

Give the case presentation below as an exercise let student submit their answer in a blank sheet of paper.

Case Presentation

Case Study:

You are a nurse trainee in a Reproductive Health clinic where a minilaparotomy training course is taking place. The participants receiving training included a physician and his nurse assistant who work in a remote hospital in the province. Also present were the trainer and a scrub nurse who work in the operating room (OR) of the clinic.

MR was a 35 year-old woman with six living children whose last delivery was 12 months ago. Consent for the minilaparotomy was given and signed by both the husband and wife who stated they wanted the operation conducted by a physician-nurse team who was being trained by the experienced trainer nurse team.

The client came to the clinic around 8:30 AM and was asked to pass urine. which she did. She was scheduled as the last case for the morning and was taken to the OR at about 11:30 of the same day.

The physician carried out a vaginal examination and after prepping the cervix and vagina with antiseptic solution the uterine elevator was inserted. Although the opening of the abdomen was successful and uneventful, the uterine fundus could not be visualized or identified because of full bladder.

Questions:

1. What was the problem?
2. Who failed in her/his duty? The circulating nurse? The assistant nurse? The operating physician or the client?
3. How can this problem be prevented in the future?
4. Was it ethical/legal to have the minilaporotomy done on this client?

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Nursing Care of Children

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INTRODUCTION

Nurses play a central role in the care of the child. Important to our practice is the provision of quality nursing care that is safe and interdisciplinary. The goal of this module is to enhance the master trainer's capability to ask the right questions, evaluate answers, and think from a multidisciplinary perspective in any clinical setting. Trainers must grasp the value of applying the core concepts in the context of the health care system in the Philippines especially for the care of children.

This module presents strategies, key concepts, and case exemplars that you as a Master Trainer (MT) can utilize in order to facilitate learning and achievement of appropriate competencies of teachers and students alike.

This instructional design seeks to explain the use of the National Nursing Core Competency Standards as applied in the care of children. Statements of responsibilities, competencies, and performance indicators were derived from the National Nursing Core Competency Standards (NNCCS, 2012). Corresponding numbers are included for ease in locating statements from the mother document. The structure for the development of the instructional design follows the competency-based framework. Thus, the instructional functions for the Teaching Skills intended for you, as Master Trainer, serve as guiding framework, and for the Implementing Skills, the instructional activities are used. For this project you must learn both teaching and implementing skills.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the care of children which should be enhanced in a learner.
2. Select learning activities that will enable the learners to implement the NNCCS on the care of children.
3. Apply nursing practice tools, guidelines and/or frameworks, and describe teaching-learning activities to guide trainees through critical thinking, clinical reasoning and decision-making in the care of children.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the care of children.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of children will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on the care of children.

Table 5.1.1	NNCCS on the Utilization of the Nursing Process in the Care of Children	
Responsibility 2	Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS	
2.1. Ensures a working relationship with the client and /or support system based on trust, respect and shared decision making.		
2.1.1. Establishes rapport with the client and/or support system ensuring adequate information about each other as partners in a working relationship.	<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner. 2. Addresses with respect and trust the client-partner's concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship. 	
2.1.2. Formulates with the client-partner the objectives and expectations of the nurse-client working relationship	<ol style="list-style-type: none"> 1. Explains nature and purpose of client-partner working relationship 2. Prepares with the client a list of objectives and expectations 	
2.1.3. Maintains shared decision making and client's participatory capability throughout the nurse-client working relationship.	<ol style="list-style-type: none"> 1. Assesses client's participatory capability 2. Determines strategies to ensure shared decision-making and client participation throughout the working relationship. 3. Carries out appropriate strategies to ensure continued participation of client. 	
2.1.4. Enhances client-partner's readiness for taking over/being in-charge when objectives and expectations of the working relationship have been achieved.	<ol style="list-style-type: none"> 1. Assesses client-partner's readiness for taking charge of the condition or situation 2. Uses strategies to prepare the client for being in-charge/ taking over when objectives/ expectations have been achieved or when the situation necessitates termination of the nurse-client relationship. 3. Supports client as he/she takes charge of maintaining health or managing the condition/situation e.g. taking over self-care or implementation of prevention & control measures). 	
2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/ competence.		
2.2.1. Develops the data gathering plan with the client, specifying methods and tools.	<ol style="list-style-type: none"> 1. Uses strategies to develop/enhance the skills of the client to participate in developing/specifying the methods and tools for data gathering 	

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.2.2. Obtains assessment data utilizing appropriate data gathering methods/ tools guided by type of client and work setting requisites.</p>	<ol style="list-style-type: none"> 1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by work-setting requisites. <ol style="list-style-type: none"> 2.1. Individual as client – obtains assessment data through nursing history taking, physical/ developmental/psychosocial assessment and other assessment protocols, laboratory and diagnostic procedures. 2.2. Family/population group/community as a client – obtains assessment data through family health history, assessment of the home and environment, records review and other assessment protocols such as laboratory and diagnostic procedures/reports, epidemiologic and social investigations and assessment of client competence, risk factor assessment, screening of vulnerable risk groups, and assessment of issues of vulnerability (health risks, limited control, powerlessness, disenfranchisement, victimization and disadvantaged status).
<p>2.2.3. Analyzes data gathered.</p>	<ol style="list-style-type: none"> 1. Groups assessment data by condition or category using appropriate assessment framework by type of client. 2. Relates data with each other to determine patterns recurring themes or processes. 3. Compares data, patterns, recurring themes with norms/ standards, clinical/health indicators or research findings using algorithms and standard protocols.
<p>2.2.4. Synthesizes data gathered:</p>	<ol style="list-style-type: none"> 1. Interprets data gathered. 2. Draws inferences from data gathered by specifying the nature, magnitude/extent and sources of/reasons for the alterations (e.g. pathophysiology, psychopathology), gaps, deficiencies and/or barriers to opportunities for change/ improvement, health promotion/wellness, disease prevention, problem/disease management, rehabilitation.

COMPETENCIES	PERFORMANCE INDICATORS
2.2.5. Specifies client's status/ conditions/ problems to be addressed identifying reasons (etiology) for the existence of the condition or problem.	<ol style="list-style-type: none"> 1. Identifies the factors associated with the condition/s or reasons for the existence of the problem. 2. States nursing diagnosis/nursing problem. 3. Seeks concurrence with the client regarding problems identified.
2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities.	<ol style="list-style-type: none"> 1. Sets priorities among a list of conditions or problems. 2. Specifies goals, objectives and expected outcomes of care maximizing clients' competencies. 3. Selects appropriate interventions/strategies enhancing opportunities for health promotion, wellness response, prevention of problems/ complications and eliminating gaps/deficiencies. 4. Uses methods and tools to maximize client/family participation in planning appropriate interventions/ strategies. 5. Develops with the client an evaluation plan specifying criteria/indicators, methods and tools. 6. Collaborates with the client and inter-professional health care team in developing plan of care. 7. Modifies plan of care according to one's judgment, skill or knowledge as the client's needs change.

TOPIC OUTLINE

1. Enhancing competencies in the care of children
2. Recommended topics and instructional activities to facilitate learning in the care of children
3. Evaluation methods to measure learning in the care of children

MODULE CONTENT

1. ENHANCING COMPETENCIES IN THE CARE OF CHILDREN

The core competency emphasized in this module is that of Responsibility 2 of the NNCCS Module, which is to utilize the nursing process in the care of the Filipino child. The care of the child is part of the scope of practice of nurses as mandated in the Nursing Law (R.A. No. 9173 Article VI Sec. 28), wherein the type of clientele nurses could give care to includes "infancy, childhood, toddler, pre-school, school-age, adolescence."

You, the Master Trainer, should acknowledge several challenges which deter good appreciation of the care of children. These challenges need to be considered in teaching and providing appropriate learning opportunities. In fact, there is very little locally-produced material available to fully describe the uniqueness of the Filipino child. Since every child's response is hinged on one's family background, upbringing,

environment, and culture, the nurse needs to be creative in acknowledging such uniqueness that is not usually found in books.

You need to emphasize the role of the family in the care of children, particularly in the conduct of the nursing process. The working relationship goes beyond building rapport with the child but also with the family. Once the trust and respect with the family is gained, then the nurse would be able to holistically assess the patient and formulate a plan that would be appropriate for the environment the child is in.

You need to keep in mind the following considerations in creating a learning environment to trainees: (1) situating child care in the Philippine health care system; (2) understanding anatomic, physiologic, psychological differences and responses of children; (3) utilization of the Family-Centered Care model.

Situating Child Care in the Philippine Health Care System

The nurse needs to understand the psychosocial, environmental, and cultural situation surrounding the health condition and responses of the child. The acknowledgment of such ensures that the nursing care plan done by the nurse is realistic and is more workable for the parents of the child. This will ensure a working relationship with the child's support system and better compliance to health care.

In training subsequent trainers, you may refer to the National Objectives for Health (2005-2010) for the overview of the health care delivery system of the country. One of its highlights is the status of maternal and child health in the Philippines. The material is easily downloadable at the Department of Health (DOH) website. US-AID (www.usaid.gov/pop_health) also has a good situational analysis of newborn health in the Philippines and may serve as a worthwhile resource.

Web Resources

Written below are good portals for updated resources regarding child health situation and programs in the Philippines and in the World Health Organization:

<http://www.census.gov.ph> (search for maternal and child health for latest updates)
<http://www.countdown2015mnch.org/country-profiles/philippines>
<http://www.doh.gov.ph/sites/default/files/MNCHN%20MOP%20May%204%20with%20ECJ%20sig.pdf>
http://www.wpro.who.int/philippines/areas/maternal_child_nutrition/en/
http://www.who.int/topics/child_health/en/

In addition to the epidemiological data, it is also important that you are well-versed with the current programs of the Department of Health. Such programs address health disparities particularly with Maternal and Child Health Care. These are as follows:

1. Infant and Young Child Feeding
2. Milk Code Implementation
3. Newborn Screening
4. Malnutrition Prevention and Control
5. Expanded Program on Immunization
6. Integrated Management of Childhood Illnesses

You should also be mindful that these efforts by the government are hinged on the three of the eight

Millennium Development Goals (MDGs). These are:

- (4) Reduce Child Mortality
- (5) Improve Maternal Health
- (6) Combat HIV/ AIDS, Malaria

Web Resource

The details about the MDGs may be read from the United Nations website:
<http://www.un.org/millenniumgoals/>

Understanding anatomic, physiologic, psychological differences and responses of children

The phrase, “children are not little adults” is commonly quoted from books and by many professors. This phrase is indeed true because the responses of children to health and illness varies. Their cognitive levels vary per age group as they continue to accommodate and assimilate new stimuli during growth and development.

Some children manifest fast rates of growth, while the others are slow. The rate of growth depends on the amount of nutrition, psychosocial stimuli, and familial or hereditary differences. These variations must be taught as it is crucial in the care of children. You should emphasize that trainers and learners alike need to identify activities that fit the uniqueness of each age period of children. For example, communication with preschoolers and school-age children must be different. Preschoolers respond based on previous experiences while school-age children tend to be more objective in their thinking and reasoning.

Family-Centered Care (FCC)

“Family-Centered Care (FCC)” is a model for health care delivery to children and their families. It assures the health and well-being of children and their families through a respectful family-professional partnership (Arango, 2011). FCC honors the cultures and traditions, as well as the strengths and expertise within the relationship. The four (4) components of family-professional partnership that are invoked in the FCC include:

1. shared decision-making
2. willingness to negotiate
3. respect and trust by partners
4. open communication.

One of the key attributes of FCC is that it acknowledges the family as a significant influence in a child's life. With this, the health care worker should build on the family's strengths.

Nurses should recognize the value of properly supporting the child by providing appropriate access to the family in actual care and in health care planning. You should be mindful of integrating these values in the care of children.

2. RECOMMENDED TOPICS AND INSTRUCTIONAL EXEMPLARS

The following is a recommended outline that you can utilize in order to facilitate learning in the care of children. It can be noted that the outline begins by presenting the situation of child care, before specifying nursing care activities such as assessment and formulation of the care plan. This addresses the key challenges and considerations about nursing care of children that have been earlier mentioned.

The outline serves as a general framework, and you can be more specific by highlighting a particular disease after depicting the health care system context. For example, you are interested in presenting a case of Pneumonia in a community, you can present first the epidemiological data as a background on prevalence, home care practices, etc. After this, provide specifics as to the clinical presentation and available treatments for such a disease.

Recommended Topics (General Guide)

1. Situationer: Child Care in the Philippine Health System
 - 1.1. Epidemiologic Data: Infant and Young Child Mortality and Morbidity Status
 - 1.2. Related health programs of the WHO, UNICEF, and DOH
2. The infant and young child as a patient
 - 2.1. Children are not little adults: Unique features of pediatric patients
 - 2.2. Principles of growth and development
3. Nursing care of the infant and young child
 - 3.1. Pediatric health assessment
 - 3.2. Identification of appropriate nursing diagnoses
 - 3.3. Implementing care based on the developmental status of the patient
 - 3.4. Family-centered Care, Culturally- sensitive care

Instructional Exemplars

As Nursing is a professional discipline, the preparation for it has to go beyond the classroom, more so when preparing trainees for nursing care of children. You should envision a nurse who is not only skilled and knowledgeable but also one who appreciates and values challenges in the care of children.

The process by which you can craft instructional activities depends on the outcome he/she intends for the trainee. Learning should focus on essential knowledge, skills, and attitudes (Gaberson & Oerman, 1999, 2010). These essentials refer to three main domains such as the cognitive, affective, and psychomotor domains. You should be able to design activities which would hone each of the domains and eventually facilitate the development of all three in an integrated manner.

Crucial to the generation of knowledge is to facilitate problem solving capabilities, critical thinking, and decision-making on the part of the trainee. Important to the development of the skill is the honing of the trainee's interpersonal and organizational skills particularly for a patient with varied behavioral responses like toddlers or preschoolers. The trainee has to be conditioned to have proper attitude, patience, and to demonstrate cultural appropriateness when teaching about care of children and their families.

There are four (4) strategies that you can emphasize and demonstrate to the trainee in order to facilitate the appropriate knowledge, skills, and attitude. These strategies are not new, but have been proven to be effective in inculcating the proper foundations for clinical learning among students or even professionals. These are:

1. Lectures and use of the laboratories;
2. Self-directed learning activities;
3. Case analyses;
4. Actual patient care and clinical teaching.

These are further explained in the latter part of this section.

The identification of the goals of learning is crucial to the selection of the appropriate teaching strategy. The higher the goals of learning (analysis, evaluation or creation), the more complex strategies of questioning,

reflection and inquiry-based techniques should be used. However, if the goal of learning is just to know or remember information, strategies such as lectures or independent reading or computer search may be used.

Lectures and Use of the Laboratories

Lectures have been the most common form used to transmit knowledge. This has been the easiest, yet in recent years, acknowledged to be lacking in terms of generating appropriate knowledge, skills, and attitude. In teaching nursing care of children, lectures should be more lively and interactive and depict the varied character of children. The trainer can use recent instructional media to make lectures more meaningful. You, the MT, can utilize interactive slides, photographs, films, or videos to facilitate interest, and promote better discussion.

The slide example below presents an anecdote of a conversation that transpired between a mother and a preschooler. You may instruct the trainee to use these examples to promote discussion about psychosocial development at this age group.

Anecdote

Lhen-lhen is 5 years old. One day Lhen-lhen was sitting and watching her mother do the dishes at the kitchen sink. She suddenly noticed that her mother had several strands of white hair sticking out of her previously shiny black hair.

She looked at her mother and inquisitively asked, “Why are some of your hair white, Inay?”

Her mother replied, “well, everytime that you do something naughty, one of my hair turns white.

Lhen-lhen thought about this revelation for awhile and then said, “Inay, how come all of Lola’s hair are white?”

Laboratories may also be used primarily for skill development. You may instruct trainees to use such for psychomotor demonstration and for return demonstration. The usual skills done for pediatric patients can become challenging for both students and nurses alike. For example, physical assessment is different among pediatric patients, with due emphasis on the uniqueness of responses from each age group. For example, assessment of the eyes, nose, and throat is advised to be the last until toddler age group, since it is very irritating and considered as invasive for young children. It would be best to use simulated patients in demonstrating physical examination.

There are also other basic procedures that should be done more carefully among children. Some of these procedures include insertion of oral or nasogastric tubes, suctioning, catheter insertions, etc. It would be best for any teachers to make a validated skill checklist before demonstration. Whaley and Wong’s (2007) *Clinical Manual of Pediatric Nursing* is one of the many books which can be used as a guide to several procedures in the care of children.

Self-directed Learning Activities

Self-directed learning opens avenues for learners to discover the uniqueness of children. The use of self-directed learning can be explored by the trainees if the topic is about growth and development, behavioural responses of children, or family dynamics. For example, participants may be asked to observe a child for one hour. That should be enough for the learner to catalogue motor activities, behavior, and language of

a child. The participant may then bring it to class for analysis and discussion. In order to maximize this strategy, guide questions as well as recommended resources should be given to properly direct the trainee.

Additional Resources

The following books are good references you may recommend to trainees:

Hockenberry, M.J. (2010). Wong's Nursing Care of Infants and Children.
 Hockenberry MJ & Wilson, D (2012). Wong's Essentials of Pediatric Nursing, 9th Ed.
 McKinney, E.S. (2012). Maternal-Child Nursing
 Milner, J. (2011). Working with Children and Teenagers using Solution- focused Approaches.
 Perry, S.E., Wilson, D., Hockenberry, M.J., & Lowdermilk, D.L.(2009). Maternal Child Nursing Care.
 Pillitteri, A. (2013). Maternal and Child Health Nursing and Childrearing Family, 7th Ed.
 Smith, L. (2009). Child and Family- centered Healthcare.
 Wong, D.L. & Whaley, L.F.(1997). Whaley & Wong's Essentials of Pediatric Nursing, 5th Ed.

Case Analysis

The analysis of a scenario is one good way to facilitate higher level of learning. This strategy enhances problem solving skills, decision-making, and critical thinking. This is one of the best avenues to also evaluate the capacity of learners prior to the actual patient care.

Cases may be crafted or may be based on an actual case. You need to be mindful of ethical considerations when using data from an actual case. Cases for discussion may be with varying levels of complexity, based on the level of learner and the goal of learning. Care should be taken in formulating a case, as an ill-structured problem leaves learners more confused than encouraged. You should always have the end in mind while crafting the case and then work backwards in order to build an appropriate scenario.

In creating a case for nursing care of children, consider these features:

1. the child's health condition
2. the mother's condition
3. the family situation, environment and culture

Consider the following example:

Case Scenario

The Case of BG and Bitoy:

BG is an 18-year-old adolescent who brings her 24 month old child with the chief complaint of "hindi mawala-wala ang ubo at sipon." She and her child live with her partner, who is working as a tricycle driver in town. The family lives in a far flung area in Antique. Bitoy, her child, seemed to be sleepy, breathing fast and deep, and has a very high fever. Upon further assessment you learned that Bitoy weighs 9 kg, who is low weight for his age.

The above example shows the condition of the mother, who is an adolescent, the signs and symptoms presented by the child, and the family situation. You should take careful steps in providing the focal point, or problem of the entire case by asking questions to guide the discussion.

In the above scenario, you may choose to focus on any of the three: the challenges of an adolescent

mother, the illness of Bitoy, or the poor health care access of the family.

Example of questions which can draw out interest are as follows:

1. The mother is a teen-ager, what are the health needs and demands of an adolescent mother?
2. The child seem to be unwell, what are the presenting signs and symptoms which should prompt immediate care?
3. The family has poor access to health care, what are the current government programs to support child growth and development?

After drawing out the learners' perceptions of the situation, you can then provide more guide questions to open up the discussion, and provide transition to the key concepts the trainees/ implementers should know. Consider the flow of questions below. The following presents a progressive list of queries which ought to guide trainees and learners alike. Notice also that there are crucial topics which are being derived by every question. This implies that you have to be clear about the purpose of each question that would be asked to the trainee.

Guide Questions:

1. Cases like BG and Bitoy seem to be common especially in remote areas of the country. What is the actual status of infant and young child health in the Philippines? Present the evidence.

In this question, you, the MT can either:

- Present infant and young child morbidity and mortality status
- Give trainees or implementers the assignment to search out the latest statistics themselves, for further discussion the following day.

2. Several programs are instituted by the Department of Health, UNICEF, and WHO in order to address cases similar to Bitoy. What are these programs?

The program that you may choose to highlight for this scenario is the Infant and Young Child Feeding and the Integrated Management of Childhood Illnesses. There are specific trainings implemented by the Department of Health to those who would like to become trainees on these. You are just supposed to provide the introduction.

3. The aforementioned programs were implemented in response to the Maternal and Child Health and Nutrition Framework. What is this? What are the 3 important Millennium Development Goals on which this framework is hinged?

The Millenium Development Goals (MDGs) being referred here as earlier discussed are as follows:

- (4) Reduce Child Mortality
- (5) Improve Maternal Health
- (6) Combat HIV/ AIDS, Malaria

4. BG and her family come from a far-flung place in Antique. As the nurse who is supposed to provide care, you need to be aware of the cultural underpinnings of the family's health behaviour. What are the child-rearing practices employed by Bitoy's family?

You can then make an assignment or open the discussion:. "From what provinces does the trainee come from? Can you share a little about the child-rearing practices in your region?" You can also back it up with several readings regarding child-rearing practices in the Philippines.

In the course of the training, you may also build on the first scenario and add a few more details.

For example, should you choose to build on the case of the child, the signs and symptoms may be presented as shown in the following box:

Case Scenario

The Case of BG and Bitoy:

You continued to assess Bitoy and learned that he had been coughing for 3 days, and the trouble in breathing has been persistent, causing him to be very weak. You proceeded with counting Bitoy's breathing and found it to be 55 breaths per minute.

Using the additional information above, you can then add further guide questions as shown below.

Guide Questions:

5. Let us review the important parameters in assessing pediatric patients in order for us to properly evaluate Bitoy's condition.

You may discuss these important parameters or make these as an assignment to participants. The following topics should be discussed:

1. Principles and techniques that should guide physical assessment of children
2. Differences in taking history between children and adults
3. Components of well-child assessments at various ages
4. Deviations from normal

The resources provided in the previous sections present these parameters at good length.

6. Acknowledging the important principles, what are the things that we should continue to assess on Bitoy in order to further examine his condition?

The participants should identify salient parameters in a toddler such as activity tolerance, development, immunization, and nutrition. As the participants identify each of these components, you can enhance learning by providing further details about each of these in the toddler.

7. What are the significant findings we should identify about Bitoy's condition?

You should draw these out from the participants. In this case, significant findings include persistent coughing, fast breathing, chest indrawing, and mild inspiratory wheeze. You should now present some supportive slides or other presentations which depict the signs above.

8. Let us cluster the significant findings and do some inferences about Bitoy's condition. What are the most relevant nursing diagnosis we can identify?

You may now elicit the participants' learning on Nursing Diagnoses (NDx's).

Web Resources

Visit the web resources below to access a comprehensive list of Nursing Diagnoses.
faculty.mu.edu.sa/download.php?fid=74289
<http://www.nanda.org/>

9. Acknowledging the principles we have been learning about growth and development, what care plan would be suitable for Bitoy?

You can divide the participants in groups and ask them to create their own care plan about Bitoy. Make sure that they will include growth and developmental principles (Bitoy is a toddler) in their plan of care.

10. How can we now involve the whole family in providing care for Bitoy?

With this question, you can include the concept of Family-Centered Care and help the trainees think of ways by which realistic nursing care plans can be made with the family.

Clinical Teaching

The adjective clinical means involving direct observation of the patient (Gaberson & Oermann, 1999). The goal of clinical teaching should be for the learner to experience learning in an actual, personal process. You should emphasize that clinical teaching goes beyond supervision. It is in this avenue where learning is active and dynamic. It should be where knowledge, skills, and attitudes are purposefully integrated.

Clinical teaching does not only involve the selection of a hospital or a health institution to be affiliated with. You have to make sure that the unit selected would indeed provide the avenue to achieve the learning objectives. It should also be conducive for learning in that there should be an opportunity given for students to practice and appreciate their gained knowledge and skills. In addition, you have to make careful plans on how to facilitate learning and yet ensure patient safety. You need to be keen on ethical responsibilities of the trainees and learners alike since children are a vulnerable population.

In clinical teaching you have to craft realistic learning objectives which address the development of the cognitive, psychomotor, and affective states of the trainee. However, the goal of clinical teaching should not just be for the learner, but for the patients as well. Patient needs and requirements should match the capability of the trainee/learner to provide care.

Depending on the intent of the clinical exposure, you may assign one trainee to one patient or multiple-trainees to one patient. The length of exposure would also depend on the skill or care focus you as the Master Trainer intend to develop on the trainee. It is important that these are set prior to the actual conduct of clinical teaching.

3. EVALUATION MEASURES

Evaluation tools depend on the strategy of instruction employed by the Master Trainer. Evaluation can be formative or summative. Formative evaluation measures how well the trainees have met the clinical objectives or competencies. Summative evaluation measures the extent to which the objectives or competencies were achieved.

The type of evaluation also depends on the knowledge dimension that you would like to address. If the knowledge dimension being addressed is simply factual, paper and pencil tests with questions that require recall and comprehension would be enough. However, if the dimension involves concepts, you may need to ask questions that require application, analysis, synthesis and problem-solving.

Laboratory demonstrations, which require procedural knowledge dimension, entail the use of skills checklist where you can observe if the trainee is performing according to the procedure taught. Depending on the intent of observation, you can just indicate whether the details of the procedure is done or not as in a checklist or a rating scale which describes the degree of the performance.

Case analyses would necessitate essay types of evaluation, whereby trainees can be asked to submit their own case report, or perhaps provide answers to the guide questions as exemplified earlier.

Clinical teaching strategies may necessitate more complex evaluation methods. Usually one method would not be enough to measure learning. The following are recommended tools for evaluation:

1. Performance evaluation scale - may be in the format of pass-fail rating scale, where parts of activities are written and evaluated by the MT.
2. Skills checklist - this includes a list of steps to be followed in performing a procedure. Since learning objectives should include the skills needed to be achieved by the trainee and eventually the learner, there should be critical steps and sequence that the participant should never miss in the course of performing the procedure. A skills checklist should parallel that which was used in laboratory demonstrations.
3. Anecdotal note - this is a narrative description of your observations of the trainee's/learner's clinical practice. This provides a picture of the participant's behaviors, actual activities done, and even your judgments or interpretations of the trainee's/learner's performance. Significant incidents, whether positive or negative, should be included.
4. Written assignments - written assignments provide the avenue for trainees to apply concepts and theories particularly in the crafting of nursing care plans.
5. Journal - considering that the patients to be cared for are children, trainees may utilize a journal where they can describe their unique experience. Since the goal of the clinical exposure is to facilitate personal learning, the participant may document how the experience contributes to their development. Journals may also be useful for the trainees to express their opinions, feelings, and so would be a good basis for you as Master Trainer to provide feedback.
6. Clinical conference - Quinn (1995, as cited by Gaberson & Oermann, 1999) identified outcomes of small group discussions like clinical conferences. Some that are vital to the care of children are as follows: (1) intellectual — which facilitates the discussion on how the experience relate to theory; (2) affective — which facilitates expression of self in the midst of other people having the same experiences; (3) social — which develops the participant's sensitivity to the weakness and strength of others.

SELF-ASSESSMENT QUESTIONS

1. What teaching-learning activities that have been discussed can be used to facilitate learning about the care of children?
2. What evaluation tools can be used to determine achievement of competencies in the learners at the end of an activity?

SUMMARY

The nursing care of children entails not only identification of the state of wellness or health problems of a child. You need to acknowledge the role of the family, environment, culture, and health care system context in the maintenance of health of children. The nurse should be keen on identifying the developmental needs of the child, and the child rearing needs of the family as well. In all these, the nurse can use the nursing process from assessment, identification of an appropriate nursing diagnosis, crafting of a culturally and developmentally- appropriate care plan and evaluation.

Facilitating learning in the care of children necessitates careful identification of the knowledge, skills, and attitude dimension. This should assist you in selecting and implementing instructional activities that are purposeful and meaningful for the trainee. Evaluation tools should be parallel with the instructional activities,

and should also be based on the learning objectives.

REFERENCES

Arango, Polly (2011). Family-centered care. *Academic Pediatrics*. 11:97-99.

Gaberson, KB & Oermann, MH (1999). *Clinical Teaching Strategies in Nursing*. New York: Springer Publishing Company, Inc.

Care of Childbearing Women

TERESITA I. BARCELO, RN, PhD

INTRODUCTION

When setting the stage for the learner to get motivated to learn concepts of maternity care, it is good to start with the status of the Millenium Development Goals particularly MDG #4 and #5 as a background for the discussion on maternal health in the country. Access the Department of Health (DOH) data base to get updated information on the MDGs (<http://www.nscb.gov.ph/mdg/MDGposter%20revnov>) (See also Annex G - MDG poster and Enrichment Activity 1)

Emphasis should also be given to the provision of Republic Act 9173 the Philippine Nursing Act of 2002 Section 28 on the scope of practice which states that nurses take care of various types of clients "... It includes but not limited to nursing care during conception, labor, delivery, infancy, childhood, toddler, preschool, school age, adolescence, adulthood and old age." There is a need to dispel a common misconception that nurses are not allowed to handle normal delivery of a pregnant woman unless one is a registered midwife. Our nursing law clearly provides us the mandate.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on care of the childbearing woman as a client.
2. Select learning activities that will enable the learners to implement the NNCCS on the care of the childbearing woman as a client.
3. Apply nursing practice tools, guidelines and/or frameworks in the care of the childbearing woman as a client.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the care of a childbearing client.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of the childbearing woman as a client will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on the childbearing woman as a client.

ASSESSMENT, PROBLEM IDENTIFICATION, NURSING INTERVENTION, EVALUATION, DOCUMENTATION

Table 5.2.1	NNCCS on the Utilization of the Nursing Process in the Care of Childbearing Women	
Responsibility 2	Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care.	
COMPETENCIES		PERFORMANCE INDICATORS
2.1. Ensures a working relationship with the client and/or support system based on trust, respect and shared decision making.		
2.1.1. Establishes rapport with client and/or support system ensuring adequate information about each other as partners in a working relationship.		<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner 2. Addresses with respect and trust client-partner's concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship.
2.2. Assesses with the client (individual, family) one's health status/competence.		
2.2.2. Obtains assessment data utilizing appropriate data gathering methods/ tools guided by type of client and work setting requisites.		<ol style="list-style-type: none"> 1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by work-setting requisites. <ol style="list-style-type: none"> 2.1. Individual as client – obtains assessment data through nursing history taking, physical/ developmental/psychosocial assessment and other assessment protocols, laboratory and diagnostic procedures 2.2. Family/population group/community as a client – obtains assessment data through family health history, assessment of the home and environment, records review and other assessment protocols such as laboratory and diagnostic procedures/reports, epidemiologic and social investigations and assessment of client competence, risk factor assessment, screening of vulnerable risk groups, and assessment of issues of vulnerability (health risks, limited control, powerlessness, disenfranchisement, victimization and disadvantaged status).

COMPETENCIES	PERFORMANCE INDICATORS
2.4.7. Implements safe and quality nursing interventions addressing health needs, problems and issues affecting pregnant woman during the peripartal phases and newborn from perinatal to neonatal stage.	<ol style="list-style-type: none"> 1. Provides appropriate physiologic interventions to address needs of women during the peripartal phases of pregnancy and of the newborn from perinatal to neonatal stages of care (e.g. IMCI- Integrated Management of Childhood Illness) 2. Performs autonomously a wide range of nursing interventions (actions, treatments and techniques) that: <ol style="list-style-type: none"> 2.1. Promote health covering the following areas of health concerns e.g. women's health, safe and quality Care for Birthing Mothers prepartal/ intra-partal/ immediate post-partum and puerperium care 2.2. Prevent disease/injury/ complications during the peripartal phases. 3. Performs evidence-based nursing procedures safely and effectively in the care of the mothers along the following areas of concerns: <ol style="list-style-type: none"> 3.1. Essential Intrapartal Care practices following the WHO Essential Intrapartal Care guidelines 3.2. Essential neonatal care practices following WHO guidelines.

2.1. Client Focus: **Women in the Childbearing Period**

Role: Beginning Nurse's Role on Client Care

TOPIC OVERVIEW

This module focuses on **some essential concepts as an exemplar for teaching maternity nursing concepts** following the nursing process: assessment, problem identification, implementation/nursing intervention, and evaluation. **Suggested teaching-learning methods** in each of the steps of the nursing process are given as well as **evaluation methods to assess learners' achievement**. Through this module, you will get some ideas on how the core competency standards can be embedded in the curriculum for BSN and in the practice of nursing whether in the hospital or community. The different modules in this training kit discuss varied types of teaching learning strategies which you can use not only in the specific topic wherein it is discussed but also in other topics where it maybe appropriate. The different writers of this set of training modules tried their best to discuss many teaching-learning strategies from which you can select.

This module intends to show how care of the individual, in this case the pregnant mother, can be done integrating the National Nursing Core Competency Standards (NNCCS). While Responsibility 2 of the NNCCS is on care of individual, family and community, in this module the focus is on the individual pregnant mother. The focus on the whole family with pregnant mother is tackled in a separate module (care of population groups and care of family). Further, there is a separate module (Module 4) which discusses the ethical-legal dimension of nursing practice in various settings as well as various types of clients and another module that extensively covers the psychosocial aspects of care. Hence, the intent of this module is to illustrate strategies for teaching-learning on the care of the pregnant mother using assessment, problem identification and nursing interventions as the content focus. Admittedly, care of the pregnant mother does

not end with just providing the interventions as appropriate. However, the topic on documentation is not covered in this module because there is a separate module that discusses this topic comprehensively.

This module is not intended to provide the needed content on the major concepts on maternity nursing. However to assist you, as the trainer, on the content needed when teaching this module I have provided the references and additional content in soft copy provided in the CD.

Self-Assessment Questions (SAQs) are intended for the learner (trainer) as a self-check on one's learning from this module.

You as the learner (trainer) is requested to See Annex H for detailed topical outline of maternity concepts based on the CHED Memo 14 s. 2009 from which you can draw the content on maternity care.

MODULE CONTENT

1. ASSESSMENT

A good assessment of the pregnant woman is important for the nurse to have a sound basis for problem identification and plan of care. Data about the woman's health pre-pregnancy and during the pregnancy need to be comprehensive and accurate because the woman's health will definitely affect the fetal health and subsequently neonatal health.

In pregnancy, the woman's body undergoes physiologic adaptation to allow for the fetus to grow and develop normally.

Focused assessment for pregnant women must include physical assessment to determine vital signs, height and weight, fundic height, Leopold's maneuver, edema in the upper and lower extremities and the face as well as fetal heart sounds determination and fetal movement determination. Emphasize to the learner that there are two clients being assessed: the mother and the fetus.

In pregnancy, there are two clients
- the mother and the fetus.

Simple laboratory assessment that a nurse can do in the health center or home setting are heat and acetic acid test for proteinuria and Benedict's test for glycosuria. These laboratory tests will help to screen for high risk cases who need closer supervision and referral to an obstetrician for appropriate care.

Home based maternity record (HBMR) is a tool used in the health center or community setting that serves two purposes a) documentation of assessment data and b) for systematic health teachings to the mother to empower her regarding her own health. HBMR is also used for risk assessment and the record is kept by the mother to guide her of what danger signs to watch out for and schedule of next clinic visit. (See Annex I)

Suggested Teaching-Learning Strategies for Learners

1. Video presentation

Show video presentation on Leopold's Maneuver prepared by Prof. Marita Hernandez, R.N. and Dr. Marie Lourdes Tejero, R.N. (need to ask permission to reproduce and give as CD to learners). After the presentation, ask the learners to summarize what essential concepts they have learned from the video. You may ask the learner to do a return demonstration of the Leopold's maneuver using a mannequin.

2. Case Scenario

Maria is 22 years old and has completed high school. She came to the health center for check-up since she has missed her menses for the last two months. She wants to have a baby now since her marriage to Jose a year ago but is not sure if her missed menses is due to pregnancy because she has not experienced the usual signs and symptoms of pregnancy that she has heard from the older women in her barangay.

2.1. What data are needed to determine if Maria is indeed pregnant?

2.2. What tests can be done to confirm presence of pregnancy?

2.3. What signs and symptoms of pregnancy would be expected if Maria is on her first trimester?

2.4. What data are needed to determine obstetric history?

2.5. Determine the age of gestation (AOG) and expected date of delivery (EDD).

Pregnancy is a family affair thus the nurse needs to know not just the client's health status but also the family relationships, home environment, socio-economic status and health history of the family.

3. Clinical Activity

Make the learner assess a pregnant woman preferably in their 2nd or 3rd trimester and perform focused assessment including Leopold's Maneuver and record findings using the HBMR form of the health center. Ask the learner to discuss assessment data gathered incorporating the preparation of the woman before the physical assessment was done.

The assessment process should be able to identify the women with normal pregnancy and those with a high risk one. For the high risk conditions, focus your discussion on the common complications brought about by pregnancy such as pregnancy-induced hypertension, bleeding complications and gestational diabetes. Report to the obstetrician the mothers with high risk condition for proper medical management and document accurately your assessment findings and problems identified.

During labor, assessment of the mother is done using the partograph. This is a tool that integrates important information about the progress of labor such as status of the bag of water, cervical dilation and effacement, descent of fetal presenting part, uterine contraction; maternal condition such as blood pressure (BP), temperature, pulse and respiratory rates, intake and output; as well as fetal heart rate. (See Annex J)

In the postpartum period, assessment of the mother includes lactation, level of the fundus, uterine muscle tone, lochia, episiotomy wound using assessment acronym, REEDA (R- redness, E- edema, E- ecchymosis, D- drainage, A- approximation of wound); leg edema and presence of thrombophlebitis. Assess also the parenting skills of both the mother and the father as well as their attachment to the baby. Reva Rubin's theory of Maternal Role attainment (MRA) and Ramona Mercer's Theory of Becoming a Mother (BAM) can be used as bases in assessing maternal-fetal/infant bonding.

2. PROBLEM IDENTIFICATION AND NURSING DIAGNOSIS

Health Promotion during pregnancy:

Self-care needs- bathing, breast care, dental care, perineal hygiene, dressing, sexual activity, exercise, rest and sleep, physical activity, nutrition.

In our country there are many beliefs and traditional practices related to pregnancy. Using **brainstorming technique**, make the learner identify which beliefs are facts or myths, harmless from harmful traditional practices and what the nurse can do to encourage the mother and the family to have correct practices and sufficient knowledge.

Guide the learner in clustering assessment data into the physiologic and psychological; client and family; normal and pathological. Ask the learner to identify priority nursing problems based on the cues and clues obtained integrating as well laboratory results.

Pregnancy is a physiologic process hence the emphasis is on self-care and health promotion activities.

While pregnancy is a physiologic condition, discomforts related to the bodily changes in pregnancy can cause some discomforts. These discomforts should also be the focus of health teachings that the nurse must provide.

Suggested Teaching-Learning Strategies for Learners

1. Case Scenario:
Maria came for her prenatal check-up on her 8th month. On interview she said that she was having irregular bowel movement (every 2-3 days), pedal edema, and back pains especially after long standing.

She also verbalized that she was having ambivalent feelings about the baby and asked the nurse whether the feeling is normal.
2. Case scenario analysis:
 - 2.1. Identify nursing problems/diagnosis based assessment data. Prioritize problems and identify the top three (3) to be addressed in the nursing care plan.
 - 2.2. Make a teaching plan for Maria to address the discomforts stated above. The plan must include teaching objectives, content, method/s of teaching and plan for evaluation.
 - 2.3. Using Mercer's theory of Becoming a Mother, assess the feelings of Maria toward her baby. Discuss how Maria can develop attachment to her baby in utero.

3. SELECTING APPROPRIATE NURSING INTERVENTIONS

Suggested Teaching-Learning Strategies for Learners

1. Show a video of a normal vaginal delivery from Youtube. There are several available but you need to annotate the later part since Essential Intrapartum Newborn Care (EINC) guidelines are not yet incorporated in the available videos in the internet. After video presentation, ask the learners to make a critique of the video focusing on the principles/ guidelines on how to assist the mother during delivery ensuring safety and quality care. Check CD on EINC with Association of Deans of Philippine Colleges of Nursing (ADPCN).

Suggested Teaching-Learning Strategies for Learners (Continued)

2. Clinical Activity

- 2.1. Assign the learner a pregnant mother to care for and ask the learner to make a nursing care plan for the identified three (3) priority nursing problems. Incorporate in the justification for the interventions applicable nursing theories, evidences from literature and research findings.

For the pharmacologic interventions, include classification of the drug on safety for the fetus.

Make a teaching plan to cover the areas for health promotion in pregnancy.

Make the learner evaluate effectiveness of interventions as planned.

- 2.2. Assign the learner to take care of a mother in labor. Using the partograph, let the learner monitor the progress of labor. Based on the assessment data, ask the learner to identify when is the appropriate time to transfer the mother to the delivery table in preparation for the delivery of the baby. Make the learner prepare the mother and the needed instruments for a normal vaginal delivery. Supervise the learner in assisting the mother deliver her baby following the guidelines of Essential Intrapartal and Neonatal Care (EINC). (See Annex K for EINC Protocol for Unang Yakap)

Conduct an individual post conference with the learner after the mother has been transferred to the ward. Allow the learner to make one's own reflection on the activity- what was learned and what areas need to be improved.

In subsequent cases for delivery, focus the supervision more closely on the areas that need improvement. Summative evaluation is done after the third case to determine attainment of competencies in the care of a mother in labor and delivery.

- 2.3. Assign the learner to care for a postpartum mother who has just delivered via normal vaginal delivery. Focused assessment of a postpartum mother include the following:
 - 2.3.1. Vital signs
 - 2.3.2. Breast and lactation
 - 2.3.3. Fundus - consistency and height
 - 2.3.4. Perineum - lochia, episiotomy wound if present (using REEDA)
 - 2.3.5. Lower extremities - presence of edema and thrombophlebitis
 - 2.3.6. Elimination - bowel and urinary
 - 2.3.7. Maternal attachment to newborn

SUGGESTED EVALUATION TOOLS FOR ASSESSMENT OF LEARNER COMPETENCIES

- A. **Formative Evaluation** (usually non-graded intended to assess the progress in the attainment of the objective/competency)
 1. Exercises on computation of AOG, EDD, obstetrical history
 2. Individual conference on the performance of 1st and 2nd actual delivery of a baby

- B. **Summative Evaluation** (usually graded and done at the end of the activity intended to measure the achievement of the objective)
1. Teaching Plan for a Pregnant Woman graded following specific rubrics or criteria
 2. Nursing Care plan graded following specific rubrics or criteria
 3. Graded performance of Leopold's maneuver and fetal heart sounds determination using a performance checklist with rubrics or criteria
 4. Graded performance of actual delivery of a baby (on the 3rd case) following rubric or criteria
 5. Written test - combination of multiple choice items, identification of terms, and concept mapping

SELF-ASSESSMENT QUESTIONS

These questions are to be answered by the learner of this module.

1. What teaching-learning strategies/activities have been discussed that can be used to develop critical thinking in the learner?
2. What evaluation tools can be used to determine achievement of competencies in the learners at the end of an activity or clinical exposure?
3. What nursing assessment tools can be used in developing assessment skills of the learner?
4. How do you plan to cascade what you learned in this module to your "end-learner"?

APPLICATION (PRACTICE)

A. Outpatient Department/Health Center

In the Prenatal Clinic of the Health Center or Outpatient Department, the nurse assesses the health status and condition of a pregnant woman. Through interview, the nurse obtains personal and obstetrical data using the Home Based Maternity Record (HBMR) also known as Woman Held Maternity Record (WHMR) which is used in many primary health care units worldwide. Data obtained helps the nurse determine obstetrical history, age of gestation, expected date of delivery.

A good rapport with the client is important for the nurse to be able to obtain personal data like sexual activity, marital status, use of contraception etc. In our culture, women are rather shy to discuss their personal data especially as it refers to reproduction. Usually one begins with the interview focusing on the more general information first like nutrition, activity, immunization and the like and going to the more intimate data like sexual activity in the later period when the woman is more comfortable and rapport is well established.

Focused physical assessment is done to include characteristics of the breast and nipples, measuring fundic height, using Leopold's maneuver to determine fetal position, presentation and attitude, presence of edema and varicosities.

Knowledge, practices and attitudes related to childbearing of the woman and the partner, if present, need to be assessed so that these information serve as the take-off point in the preparation of the health teaching plan. In the Philippine culture, several significant persons influence the actions/behaviors of the pregnant woman more so if she is a primigravida. They are the spouse/partner, mother of the client, mother-in-law and also the old women of the community in the remote rural areas. This is an important consideration that the maternity nurse needs to keep in mind.

Data obtained from interview and physical assessment serve as the basis for the nursing care plan and health teaching plan. Also, teach the mother how to use her HBMR as a tool to determine whether she is experiencing normal/abnormal signs and symptoms of pregnancy and as a reminder of her schedule for prenatal visit and immunization.

- B. In the Lying-in Clinic, the nurse who admits a mother in labor performs assessment to determine status of labor using the partograph as a guide for assessment as well as the form for documentation. A thorough assessment of the mother is important so that the nurse can determine whether the labor and delivery is normal. It is important to remember that even if the prenatal assessment data have been normal all along, complication may occur during the labor and delivery. This is why mothers are advised to have the delivery of the baby in a health facility and are discouraged from having home delivery.
- C. In the Labor and Delivery Room, the partograph is a good tool to use in documenting and monitoring the progress of labor. The partograph can be a multi-disciplinary communication tool that can be used by doctors, nurses and midwives taking care of the mother and monitoring the progress of labor and condition of the fetus.
- D. In the postpartum unit, the nurse must be alert for signs of postpartal bleeding. The most common cause of maternal mortality is postpartal bleeding during the fourth stage of labor until 48 hours after delivery. Hence, the nurse needs to assess the status of the uterine contraction, amount and character of vaginal discharge and vital signs of the woman which are among the early signs of postpartal hemorrhage. Proper documentation of the assessment data particularly the amount (using perineal pad count) and characteristics of vaginal discharge and tone of the uterine muscle are significant observations that must be documented.
- E. The maternity nurse during the immediate postpartum period can very well help the mother have a successful breastfeeding of her infant. One of the primary functions of a maternity nurse is being a lactation nurse giving support to mothers especially first time mothers in order to successfully breastfeed her baby. The nurse can be an advocate for immediate rooming-in of babies with their mothers to avoid the practice of giving the babies artificial feed while in the nursery. These are strategies being encourage by the DOH Essential Newborn Care (ENC) or the Unang Yakap Program.
- F. For the public health nurse, conducting a home visit to the mother who has just delivered needs to be done. Focus of the home visit on aspect of maternity nursing would be status of lactation, fundic height and consistency of the uterus, characteristics and amount of lochia, status of the episiotomy wound if any, presence of edema or thrombophlebitis, status of elimination of both the bowel and the bladder. Assess also the mother's ability to care for herself and her baby and her attachment to her baby. After assessing mother's readiness to discuss about family planning, the nurse includes in her teaching plan the topic on family planning. Ideally, the nurse discusses this matter with both spouses present since family planning must be a couple decision.
- G. For documentation of nursing intervention in a primary health care setting, the nurse uses the HBMR form which the mother keeps to herself and presents again to the nurse during the postpartum check-up 6-8 weeks after delivery as well as in future pregnancies. This form also serves as a health education tool particularly on what danger signs to watch out for.

ANSWERS TO THE SELF-ASSESSMENT QUESTIONS (ASAQs)

1. What teaching-learning strategies/activities have been discussed that can be used to develop critical thinking in the learner.

Answer: Teaching-learning strategies that intend to develop critical thinking are methods that allow the learner to synthesize, evaluate, create. Discussed in this module are the following strategies: brain storming, video presentation with post video discussion, case scenario analysis, and supervised direct client care in the clinical setting.

2. What evaluation tools can be used to determine achievement of competencies in the learners at the end of an activity or clinical exposure?

Answer: There are varied evaluation tools that can be used for determining learner's achievement of the competencies. In this module both the formative and summative evaluation tools have been given. Formative evaluation intends to determine the learner's progress in the achievement of the objective or competencies. The primary purpose is to identify additional learning needs of the learner which need to be addressed so that in the end the learner will achieve the objectives. Since the purpose of formative evaluation is check the progress towards the attainment of the objective, it is usually non-graded. Corrective or supplementary measures are done to address the identified additional teaching-learning points/areas.

Summative evaluation is primarily intended to measure the learners' achievement of the learning objectives at the end of the activity/course. Hence if grades are needed to show whether the learner finally achieved the competency desired, summative evaluation is done.

All the different evaluation tools under each category- formative and summative are given in the section on evaluation tools. You are requested to go back to this section for the enumeration of these tools.

3. What nursing assessment tools can be used in developing assessment skills of the learner caring for a pregnant woman, mother in labor and postpartum mother?

Answer: In this module, the following assessment tools of a woman in the various stages of childbearing were discussed: HBMR, partograph, REEDA.

4. How do you plan to cascade what you have learned in this module to your "end-learner"?

Answer: If you go back to the discussion of the section on Application, you can derive some ideas on how you can cascade your learning from this module. Remember that the goal of this whole set of modules is to be able to bring down to the level of the beginning nurse (end-learner) the National Nursing Core Competency Standards so that the care of the various clientele, in particular for this module the childbearing mother, will be guided by standard core competencies.

ANNEXES AND SUGGESTED READINGS

Annexes:

- | | |
|---|--|
| A. MDG Poster (Annex G) | E. Essential Intrapartal and Neonatal Care (EINC) Protocol Unang Yakap (Annex K) |
| B. Topical Outline (Annex H) | F. 10 Steps to Successful Breastfeeding (Annex L) |
| C. Home-based Maternal Record (Annex I) | |
| D. WHO Modified Partograph (Annex J) | |

Suggested Readings (found in the CD)

1. MDGs After 2015
2. Asia-Pacific MDG Report 2011-2012
3. WHO Guidelines on Essential Intrapartum and Neonatal Care
4. EINC OF WHO

REFERENCES

Perry, S.E., Cashion, M.C. & Lowdermilk, D.L. (2007). *Maternity and women's health care*. (9th ed.). Missouri: Mosby Elsevier.

Pillitteri, A. (2007). *Maternal and child health nursing: Care of the childbearing and childrearing family*. (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Tomey, A.M. & Alligood, M.R. (1998). *Nursing Theorists and their works*. (4th ed.). St. Louis: Mosby (chapter 27: Ramona Mercer).

Web Resources

www.who.int/reproductivehealth/publications/maternal_

[perinatal_health/9789241548335/en/index.html](http://www.who.int/reproductivehealth/topics/maternal_perinatal_health/9789241548335/en/index.html)
www.who.int/reproductivehealth/topics/maternal_perinatal/en/index.html

<http://www.reproductive-health-journal.com/content/pdf/1742-4755-10-23.pdf>

www.doh.gov.ph

<http://unangyakap.doh.gov.ph/enc.html>

<http://www.un.org/millenniumgoals/beyond2015>

http://www.who.int/topics/millennium_development

<http://www.unescap.org/pdd/calendar/CSN-MDG>

<http://www.nscb.gov.ph/mdg/MDGposter%20revnov>

Health Promotion

SHEILA R. BONITO, RN, MAN, DrPh

INTRODUCTION

Health promotion is the process of enabling people to increase control over, and to improve, their health (WHO, 1986). This definition was ratified during the First International Conference on Health Promotion in Ottawa, Canada. The Ottawa Charter recommends by five priority action areas in health promotion, namely:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills, and
- Re-orient health services

The American Journal of Health Promotion defined health promotion as the “science and art of helping people change their lifestyle to move toward a state of optimal health, which is a balance of physical, emotional, social, spiritual, and intellectual health (O'Donnell, 2009). Pender et al (2006) defined health promotion as “behavior motivated by the desire to increase well-being and actualize human health potential”. The 2000 Joint Committee of Health Education and Promotion (Gold & Miner, 2002) described a healthy lifestyle as “patterns of behaviors that maximize one's quality of life and decrease one's susceptibility to negative outcomes”. These definitions of health promotion differ from the socio-ecological approach to health promotion identified in the international health promotion community. However, it is the current standard to which nurses are being held accountable.

The goal of this module is to guide master trainers to facilitate learning to enable learners to perform the specific competencies related to health promotion in the care of adults and older persons. These competencies with their corresponding performance indicators are listed below.

Table 5.3.1 | NNCCS on Health Education/Promotion

Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.5.1. Determines the health education promotion planning models appropriate to target clientele expected objectives and outcomes.	<ol style="list-style-type: none"> 1. Specifies the characteristics of each health education/promotion planning model. 2. Selects appropriate health education/promotion planning model.

COMPETENCIES	PERFORMANCE INDICATORS
2.5.2. Utilizes health education promotion process to accomplish the plan to meet identified client's learning needs.	<ol style="list-style-type: none"> 1. Assesses the needs of the target population. 2. Prioritizes the learning needs/problems in partnership with client partner. 3. Formulates appropriate goals and objectives 4. Designs a comprehensive health education promotion plan. 5. Implements the health education/promotion plan utilizing appropriate teaching strategies 6. Evaluates the results of client's learning experiences using the evaluation parameters identified in the health education/promotion plan.

Competencies are formulated to reflect the performance indicators needed to achieve the above competencies in health promotion. Health education competencies are also included since health education is one strategy used in health promotion and is one of the major roles of nurses in caring for patients.

This module also describes the teaching-learning strategies needed for learners to achieve the competencies in health promotion. These learning strategies ensure that learners are able to achieve the learning objectives needed to perform the competency. These include the use of activities that foster critical thinking and decision-making skills. It also provides hospital and community scenarios to help learners and master trainers apply the competencies.

Some resources are also listed to help master trainers and learners in teaching and learning these competencies. These resources include technical content, pedagogical tools, and learning technologies in health promotion.

MODULE OBJECTIVES

After going through the module, you as the master trainer will be able to guide learners to:

1. Discuss specific health promotion theories, models and strategies to promote health and wellness of individuals and populations;
2. Plan and implement health promotion activities/programs to promote and wellness of individuals and populations;
3. Utilize participatory and empowerment strategies in promoting health and wellness of individuals and populations; and
4. Evaluate application of health promotion programs and activities

TOPIC OUTLINE

1. Health Promotion Theories and Models
2. Health Promotion Strategies
3. Planning and Implementing Health Promotion Activities/Programs
4. Empowering Clients and Communities
5. Evaluating Health Promotion Activities/ Programs

MODULE CONTENT

1. HEALTH PROMOTION THEORIES AND MODELS

Health promotion theories and models guide the assessment, implementation and evaluation of health promotion activities towards improving the quality of life of individuals and communities. Theories and models in health promotion can be classified as (1) intrapersonal, 2) interpersonal and (3) community level (Glanz & Rimer, 2005).

Intrapersonal theories focus on factors that exist or occur within the individual, which include knowledge, attitudes, beliefs, motivation, self-concept, developmental history, past experience, and skills.

1. Intrapersonal theories and models

- **Health Belief Model** addresses the individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy).
- **Stages of Change (Transtheoretical) Model** describes individuals' motivation and readiness to change a behavior.
- **Theory of Planned Behavior** examines the relations between an individual's beliefs, attitudes, intentions, behavior, and perceived control over that behavior.

2. Intrapersonal theories and models

At the interpersonal level, theories of health behavior assume individuals exist within, and are influenced by, a social environment. The opinions, thoughts, behavior, advice, and support of the people surrounding an individual influence his or her feelings and behavior, and the individual has a reciprocal effect on those people. The social environment includes family members, co-workers, friends, health professionals, and others.

- **Social Cognitive Theory** explores the reciprocal interactions of people and their environments, and the psychosocial determinants of health behavior.
- **Health Promotion Model** describes the sets of variables that affect an individual's health promoting behaviors. These variables include personal characteristics and experiences that can be modified through nursing actions towards improved health, enhanced functional ability and better quality of life at all stages of development.

3. Community level theories and models

Community-level models explore how social systems function and change and how to mobilize community members and organizations. These offer strategies that work in a variety of settings, such as health care institutions, schools, worksites, community groups, and government agencies. Embodying an ecological perspective, community-level models address individual, group, institutional, and community issues. Initiatives serving communities and populations, not just individuals, are at the heart of public health approaches to preventing and controlling disease.

- **Community Organization and Other Participatory Models** emphasize community-driven approaches to assessing and solving health and social problems.
- **Diffusion of Innovations Theory** addresses how new ideas, products, and social practices spread within an organization, community, or society, or from one society to another.
- **Communication Theory** describes how different types of communication affect health behavior.

Learning Strategies

- Lecture discussion on health promotion models

Describe the above theories and models, emphasizing the following:

- Background of the theory – proponent, date, how this was developed
- Purpose of the theory – what is the intention of the theory, or objectives/ aims of the theory
- Key concepts and propositions in theory – what are the major concepts in the theory and how do they explain the factors in health promotion
- Application in nursing – cite case studies where application was/ can be implemented

- Online treasure hunt

Ask learners to collect and read health promotion theories from books, journals and online resources. Ask them to describe these theories using the following table:

Table 5.3.2 Matrix for Describing Health Promotion Theories				
Name of Theory	Theory Proponent	Key Concepts and Propositions	Application in Nursing	Reference
<i>What is the title of the theory</i>	<i>Who proposed this theory (include year)</i>	<i>What are the key concepts in the theory and how are they put together to explain health promotion</i>	<i>How is this theory applied in nursing? Cite specific example/s</i>	<i>Cite where the theory was taken, use APA style in reference citation</i>

Resources

Glanz, B. and Rimer, K. (2005). Theory at a glance: A guide for health promotion practice. National Cancer Institute, US Department of Health and Human Services. Available at www.cancer.gov/pdf/481f5d53-63df-41bc-bfaf.../taag3.pdf

2. HEALTH PROMOTION STRATEGIES

Health promotion strategies can be categorized into two: (1) individual change strategies, (2) social-environmental change strategies. Individual change strategies include: health education, health communication, and social marketing. Social-environmental change strategies include: organizational development and change, community development and mobilization, and healthy public policy and advocacy.

Health education

Health education refers to opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills, which are conducive to individual and community health. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours, and use of the health care system. Health education is often done through one-to-one sessions or small groups or classes. Health education initiatives are interactive, allowing for the continuous exchange of ideas, insights and feedback between participants and facilitators. Health education

sessions are often learner-directed, thereby allowing for more flexibility in accommodating diverse needs and learning styles (WHO, 1998).

Health communication

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. Health communication is directed towards improving the health status of individuals and populations. It entails the use of the mass media and multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development. Some forms of health communications include edutainment or enter-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing (WHO, 1998).

Social marketing

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence voluntary behavior of target audiences in order to improve their personal welfare and that of society (Andreasen, 1995). In health promotion practice, the target is to develop healthy behaviors to improve personal welfare and that of society.

Social marketing can be used to influence the behavior of individuals or the behavior of policymakers and influential persons for policy and environmental changes. The structured planning process allows well-informed decisions about what audiences to target, what are their specific needs, and how to meet those needs (CDC, 2011).

Community empowerment

An empowered community is one in which individuals and organizations apply their skills and resources in collective efforts to address health priorities and meet their respective health needs. Through such participation, individuals and organizations within an empowered community provide social support for health, address conflicts within the community, and gain increased influence and control over the determinants of health in their community (WHO, 1998).

Creating supportive environment

Supportive environments for health offer people protection from threats to health, and enable people to expand their capabilities and develop self-reliance in health. They encompass where people live, their local community, their home, where they work and play, including people's access to resources for health, and opportunities for empowerment. Action to create supportive environments for health has many dimensions, and may include direct political action to develop and implement policies and regulations, which help create supportive environments; economic action, particularly in relation to fostering sustainable economic development; and social action (WHO, 1998).

Recommended Resources

WHO (1998). Health promotion glossary. Available at <http://www.who.int/healthpromotion/about/HPG/en/>

Learning strategies

- Lecture discussion on health promotion strategies

Describe the above health promotion strategies and provide examples for each given any case scenario.

- World Café

Case scenario examples:

- o A 50 year-old male suffered from myocardial infarction and need to change his lifestyle
- o Obesity in children was observed to be high in a primary school
- o Smoking in public places has been banned through a municipal ordinance
- o Road and traffic injury has been shown to be increasing in the last few years
- o Rising cases of dengue hemorrhagic fever during rainy season

Objective:

Develop an appropriate health promotion strategy or sets of strategies to address the specific concerns in the given case scenarios.

Task:

Given the above case scenario, learners choose health promotion strategies on how they can improve the quality of life of individuals and communities.

Process:

- Form groups of five. Assign each group with a health promotion strategy. Let each group choose a leader to facilitate their discussion and another member to be the reporter for the group (or in this case, the “café shop” owner to sell the presentation).
- In 20 minutes, each group prepares a presentation featuring their assigned health promotion strategy to address the case study given. Each group should make their presentation attractive and convincing so that they can attract people to their “café shops”.
- After 20 minutes, gather the class again and let them visit the “café shops” for another 20 minutes.
- In the end, process the experience of the group by asking the following questions:
 - What did you learn from the group activity?
 - What health promotion strategy seemed effective?
 - Which “café shop” was popular? Why?
 - What could be done to improve this group activity?

Resources

Andreasen, AR. (1995). Marketing social change: Changing behavior to promote health, social development, and the environment. San Francisco, CA: Jossey-Bass

Centers for Disease Control and Prevention (2011). Social marketing resources. Available at <http://www.cdc.gov/nccdphp/dnpao/socialmarketing/index.html>

WHO (1998). Health Promotion Glossary. Division of Health Promotion, Education and Communications (HPR) Health Education and Health Promotion Unit (HEP). Retrieved from <http://www.who.int/healthpromotion/about/HPG/en/>

3. PLANNING AND IMPLEMENTING HEALTH PROMOTION PROGRAMS/ACTIVITIES

Planning a health promotion program for individuals would depend on the theory, model and strategy that you want to adopt. An individual who needs to change his lifestyle to reduce existing risk factors could benefit

from several health promotion strategies too, such as health education, health communication, etc. For example, following the Health Belief Model, an individual who needs to stop smoking could be persuaded to change his behavior by conducting health education sessions by emphasizing the bad consequences of smoking and benefits of quitting smoking and providing information on how the client could succeed in quitting smoking.

There are also models in planning and implementing health promotion programs for population groups. One commonly used model is the PRECEDE-PROCEDE model that identifies predisposing factors, enabling factors and reinforcing factors related to health problems, behaviours and program implementation. Predisposing factors are forces that motivate an individual or group to take action such as knowledge, beliefs, attitudes, values, cultural norms, etc. Enabling factors include both new personal skills and available resources needed to perform behaviour. Reinforcing factors provide an incentive for health behaviours and outcomes to be maintained (Green and Kreuter, 1991).

The Health Communication Unit at the Centre for Health Promotion, University of Toronto developed a workbook to assist health promotion practitioners in the process of planning health promotion programs. This planning program is based on the following steps: (1) pre-planning and project management, (2) situational assessment, (3) identify goals, populations of interest and objectives, (4) identify strategies, activities and resources, (5) develop indicators, and (6) review the program plan.

Recommended Resources

Introduction to health promotion program planning (2011). Available at <http://www.thcu.ca/infoandresources/publications/planning.wkbk.content.apr01.format.oct06.pdf>

Learning strategies

- Lecture discussion on health promotion planning models

Describe the process of health promotion program planning using different models, such as Health Belief Model, Green & Kreuter (1991) or The Health Communication Unit (2011). Specify the characteristics of each health promotion planning model and select appropriate health promotion planning model.

- Develop a case study featuring the steps in health promotion program planning using any model. The case study should have the following parts:
 - o Needs assessment of the target client or population
 - o Prioritization of health and learning needs
 - o Goals and objectives of health promotion activity
 - o Health promotion strategies and activities and resources
 - o Evaluation plan

Resources

Glanz, B. and Rimer, K. (2005). Theory at a glance: A guide for health promotion practice. Available at www.cancer.gov/pdf/481f5d53-63df-41bc-bfaf.../taag3.pdf

Green, Lawrence, and Kreuter, Marshall (1991). Health promotion planning: An educational and ecological approach. Mountain View, California: Mayfield.

The Health Communication Unit (2001). Introduction to health promotion program planning. Center for Health Promotion, University of Toronto. Available at <http://www.thcu.ca/infoandresources/publications/planning.wkbk.content.apr01.format.oct06.pdf>

4. CLIENT PARTICIPATION AND EMPOWERMENT

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health. Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, and is an important goal in community action for health (WHO, 1998).

Learning strategies

- Lecture discussion on health promotion models

Describe health promotion activities providing examples of client participation and empowerment.

- Journal reporting

Objective:

Provide examples of client participation and empowerment in health promotion programs or initiatives.

Task:

Learners are to look for journal articles that illustrate client participation and empowerment in health promotion programs.

Process:

- Ask learners to look for journal articles reporting the use of client participation and empowerment.
- Ask learners to bring this journal article to class and report what it says by citing the following:
 - What is the title of the journal article?
 - What is the article about? Is it a research article, feature article, opinion, etc.?
 - How does this article feature client participation and empowerment? Describe the empowerment strategies used related to promotion of health, healthy lifestyle/ adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access.
- In the end, process the learning experience by asking the following questions:
 - What did you learn from the group activity?
 - What was the advantage (or disadvantage) of using client participation and empowerment in the health promotion program?
 - What strategies were used to create supportive environments or enable client participation and empowerment?

Resources

WHO (1998). Health Promotion Glossary. Division of Health Promotion, Education and Communications (HPR) Health Education and Health Promotion Unit (HEP). Retrieved from <http://www.who.int/healthpromotion/about/HPG/en/>

5. EVALUATING HEALTH PROMOTION

The Health Communication Unit at the University of Toronto developed a workbook in evaluating health promotion programs using a logical, ten-step model.

Steps in evaluating health promotion programs

1. Clarify your program
2. Engage stakeholders
3. Assess resources for the evaluation
4. Design the evaluation
5. Determine appropriate methods of measurement
6. Develop work plan, budget and timeline for evaluation
7. Collect the data using agreed-upon methods and procedures
8. Process and analyze the data
9. Interpret and disseminate the results
10. Take action

Recommended Resources

The Health Communication Unit (1997). Evaluating Health Promotion Programs. Available at http://www.thcu.ca/resource_db/pubs/107465116.pdf

Learning strategies

- Lecture discussion on health promotion strategies

Describe the above steps in evaluating health promotion programs and provide an example.

- Critiquing studies

Objective:

Critique health promotion programs using the guiding principles of evaluating health promotion programs.

Task:

Critique health promotion programs published in journals

Process:

- a. Ask learners to look for research articles featuring health promotion programs and describe it:
 - i. What is the title of the journal article?
 - ii. What is the article about? Is it a research article, feature article, opinion, etc.?
- b. Critique the research article using the guiding principles on evaluating health promotion programs of The Health Communication Unit:
 - clear description of the program
 - explicit purpose for identified need
 - specific evaluation questions
 - ethical conduct
 - systematic methods
 - clear and accurate reporting
 - timely and widespread dissemination
 - multi-disciplinary approach
 - stakeholder involvement
 - utilization of evaluation findings
- c. In summary, ask learners to answer the following questions:
 - i. What were the strengths and weakness of the health promotion program based on the guiding principles?

- ii. What did you learn from the activity in terms of importance of evaluation?

Resources

The Health Communication Unit (1997). Evaluating Health Promotion Programs. Available at http://www.thcu.ca/resource_db/pubs/107465116.pdf

APPLICATION

This module focuses on preparing learners perform their professional roles in health promotion whether promoting health of individuals or communities. Learners need to learn the health promotion theories, models and strategies that can guide their actions in implementing health promotion programs. Specific skills in planning, implementing and evaluating health promotion programs are also important to the success of the program and to improve quality of life of the clients. In the specific learning strategies presented, case scenarios were used to situate and put context in the performance of the competencies. These case scenarios should facilitate the performance of specific skills as reflected in the following learning activities:

- Apply health promotion theories, models and strategies in addressing health issues of individual and community clients
- Conduct needs assessment of the target client or population
- Prioritize health and learning needs that should be addressed
- Formulate goals and objectives of health promotion activity
- Identify appropriate health promotion strategies and activities and resources to address health issues
- Implement health promotion program involving client participation and empowerment
- Evaluate health promotion program

SUMMARY

The knowledge, skills and attitudes achieved by learners in this module should help them in promoting health of individuals and communities. These include the following competencies:

- Determine the health education/promotion planning models appropriate to target clientele/expected objectives and outcomes
- Utilize health education/promotion process to accomplish the plan to meet identified client's learning needs

Understanding the health promotion theories, models and strategies is important in guiding the planning, implementation and evaluating care of different types of clientele, whether the individual or community. Developing a case study featuring the steps in health promotion program planning exposes learners to the importance of doing: (1) needs assessment of target client, (2) prioritization of health and learning needs, (3) formulating goals and objectives of health promotion activity, (4) identifying appropriate health promotion strategies and activities and resources, and (5) conducting evaluation. Exploring journal articles featuring client participation and empowerment underscore the advantages of participatory approach and emphasize the role of nurses in empowering clients. Learners' critiquing skills are also enhanced by providing them with the tools on how to critique health promotion programs.

EVALUATION

1. What are the common health promotion theories and models that are applied in nursing practice to promote health and wellness of individuals and populations?
2. Give examples of applications of health promotion theories and models in nursing practice to promote health and wellness of individuals and populations.
3. What are the common health promotion strategies to promote health and wellness of individuals and populations?
4. Give examples of health promotion strategies in nursing practice to promote health and wellness of individuals and populations.
5. What are the steps in planning and implementing health promotion strategies to promote health and wellness of individuals and populations?
6. Why is there a need to advocate for a participatory approach and empowerment strategies in promoting health and wellness of individuals and populations?
7. What are the guiding principles in evaluating health promotion programs?

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- Centers for Disease Control and Prevention. (2011). *Social marketing resources*. Available at <http://www.cdc.gov/nccdphp/dnpao/socialmarketing/index.html>
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Introduction to the Cluster and Case Report: Applied to Modules 5.5, 5.6 and 5.8

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INTRODUCTION TO THE CLUSTER: TEACHING THE NURSING PROCESS

The nursing process is the chosen framework for this project. The nursing process is the essential core of nursing practice and the common thread that unites nurses as they care for clients throughout the lifespan, the continuum of care, and across care settings. More importantly, the nursing process is the basis for identifying nurses' accountability through the development of a nursing care plan, which is the document that identifies the care to be given.

The nursing process is a systematic, rational method of planning and providing care which requires critical thinking skills for identification and management of actual and/or potential problems and to promote wellness. It uses a systematic, holistic, and problem-solving approach in partnership with patients, their families, and members of communities.

It consists of five (5) sequential and interrelated phases: assessment, diagnosis, planning, implementation, and evaluation. It is best that each step of the nursing process is taught with concrete examples from a case.

There are generally two approaches to teaching the nursing process: the pragmatic method and the theoretical method. The pragmatic method consists of describing the steps of the nursing process, with the intention of ensuring that the learners are able to apply, rather than explore, the steps. The second method is to teach the nursing process in a manner where the learners develop their own concept of the nursing process.

The nursing process is a concept that may be difficult for a novice to comprehend. As knowledge, concepts, and ideas build, so does the need to recognize, apply, and utilize these materials for providing safe and patient-centered outcomes, increase. A progression strategy for adequately understanding the client, formulate nursing diagnosis, plan interventions, establish goals, and evaluate client outcomes, needs to be followed. To ensure learner success, multiple teaching and evaluation methods must be incorporated in the teaching strategy. Challenges to the teaching of the nursing process include confusion related to terminology (patient problem vs nursing diagnosis), multiple and competing nursing diagnoses, difficulty related to understanding evaluation and outcome criteria, and the relationship between the stages of the nursing process and the resulting nursing care plan. The nursing process and the nursing care plan are identical processes; the former is a thought process, while the latter is the written version of the thought process.

When taught properly, learners realize that the nursing process is a method of organizing thoughts about nursing action and priorities for nursing action.

CLUSTER ON THE “NURSING PROCESS”: CASE REPORT

METHOD: CONCEPT MAPPING

Concept maps are metacognitive tools that assist learners “to see” their own thinking and reasoning about a topic as they depict relationships among factors, note cause and effects, identify predisposing factors, formulate expected outcomes, and so on. Concept map direct learners to consider the context in which a situation occurs, and they help learners make purposeful judgments. Concept mapping is a way to help learners develop their critical thinking skills and to make their thinking visible. It promotes integrated thinking and points out areas where conflicting information exists, both of which are important factors in critical thinking and effective clinical practice (De Young S, 2003, Teaching strategies for nurse educators, 227).

Case Report

CASE REPORT ON OLDER PERSON WITH DEVELOPING HEART FAILURE

Mang Pedro de Legaspi is a fisherman, who lives in the coastal town of a nearby island. He lives with his wife of 40 years, Zenaida. His wife of the same age, is a retired elementary school teacher. They enjoy a peaceful life in a fishing community. Mang Pedro joins the fishing boat about 3 times a week, and on other days, he goes fishing as he pleases. Whatever share he gets is being sold in the inland market by his wife and married daughter, in their market stall. They also are in the business of making dried fish, and this adds to their economic support.

Mang Pedro is 67-years old, tall but is on the heavy side. He was previously (about 10 years ago) diagnosed with hypertension, but seems to have missed medical follow-ups in the Rural Health Clinic. His reason is- he does not feel any symptom at all. He feels good, until recently. His wife noted less fishing days, and that Mang Pedro verbalized increasing episodes of fatigue, which he attributes to the hot weather. There were times that the usual walking around the village seemed difficult, and he didn't have that much interest to meet his friends for their usual drinking session, where they talk about politics, incomes, families, anything.

His eldest son, a seaman of several years, came home for vacation from an overseas contract and noted his father's behavior. He convinced Mang Pedro for a medical consult in the nearby city where a medical center is located. This is also where his son and family maintain their home. This time, Mang Pedro verbalized shortness of breath on activity, and had difficulty performing activities of daily living, and had to be always assisted his wife. Mang Pedro was admitted and was confined in a small private room. Aling Zenaida had some confidence about hospitalization, because she was a PhilHealth member, and his son is helping them.

The admitting medical impression was “Hypertension Stage 2, uncontrolled; Diabetes Mellitus Type 2, uncontrolled; and for cardiac work-up”. His electrocardiogram (ECG) findings showed myocardial ischemia of the anterior wall. This sort of confirmed the small chest discomforts that he was experiencing. He did not know about his diabetes, and was not taking any medication for hypertension. This made Mang Pedro somewhat depressed, more so, when informed that he had to stay in the hospital for a while. He was constantly asking how soon he can be back to his own home.

On Day 3 in the hospital, afternoon shift, the nurse reported the following physical examination findings, that prompted several in-house referrals: HR = 102beats/min. with occasional skip beats; RR = 28 cycles/min, fast and shallow, orthopneic, use of accessory muscles for breathing, pronounced

Case Report (Continued)

crackles on both lower lung fields; BP = 100/60 mmHg; cool and clammy skin; edema of the lower extremities.

That evening, the attending physician conferred with Mang Pedro's family, and explained to them the possible medical management processes that may take place. This included the management of developing heart failure, and once resolved the possibility of having a coronary angiogram and a coronary artery bypass surgery.

The nursing care plan for Mang Pedro was planned by the nursing staff, to include discharge plan and rehabilitation.

The outcomes of care included full recovery for Mang Pedro, self-care skills, functional capacity to perform close to usual activities, psychosocial adaptation given his chronic illness, and social support for psychosocial integration as an older person in the community, together with his wife. The outcome for the nurse include demonstration of his/her beginning role in patient/client care, beginning nurse manager/leader, and beginning researcher.

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Teaching the Care of the Chronically Ill Adult Patient

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INTRODUCTION

There is a growing number of frail, older people with multiple long-term conditions such as diabetes, heart failure, chronic respiratory problems, arthritis, cancer, Alzheimer's disease, stroke, obesity, and depression that pose a major challenge to the Philippine health care system. These patients are identified as having a chronic illness. Chronic illness is defined as "the irreversible presence, accumulation, or latency of disease states or impairments that involve the total human environment for supportive care and self-care, maintenance of function, and prevention of further disability." (Curtain & Lubkin, 1995, pp. 6-7). It is any condition that requires ongoing care for more than a year and may limit a person's activities.

In the last two decades, chronic illness has shifted from a focus on loss and burden, to images of health within illness, transformation, and some semblance of normality. This latter view has consequently moved patients from being passive recipients of health care to active partners and competent decision makers. Also, the care of the chronically ill patient has recently undergone a total overhaul as the traditional way of dealing with patients is focused on acute care, which leaves out chronically ill patients who jump in and out of the health care system.

Moreover, chronic illness is often regarded as progressive and deteriorating in nature and without the possibility of complete cure or prevention. Care of the chronically ill occurs in a continuum of care extending way beyond the confines of today's restricted hospital stays. Because these diseases are long lived and progress in stages, a chronic illness patient's health care needs to be extended well beyond the doors of the hospital or doctor's office.

Because of the poor prognosis and the chronicity of the illness, nursing students and beginning nurses may come with a plethora of negative stereotypes and a desire to just get through any "required" activity. The Master Trainer has to be sensitive to these factors that might hinder learning about this very fulfilling field of nursing.

In the traditional set-up, there is no difference in the care of acutely ill and chronically ill patients. That the patient is a chronically ill patient with an acute episode or exacerbation is not taken into consideration. But there is now an increasing realization that these two patient populations need to be treated differently. A good overview of the differences between acute and chronic illnesses is found in the Alt (2008) and Borromeo (2012) references. The Brown & Matthews (2003) handbook discusses chronic illnesses and their impact on the health care system.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer will be able to:

1. Define specific sets of competencies in the NNCCS on the care of the chronically ill adult patient.
2. Select learning activities that will enable learners to implement the NNCCS in the care of the chronically ill adult client.
3. Apply nursing tools, guidelines and/or frameworks in the care of the chronically ill adult client.
4. Utilize teaching-learning strategies that will develop critical thinking and decision-making skills in the learner when caring for the chronically ill adult client.
5. Evaluate the achievement of specified NNCCS competencies in the care of the chronically ill adult client using appropriate methods and tools.
6. Specify policies and actions necessary to facilitate implementation of the NNCCS in chronic care settings.

TOPIC OUTLINE

1. Critical Thinking in the Inquiry-based Approach
2. Relationship-centered Care
3. The Chronic Care Model
4. Establishing a Working Relationship with Chronically Ill Client
5. Assessing the Chronically Ill Client
6. Prioritizing Care of the Chronically Ill Client
7. Interventions for the Chronically Ill Client
8. Promoting Healthy Lifestyle and Wellness Strategies in the Chronically Ill Client
9. Mobilizing Community Resources for Chronic Care
10. Mobilizing Support Systems for Chronic Care
11. Providing Health Education in Chronic Care
12. Evaluating Outcomes in Chronic Care
13. Documenting Chronic Care

MODULE CONTENT

1. CRITICAL THINKING IN THE INQUIRY-BASED APPROACH TO LEARNING CHRONIC CARE

Critical thinking is a “composite of attitudes, knowledge and skills which includes: (1) attitudes of inquiry that involve an ability to recognize the existence of problems and strengths, and an acceptance of the general need for evidence in supported of what is asserted to be true; (2) knowledge of the nature of valid inferences, abstractions, and generalizations in which the weight or accuracy of different kind of evidence are logically determined; and (3) skills in applying and applying the above attitudes and knowledge.” (Watson & Glaser, 1980, p. 1) The intent of inquiry-based learning (IBL) is to move away from a focus on content coverage to a way of critical thinking that not only enhances the acquisition of knowledge and skills in the here and now, but also the application of these knowledge and skills in future situations. The importance of these learning and application skills is critical especially in the case of the novice nurse whose experience range is so limited that decisions for action are prone to error.

The traditional method of cramming content through lectures, followed by clinical experiences may no longer be effective because this method fails to engage students or prepare them to practice effectively.

IBL has been found to facilitate the development of skills in critical and analytic thinking and has been associated with greater retention of knowledge than traditional teaching methods. It is a learner-centered approach that uses case situations as a stimulus for learning. It incorporates discussions, inquiry, and then more questions to analyze and understand health situations. The focus of Inquiry-Based Learning (IBL) is to include strengths of clients as well as problems, and students are required to think beyond individuals, and to explore implications for families, communities, and societies. It has also been used to support different collaboration models for disciplinary discussion and teamwork, skills that are required for successful practice in chronic care.

There are several ways to use IBL as an instructional approach in nursing. Magnussen et al. (2000) and Holaday & Buckley describe the use of IBL to inquire into client situations where a case is revealed in a sequential manner. Students would then discuss what is “known” about the situation, distinguishing what is relevant from irrelevant data and determining what, if any, information is missing. The teacher’s role is to keep students on track, to encourage the exploration of all relevant issues and questions, and to think critically about the case under discussion. When needed, the teacher questions students to help them think about what was presented and to problem solve.

The goal of IBL strategy is to produce a nurse who uses a critical inquiry process to guide practice, decision-making and who possesses the ability to reflect upon practice experiences. Initially, the nursing student or the beginning nurse is guided by theoretical knowledge regardless of the situation, and, with experience, develops the ability to recognize more subtle nuances of situations. Then, through experience, the nurse enhances confidence in his/her ability to understand and manage more complex clinical situations and recognize the limitations of his/her individual experience and knowledge. This acknowledgment then leads him/her to seek guidance from experienced practitioners. This is the beginning of safe and quality nursing.

2. RELATIONSHIP-CENTERED CARE (RELATIONAL OR RELATIONSHIP-BASED)

Nursing is Caring Science. It is a science that brings together arts, the humanities, and science. A caring science perspective is grounded in a relational ontology of being-in-relation. This perspective is the basis of relationship-centered care. Research is demonstrating that relational variables are important in improving health care outcomes, and nowhere is this more important than in the care of the chronically ill client. Many people who are unable to afford medical coverage may be disenfranchised from the current healthcare system and may not be able to afford technological care. However, they may still have access to caring professionals and the healing aspects of the relationship. Nurses view maintaining relationships as a central part of our practice.

To be therapeutic, the relationship between nurse and client should have its foundation in a shared understanding of the meaning of the illness. This vantage point requires that the nurse respond to the experience of the client. Especially in chronic care, the nurse must also be able to understand the meaning of the illness to and through a person who is close to the patient, such as a parent, caregiver, or spouse. This type of relationship may be necessary in cases where the patient is a one who is intellectually handicapped or is in the late stages of dementia. It also occurs when the patient and the nurse speak different languages, requiring a translator to mediate between the two.

Relationship-centered care also means attention to relationships with other health-care practitioners because it takes a team to pay attention to the many dimensions of the chronic illness experience. Within a community of practitioners, the nurse, as a member of that community, must have the competencies to be able to interpret the other team members’ work, resolve conflicts related to the care of the patient, and allow responsibilities and leadership to shift as the patient’s needs change, and provide support to and accept support from the other members of the team. Especially in chronic care, the intradisciplinary team members must be able to recognize and act upon the interconnectedness of the emotional, social,

physical, and spiritual aspects of well-being and illness. The nurse must be skillful in collaborating with others, working cooperatively, and resolving conflicts in a democratic manner. Underlying these skills is the capacity to share responsibility in a thoughtful – not compulsive – way. The nurse must be open to others' ideas, maintain an attitude of humility, and value the mutual trust, support, and empathy of all involved in the care. In addition, he/she must exhibit a capacity for grace, which represents an attitude of decency, thoughtfulness, and generosity of spirit toward others.

In order to work effectively in this context, the nurse must develop knowledge and skills in, and attribute value to, each of the following four areas (Tesolini, 1994):

- a. self-awareness and continuing self-growth
- b. the patient's experience of health and illness
- c. developing and maintaining relationships with patients
- d. communicating clearly and effectively

For the nursing student or the beginning nurse, these four areas form a developmental sequence or process, starting with self-awareness, self-knowledge, and self-care, which serve as the foundation for subsequent development within other areas and ultimately as the foundation for all caring and healing relationships. Valuing self-awareness and developing a capacity for reflection are critical. Who the nurse is as a person is most relevant to the quality of care he/she gives and to the quality of the relationships that he/she is able to form. Self-knowledge, on the other hand is what keeps the nurse from causing harm to the patient by keeping in check his/her own emotional responses to the patient needs, which, if allowed to creep into the relationship, might act as a barrier to effective care. Self-care is essential and the nurse must treat him/herself with the same respect and care that is given any important resource.

But how is relationship-centered care taught, especially in a modularized approach such as the NNCCS strategy? Educational strategies for teaching relationship-centered care can be grouped within a four-stage process. The first stage of learning is characterized by strategies to promote introspection and reflection. The object is to encourage self-awareness and self-knowledge. Strategies that may be used in this phase include journal writing, magic wand exercises (e.g., If you had a magic wand, and could change anything in this situation, what would it be? Follow up with, "Why?") These strategies allow learners to reflect on work and learning experiences and represent structured opportunities to move in the direction of individual and professional full potential. The second stage is associated with strategies to promote skills in observation and listening. Learning activities in this stage include patients' and nurses' stories and exploration of the literature to ensure that the learners master knowledge of others (other authors have named this strategy "noticing" or "being mindful") and an understanding of patients' situations in the context of their lives. Third, strategies to promote effective practice include opportunities for concrete experiential practice of skills in interdisciplinary settings and with clinical role models who demonstrate a whole person approach to care. This third strategy may best be employed by a College of Nursing. Finally, a debriefing is held to provide opportunities for reflection and discussion on experiences, the growth in self-knowledge and empowerment in the care of the chronically ill patient.

The references in the latter part of this module may further serve to explicate relationship-centered care and how the academe can start this way of caring early on in the nurse learner's journey.

3. UNDERSTANDING AND TEACHING THE CHRONIC CARE MODEL

The current healthcare system and the competencies that healthcare professionals possess are largely designed for acute illness. It is now widely recognized that there is a mismatch between the chronic patients' needs and the current care delivery system. Effective system changes, including leveling up health care professionals' competencies, have been found to improve chronic care outcomes. The current care systems are organized to respond rapidly and efficiently to any acute illness or injury that came through the

door. The focus is on the immediate problem, its rapid definition and exclusion of more serious alternative diagnoses, and the initiation of professional treatment. In this situation, the patient's role is largely passive, and there is little urgency to develop patient self-management skills.

Nurses involved in chronic care will need to develop a new set of competencies to assist chronic care clients deal with a common set of challenges – dealing with symptoms, disability, emotional impact, complex medication regimens, difficult lifestyle adjustments, and obtaining health care that is helpful and focused. More often than not, in the current situation, chronic care clients wrestle with physical, psychological, and social demands of their illness without much help or support from medical care. The help that is most often extended, while well-intentioned, fails to afford optimal chronic care.

To effectively manage chronic illness, a new kind of practice, with a new set of competencies, designed expressly to meet the unique needs of patients, is imperative. These skills should be embedded in interactions during which nurses (1) elicit and review data concerning patients' perspectives and other critical information about the course and management of the condition; (2) help patients so set goals and solve problems for improved self-management; (3) apply clinical and behavioral intervention that prevent complications and optimize disease control and patient well-being; and (4) ensure continuous follow-up. This new way of practicing is embedded in the Chronic Care Model developed by E. Wagner of the MacColl Institute for Healthcare Innovation (2003).

Web Resource

The Chronic Care Model. (n.d.). In *Improving Chronic Illness Care*. Retrieved from http://www.improvingchroniccare.org/index.php?p=the_chronic_care_model&s=2

To read more about the Chronic Care Model (CCM), the learner is directed to a website: Improving Chronic Illness Care. The references below include a link to the website. The CCM identifies essential elements in a health care system that leads to high-quality and safe chronic disease care. These elements are (1) the community, (2) the health system, (3) self-management support, (4) delivery system design, (5) decision support, and (6) clinical information systems. The objective is to promote productive interactions between an informed, empowered patient and family, and a prepared, proactive practice team.

The CCM has been undergoing refinement since it was first developed in the mid 1990s. In 2013, the CCM was updated to include five themes in addition to the six elements: (1) Patient Safety (in Health System), (2) Cultural competency (in Delivery System Design), (3) Care coordination (in Health System and Clinical Information System), (4) Community policies (in Community Resources and Policies), and (5) Case Management (in Delivery System Design). Teaching aids (i.e., slideshow explaining the Chronic Care Model) are found in the improving chronic care link below.

The nurse is part of the prepared, proactive practice team. What characterizes the members of this team? A prepared, proactive team (of which the nurse is a member) means that at the time of the interaction, the nurse has the EXPERTISE, the patient information, decision support, and the resources necessary to give safe and high-quality care. Nurses must therefore be organized, trained and equipped to conduct productive interactions.

4. ESTABLISHING A WORKING RELATIONSHIP WITH THE CHRONICALLY ILL ADULT CLIENT

Establishing rapport, which leads to a productive working relationship with the client with chronic illness requires an understanding of the patient's "context" and needs. The unique feature of chronic care is that clients often see their nurses over an extended period of time, or the patient may also flit from one institution

to another, trying to find a treatment that “makes sense.”

A working relationship is built on positive nurse-patient communication which is crucial to the quality of life and well-being of chronically ill patients. A nurse’s interactional skills are important because of the chronic nature of the health problems.

An example of an interactional intervention is Solution-Focused Brief Therapy (SFBT). SFBT is a communication intervention that is positive, collaborative, and solution-focused. Nurses begin interactions in a positive manner and communication does not revolve around problems. The nurse should show that he/she is interested in the person as a whole, not just his/her condition. The solution-focused nurse elicits, amplifies, reinforces the strengths, abilities, and hopes of the patient. SFBT is brief and does not require long periods of time to engage the patient. Communication skills with this approach include (1) eliciting questions (i.e., What would you like instead?), (2) inquiring about details (i.e., What exactly did you do differently?) and (c) verbal rewards (i.e., You are doing good.). It may be helpful to analyze usual versus desired scenarios adapted from Boscart (2009):

Table 5.4.1	Traditional Nurse-Patient Interaction versus Solution-Focused Brief Therapy
Traditional	Patient: Wait. Nurse: Is there a problem? Patient: You’re hurting me (as the nurse dresses the patient’s wound). Nurse: Don’t worry. I will do this quick. It won’t hurt as much if I make it quick. Patient: That hurts! Nurse: Don’t worry, I’m almost done. Patient: No! You are like the others. You don’t care (starts crying).
SFBT	Patient: Wait. Nurse: Is there a problem? Patient: You’re hurting me (as the nurse dresses the patient’s wound). Nurse: How would you like me to dress it so that I’m not hurting you as much? Patient: Just take your time and don’t rush. Also use light strokes. Nurse: OK. That’s what I’ll do then. Let me know if I’m hurting you.

To learn more about SFBT, the reader is directed to read the Boscart (2009) article below.

The performance indicators in Table 5.4.2 show that building a working relationship requires that the nurse also reveals pertinent information about himself/herself. Most nurses will balk at this, especially those who value their privacy. However, sharing pertinent information like the name the nurse prefers to be called (i.e., Please call me Nurse Maria.) and how long he/she has been a nurse, may serve to allay the patient’s anxiety. The nature and purpose of the client-partner working relationship needs to be very clear from the beginning. In chronic care, the patient takes on an active role, and the nurse is a facilitator, not the actual “doer.” This is a very different stance from acute care. The Master Teacher needs to appreciate this difference and emphasize this point in the discussion. The patient’s ability to participate is assessed at the beginning of the interaction. Sometimes, there is no problem with the patient’s ability. The problem may lie in the willingness. The nurse must be able to determine the difference and act using the appropriate tools, and must not forget that the goal in chronic care is patient self-mastery.

For the patient to maintain this working relationship, the issue of trust is important. Trust, in the care of

chronically ill patients is characterized by consistency of actions and interactions. For example, in the area of establishing rapport and building a working relationship, it is important that the first few interactions between patient and nurse are characterized by the nurse making the patient feel at ease. Examples of behaviors that might result in a feeling of ease are: introducing self, explaining his/her position (i.e., I am your nurse today from 6 AM to 2 PM.), being friendly and warm, treating the patient with respect, not cold or abrupt. Other behaviors like giving the patient time to fully describe the condition in his/her own words, not interrupting, rushing, or diverting the patient; paying close attention to what the patient is saying, not looking at notes or the computer while the patient is talking, asking/knowing relevant details about the patient's life, not treating the patient as a "number."

Another way to build rapport is to focus on nonverbals. A technique called "mirroring" may be used to build rapport. A video on Physical Mirroring may be a useful tool for the Master Teacher. The tool can be found in the link on Physical Mirroring. After the video is watched, reflection questions must be asked to further self-knowledge. Examples of questions might be: Do you currently practice physical mirroring? Why or why not? Now that you know about it, would you practice it? Why or why not? What happens when you mirror behavior that is negative?

Table 5.4.2	NNCCS on Establishing a Working Relationship with the Chronically Ill Adult Client	
Responsibility 2	Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES		PERFORMANCE INDICATORS
2.1. Ensures a working relationship with the client and /or support system based on trust, respect and shared decision making.		
2.1.1. Establishes rapport with the client and/or support system ensuring adequate information about each other as partners in a working relationship.		<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner. 2. Addresses with respect and trust client-partner's concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship.
2.1.2. Formulates with the client-partner the objectives and expectations of the nurse-client working relationship.		<ol style="list-style-type: none"> 1. Explains nature and purpose of the client-partner working relationship. 2. Prepares with the client a list of objectives and expectations.
2.1.3. Maintains shared decision making and client's participatory capability throughout the nurse-client working relationship.		<ol style="list-style-type: none"> 1. Assesses client's participatory capability. 2. Determines strategies to ensure shared decision making and client participation throughout the working relationship. 3. Carries out appropriate strategies to ensure continued participation of the client.

COMPETENCIES	PERFORMANCE INDICATORS
2.1.4. Enhances client-partner's readiness for taking over/ being in-charge when objectives and expectations of the working relationship have been achieved.	<ol style="list-style-type: none"> 1. Assesses client's readiness for taking charge of the condition or situation. 2. Uses strategies to prepare the client for being in-charge/taking over charge when objectives and expectations of the working relationship have been achieved or when the situation necessitates termination of the nurse-client relationship. 3. Supports client as he takes charge of maintaining health or managing the condition/situation (e.g. taking over self-care or implementation of prevention and control measure).

5. NNCCS ON ASSESSING THE CHRONICALLY ILL CLIENT

The quick 3- or 10-minute assessment designed for the acutely ill patient simply will not do for the chronically ill patient. Although the nurse has to perform the quick assessment to assess physiological status, he/she has to do a more extensive assessment.

Aside from affecting the patient's physical health, chronic disease also has an effect on his/her mental health, social life, and employment status in radically different ways. Some chronic conditions are highly disabling, others less so. The chronic care patient needs to be holistically assessed from the social, emotional, spiritual aspects, and lifestyle, willingness or motivation for change, and motivation for self-management.

The Transtheoretical Model of Change by Prochaska (1997) is used to identify readiness of the patient to change and improve behavior. Following are the stages:

1. **Precontemplation (Not ready):** patient is not intending to take action in the foreseeable future and may be unaware that his/her behavior is problematic.

Nurse Action: Encourage the patient to become more mindful of the decision-making process and more conscious of the multiple benefits of changing an unhealthy behavior.

Tools: The Master Teacher may use OARS or "A Typical Day" during this stage. OARS (Open-ended questions, Affirmations, Reflective listening, and Summaries) is a motivational interviewing technique. The goal in using the OARS is to move the patient forward by eliciting change talk, or self-motivational statements.

2. **Contemplation (Getting Ready):** The patient is beginning to recognize that his/her behavior is problematic

Nurse Action: Encourage the patient to work at reducing the cons of changing his/her behavior.

Tools: Ask-tell-ask. This is a communication technique where the nurse asks and affirms what the patient knows, then the nurse asks permission to tell information, and then finally asks for patient feedback. This strategy is best used in conjunction with role play.

Nurses typically like to "tell" patients when giving patient information. As a Master Teacher, you

must remind your students to ask and not tell whenever providing health information. Another tool is “Pros and Cons” where the nurse asks the patient to consider both sides of behavior. To practice, nurses list the pros-and-cons of smoking, for example.

What are the good things about smoking? Followed by

What are the less good things about smoking?

Using this strategy pushes a patient “in denial” to argue for change, called “change talk.” This situation causes an “ambivalence” about the behavior in question. This move toward ambivalence moves the patient closer toward readiness to become informed and activated.

3. **Preparation (Ready):** The patient is intending to take action in the immediate future, and may begin taking small steps toward behavior change.

Nurse Action: Encourage to seek support from friends he/she trusts, tell people about their plan to change the way he/she acts, and think about what it would feel if he/she behaved in a healthier way.

4. **Action** - The patient has made specific overt modifications in modifying his/her problem behavior

Nurse Action: Help by teaching techniques for keeping up his/her commitments such as substituting activities related to the unhealthy behavior to positive ones, rewarding him/herself for taking steps toward changing, and avoiding people and situations that tempt them to behave in unhealthy ways.

5. **Maintenance** - The patient has been able to sustain action for a while and is working to prevent relapse.

Nurse Action: Encourage the patient to seek support from and talk with people whom they trust, spend time with people who behave in healthy ways, and remember to engage in healthy activities to cope with stress instead of relying on unhealthy behavior.

6. **Termination** - The patient has zero temptation and is sure that he/she will not return to his/her old unhealthy habit as a way of coping.

Web Resource

Visit this website to access Prochaska’s Transtheoretical Model: <http://peaceforsale.org/2011/03/18/before-marketing-social-change%E2%80%A6how-does-social-change-happen/>

Aside from assessing where in the stages of behavior change the patient is at the time of assessment, the nurse has to also determine the following with each hospitalization or each clinic visit: the patient’s goals for this hospitalization/consultation, the patient’s clinical status, classify/identify relevant treatments and/or advice and counsel, risk factors, and patient’s knowledge, beliefs, concerns, and daily behaviors related to his/her chronic condition and treatment.

Table 5.4.3 Assessing the Chronically Ill Client	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.2. Assesses with the client (individual, family, population group, and/or community) one's health status/competence.	
2.2.1. Develops the data gathering plan with the client, specifying methods and tools.	1. Uses strategies to develop/enhance the skills of the client to participate in developing/specifying the methods and tools for data gathering.
2.2.2. Obtains assessment data utilizing appropriate data gathering methods and tools guided by type of client and work setting requisites.	1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework. 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by work-setting requisites. 2.1. Individual as client – obtains assessment data through nursing history taking, physical/developmental/psychosocial assessment and other assessment protocols, laboratory and diagnostic procedures 2.2. Family/population group/community as a client – obtains assessment data through family health history, assessment of the home and environment, records review and other assessment protocols such as laboratory and diagnostic procedures/reports, epidemiologic and social investigations and assessment of client competence, risk factor assessment, screening of vulnerable risk groups, and assessment of issues of vulnerability (health risks, limited control, powerlessness, disenfranchisement, victimization and disadvantaged status).
2.2.3. Analyzes data gathered.	1. Groups assessment data by condition or category using appropriate assessment framework by type of client. 2. Relates data with each other to determine patterns, recurring themes and processes. 3. Compares data, patterns and recurring themes with norms/standards, clinical health indicators or research findings using algorithms and standard protocols.
2.2.4. Synthesizes data gathered.	1. Interprets data gathered.

COMPETENCIES	PERFORMANCE INDICATORS
	2. Draws inferences from data gathered by specifying the nature, magnitude/extent and sources of/ reasons for the alterations (e.g. pathophysiology, psychopathology), gaps, deficiencies and/or barriers to opportunities for change or improvement, health promotion/wellness, disease prevention, problem/ disease management, rehabilitation.
2.2.5. Specifies client's status/ condition/ problems to be addressed identifying reasons (etiology) for the existence of that condition or problem.	<ol style="list-style-type: none"> 1. Identifies the factors associated with the condition/s or reasons for the existence of the problem. 2. States nursing diagnosis or nursing problems. 3. Seeks concurrence with the client regarding problems identified.

Chronically ill persons must have a practice team that organizes and coordinates their care. This team tries to optimize patient outcomes through a series of interactions during which they (1) elicit and review data concerning patients' perspectives and other critical information relevant to the course and management of the condition(s); (2) help patients to set goals and solve problems to ensure optimum self-management; (3) apply clinical and behavioral interventions that prevent complications and optimize disease control and well-being; and (4) ensure continuous follow-up (Wagner et.al, 2000). Several studies have demonstrated the added benefits of ready access to more experienced nurses and other professionals who have the skills and time needed for optimal self-management support and assistance.

The Master Teacher's role is to assist the learner to establish assessment techniques that are systematic, comprehensive and robust.

6. PRIORITIZING CARE OF THE CHRONICALLY ILL CLIENT

It is not uncommon for chronic patients to have more than one chronic condition, so health care workers, including nurses, face enormous challenges in determining which of the presenting issues are the most important. The issue of prioritizing treatment over preventive care is also difficult. Chronically ill patients often present as "complex" patients and herein lies the makings of a "perfect storm." Many practitioners have observed that they do not have time to look for the perfect answer and often have to rely on a risk-modeling approach that is also imperfect. The highest priorities for a chronically ill patient are the self-management, treatment, and interventions that are integral to their well-being. The Master Teacher needs to assist the learners to understand that priorities have to be aligned with the patient's goals. The shift from caring for each of a patient's conditions to caring for the patient as a whole must happen. Sometimes, the solution is minimally disruptive care that allows patients to pursue their dreams. For example, if an elderly man with diabetes, depression, and a disability desperately wants to maintain his independence, perhaps the priority is to work to reduce the man's workload as a patient and simplify his routine to focus on preventing another stroke. That would be this patient's priority, given his context and situation, but may not be the focus in another patient with different circumstances.

In chronic care, the plan of care and priorities must be driven by the patient and/or family. When there is a conflict between what the patient wants versus what the family wants, the patient's priorities are carried out. Table 5.4.4 lists the performance indicators for prioritizing care in chronically ill patients. The references below will assist the Master Trainer to understand how chronically ill patients prioritize which of the health problems will be given attention.

Table 5.4.4		Prioritizing Care in the Chronically Ill Client	
Responsibility 2		Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES		PERFORMANCE INDICATORS	
2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities.		<ol style="list-style-type: none"> 1. Sets priorities among a list of conditions or problems. 2. Specifies goal, objectives and expected outcomes of care maximizing client's competencies. 3. Selects appropriate interventions/strategies enhancing opportunities for health promotions, wellness response, prevention of problems/ complications, and eliminating gaps/deficiencies. 4. Uses methods/tools to maximize client/family participation in planning appropriate interventions/ strategies. 5. Develops with the client an evaluation plan specifying criteria/indicators, methods and tools. 6. Collaborates with the client and the inter-professional healthcare team in developing the plan of care. 7. Modifies plan of care according to one's judgment, skill or knowledge as client's needs change. 	

7. INTERVENTIONS FOR THE CHRONICALLY ILL CLIENT

Chronic diseases are not easy to treat. They are not prevented by vaccines or cured by medication. Rather, the major chronic disease killers are an extension of people's daily behaviors. These conditions are often brought on or intensified due to an individual's health damaging behaviors, in particular, tobacco use, sedentary lifestyle, and poor diet (CDC). Older adults are especially susceptible to chronic illnesses. A group that is also at high risk for developing chronic illness even at younger ages are those living below the poverty line. Poor nutrition, tobacco use, and lack of exercise are risk factors for chronic disease that are prevalent among this group. Also, inadequate housing and limited access to preventive medical care are often present in poorer communities.

When the chronically ill patient presents him/herself to a health care facility for an acute problem, the priority is the acute problem. However, preparation for discharge must occur early in the in-patient admission because the care of this patient will extend beyond the hospital stay. It is also important that proper handoffs between the hospital and appropriate community resources occur so that the patient does not "fall between the cracks" of a fragmented health care system.

Empowerment interventions, such as self-management programs have been found to be highly effective in chronic disease management. Self-management programs focus on patient education and behavior modification. Nurses must learn how to build the confidence of patients in managing their disease, work with the health care system and community to have their needs met and managing the emotional effects of their illness (Long, 2002). A systematic review of chronic disease empowerment interventions is found in the references section.

The need to include the family, especially in psychosocial interventions for the chronically ill patient, cannot be emphasized enough. Again, there is an article on family-oriented interventions in the reference list at the end of this module.

The Master Teacher should also emphasize the need for autonomous nursing practice. It is in chronic care where nurses are able to demonstrate concrete contributions to positive patient outcomes. The role of nurses is pivotal in improving care for chronic diseases. The creator of the Chronic Care Model himself, Dr. E. Wagner, acknowledges the role of nurses in improving outcomes in a talk captured in a YouTube video.

The Chronic Care Model mandates the use of evidence-based practice to guide care. In fact, the model brings together the best in research and practice for chronic care interventions. The hallmark of this model is that it is evidence-based, using only those interventions that have proven themselves in research and practice. There is a peer-reviewed bibliography covering specific chronic conditions in the Improving Chronic Illness Care Website and can be accessed by clicking the link in the reference list.

Table 5.4.5 Interventions for the Chronically Ill Client	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues.	
2.4.1. Implements appropriate psychosocial/therapeutic interventions to render holistic nursing care in any setting.	<ol style="list-style-type: none"> 1. Addresses with respect, trust, and concern for safety, client's needs, issues or problems related with psychosocial adaptation using appropriate communication/interpersonal techniques/strategies. 2. Utilizes therapeutic interventions appropriate to psychosocial phenomena/maladaptive behavior patterns/problems identified. <ol style="list-style-type: none"> 2.1. Utilizes therapeutic use of self (e.g. Uses self-awareness techniques/strategies; determines appropriate strategies to achieve the goals of the nurse-patient relationship, seeks consensual validation with client). 2.2. Implements psychosocial/therapeutic interventions (e.g. Nurse-client relationship therapy, Relaxation exercise/therapy, Behavioral/Cognitive therapy, Coping Assistance, Mental Health counseling/education, Social support intervention, Environmental structuring/Milieu therapy, Psycho-spiritual care, and Crisis intervention/ Psychological stress de-briefing). 2.3. Carries out biophysical interventions (e.g. Nutritional intervention, Detoxification, Pharmacotherapeutics). 3. Collaborates with client support system and the multidisciplinary team in developing, implementing and evaluating the plan of care.

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.2. Provides appropriate evidence-based nursing care using participatory approach based on:</p> <ol style="list-style-type: none"> Variety of theories and standards relevant to health and healing research clinical practice clinical preferences client and staff safety customer care standards 	<ol style="list-style-type: none"> Develops competence of the client to participate in using appropriate evidence-based nursing care. Refers to appropriate authority client's situations not within his/her capabilities. Decides on appropriate interventions to address client's specific concerns, issues and problems based on the situation. Performs autonomously a wide range of nursing interventions (action, treatments and techniques) in accordance with nursing standards which include promote health, prevent disease or injury, maintain and restore health, promote rehabilitation, and provide palliation.
<p>2.4.3. Applies safety principles, evidence-based practice, infection control measures and appropriate protective devices consistently, when providing nursing care and preventing injury to clients, self, and other health care workers and the public.</p>	<ol style="list-style-type: none"> Performs evidence-based nursing procedures safely and effectively. Uses appropriate technology to perform safe and efficient nursing interventions. Applies consistently principles of infection control in practice. Uses appropriate personal protective equipment. Ensures that the members of the health care team and visitors perform infection control measures accordingly. Requests change in assignment when his/her competence level does not meet the client's care needs.
<p>2.4.4. Implements strategies related to the safe preparation and administration of medications based on institutional policies and protocol.</p>	<ol style="list-style-type: none"> Prepares medication according to standard procedures. Check on the medication to be administered three times. Avoids interruptions during the preparation and administration of medication. Performs the 2-patient identifier checks before administering the medication. Reviews appropriate laboratory results, assessment findings and other pertinent information prior to administration of medication. Withholds the medication when appropriate. Inform the physician of side effects and adverse reactions to the medication. Completes the adverse drug reaction (ADR) documentation appropriately. Collects data/statistics to manage and reduce risks related to medication administration. Modifies techniques of medication administration in a variety of setting based on standards.

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.5. Applies evidence-based practices on pain prevention and management of clients using pharmacologic and non-pharmacologic measures.</p>	<ol style="list-style-type: none"> 1. Selects appropriate assessment and intervention tools and techniques based literature review, consultation with colleagues and other resources. 2. Carries out evidence-based practices with the client on pain prevention and management using pharmacologic and non-pharmacologic interventions. 3. Uses a framework to structure the use of analgesia in the pharmacologic management of pain (e.g. WHO Pain Ladder which includes: assesses symptoms comprehensively, identifies common, expected and un expected symptoms, relieves symptoms through a variety of strategies, evaluates intervention for effectiveness of symptom-relief, and revises the symptom management plan as needed).
<p>2.4.6. Implements safe, adequate, evidence-based care of client during the pre, intra, and post-diagnostic and treatment procedures.</p>	<ol style="list-style-type: none"> 1. Explains to the client the diagnostic and treatment procedure. 2. Prepares adequately the client prior to the procedure (e.g. NPO, enema, informed consent). 3. Chooses evidence-based interventions pre, intra, post diagnostic and treatment procedure. 4. Performs evidence-based interventions pre, intra, post diagnostic and treatment procedure. 5. Monitors for adverse reactions and complications post procedure. 6. Reports adverse reactions and complications post procedure. 7. Reviews diagnostic and treatment procedure results using a specific effective communication model (e.g. the SBAR format – Situation, Background, Assessment, Recommendation). 8. Relays diagnostic procedure results to physician. 9. Recommends further diagnostic procedures and/or treatment options for adverse reactions and complications in coordination with a senior member of the nursing team.

COMPETENCIES	PERFORMANCE INDICATORS
2.4.8. Applies appropriate and evidence-based nursing interventions for physiologic and related psychosocial needs of patients/clients to preserve physiologic integrity and prevent complications of problems of oxygenation (ventilation, transport, perfusion); fluid and electrolyte imbalance and acid-base imbalances; nutrition and metabolism; gastrointestinal (indigestion, digestion, absorption, elimination); urinary function; perception, coordination, and altered sensation; inflammation, infection and immune responses; cellular aberration, altered genetic conditions; and reproductive problems.	<ol style="list-style-type: none"> 1. Generates adequate assessment data according to level of prescribed/ needed care. 2. Uses appropriate assessment techniques with least discomfort to patients. 3. Recognizing and prioritizes emerging problems in a timely manner. 4. Provides substantial pathophysiologic reasoning for problems and changing patient situations. 5. Integrates plans for immediate and subsequent patient care. 6. Provides for patient's hygiene and comfort continuously. 7. Where peri-operative care is needed, incorporates appropriate safety indicators and interventions to reduce anxiety. 8. Demonstrates skill in performing basic and advance nursing interventions and rehabilitation care. 9. Follows correct procedures and collaborates appropriately in the administration of medications related to IV fluids, blood, and blood products. 10. Demonstrates caring and compassionate care, especially to vulnerable patients. 11. Has the ability to anticipate changing patient situations. 12. Communicates with the health team constantly, as well as with the client and his/her family. 13. Uses complimentary, alternative and behavioural therapies appropriately. 14. Maintains holistic perspective and spiritual care. 15. When end-of-life care is needed, ensures appropriate presence of significant others. 16. Exercises good intentions and safe care practices when performing nursing interventions.

Note: Competency 2.4.7. was deleted because it refers to maternal care and is not relevant to chronic care.

8. PROMOTING HEALTHY LIFESTYLES AND WELLNESS STRATEGIES IN CHRONICALLY ILL CLIENTS

Chronic diseases are often preventable. Screening tests and other preventive services can be routinely offered. Early detection can be found through tests and also discussing risk related behaviors during physical exams. These interventions can identify who is at risk of developing a chronic condition and help them to prevent disease or lessen the severity of illness.

Wellness programs targeted at the control of risk related to chronic care include tobacco prevention and/or cessation, physical activity promotion, nutrition education and healthy eating promotion, blood pressure and cholesterol control assistance, health screenings and monitoring, and disease management. Employee/

worksite wellness programs may also involve nursing expertise.

Table 5.4.6 lists the performance indicators for this competency. The emphasis is on health promotion in chronic care. Health promotion is defined as the process of enabling people to increase control over, and to improve their health.

Table 5.4.6 Promoting Healthy Lifestyles and Wellness Strategies in Chronically Ill Clients	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues.	
2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access within the context of Primary Health Care.	<ol style="list-style-type: none"> 1. Determines participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access. 2. Creates opportunities to develop client's competence for promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access. 3. Executes appropriate participatory and empowerment strategies.
2.4.10. Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resources access or use and safe environment conducive to health maintenance.	<ol style="list-style-type: none"> 1. Develops the competence of the family to recognize opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease/problem management and environmental sanitation and protection by: <ol style="list-style-type: none"> a) Analyzing the factors affecting health, human response, the environment and its resources/realities b) Determining the relationships among these factors c) Specifying the health and related conditions/problems which need to be addressed. 2. Carries out strategies/interventions to help the family decide to take appropriate action on each health condition/problem identified. 3. Implements competency-building interventions options to help family provide appropriate care to the dependent, at-risk, vulnerable, sick, and/or disabled member/s. 4. Develops the competence of the family to provide a home-environment conducive to health maintenance and personal development.

COMPETENCIES	PERFORMANCE INDICATORS
	5. Carries out participatory and empowerment strategies to enhance the family's competence to use community resources for health care and health maintenance.
2.4.10.2. Implements strategies/ interventions to ensure healthy population/s in the school and work settings	<ol style="list-style-type: none"> 1. Carries out empowerment strategies to enhance competence for health promotion, healthy lifestyle/ adaptation, wellness, disease and accident prevention/management among population groups in the school and work setting. 2. Performs counterparting strategies to help population groups in the school and work setting carry out activities or measures in support of environment protection and maintain a safe environment.
2.4.10.3. Enhances the competencies of specific population groups to ensure wellness, healthy lifestyle/adaptation, disease prevention, management, rehabilitation and vulnerability reduction or prevention.	<ol style="list-style-type: none"> 1. Develops the competence of specific population groups/support systems to analyze the relationship of factors or patterns, home and community realities affecting health, human response, and the environment. 2. Implements effective strategies to develop/enhance the competence of specific population groups/ support system/s for decision making on appropriate action/s for healthy lifestyle/adaptation, disease prevention, management and rehabilitation. 3. Carries out empowerment strategies to develop the competencies of specific population groups and support system for health care, healthy lifestyle/ adaptation, use of health service and health resource access or use.

9. MOBILIZING COMMUNITY RESOURCES FOR CHRONIC CARE

Hospitals can enhance care and avoid duplicating efforts if community resources are mobilized. Community programs can support or expand a health care system's capacity to care for chronically ill clients. In particular, whenever disaster strikes, it is chronically ill patients that may have limited access to evacuation activities due to limitations in their physical condition. The nurse's ability to mobilize community resources to meet the chronic patient's needs is crucial and can make a difference.

Table 5.4.7 breaks down performance indicators for mobilizing community resources for chronic care.

Table 5.4.7 Mobilizing Community Resources for Chronic Care	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues.	
2.4.10.4. Implements participatory and empowerment strategies for community competence to identify and collaborate effectively in addressing needs and problems related with health resource availability, access or use, environmental sanitation, environment protection, safety and security.	<ol style="list-style-type: none"> 1. Develops the competence of community work groups to: <ol style="list-style-type: none"> a) Analyze population and environmental factors/ community patterns/realities which generate need to address specific health conditions/situations/ patterns b) Articulate commitment and opportunities for community improvement on health resource availability access/use, environmental sanitation and protection, and safety/security. c) Handle/address issues and conflicts as creative options for collaboration and shared responsibility for decision-making by generating new ways of analyzing situations/problems for multiple possibilities/effective solutions. 2. Carries out participatory and empowerment opportunities to increase community's competence for interaction, decision-making, effective implementation of actions and management of community's relationship with the larger society for environmental sanitation and environmental protection, safety, security and for creating or using appropriate and/or supplementary resources especially for the marginalized or the vulnerable risk groups.
2.4.11.Implements appropriate care to individuals, families, vulnerable groups and communities during three phases of disaster situations, such as: 1) Pre-incident phase, 2) Incident phase, and 3) Post incident phase.	<ol style="list-style-type: none"> 3.2.1. Participates in the prevention and mitigation of adverse effects of a disaster. 3.2.2. Performs preparedness activities as a member of the multi-disciplinary team. 3.2.3. Executes appropriate nursing interventions in collaboration with disaster response team. 3.2.4. Provides care and support to those injured with chronic disease, maladaptive patterns of behaviour and disabilities during recovery/ reconstruction/rehabilitation period.

10. MOBILIZING SUPPORT SYSTEMS FOR CHRONIC CARE

Support systems, especially family support systems, have been found to assist chronically ill patients

cope with the disease as well as motivate toward self-management. Support system programs may have three separate foci: family members set goals to support patient self-care behaviors, family members are trained in supportive communication techniques such as prompting patient coping techniques or use of autonomy supportive statements, and families are given tools and infrastructure to assist in monitoring clinical symptoms and medications. In the Philippines, spiritual care is viewed as a priority, since religion is a source of strength for Filipinos as they go through trying circumstances. The role of religion in health care in Filipinos is further discussed in Purnell's book.

Learning to manage a chronic illness effectively can take years and can be viewed as a lifelong process that is difficult for the patient to bear alone. Fortunately, there is increasing recognition of the need to partner in self-management support. The Institute for Healthcare Improvement (IHI) has developed a toolkit for clinicians which encourages patients with chronic conditions and their families to understand their central role in managing their illness, make informed decisions about care, and engage in health behaviors. This reference has specific scripts that help convey support for specific areas like coping with stress and negative emotions.

Table 5.4.8 Mobilizing Support Systems for Chronic Care	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues.	
2.4.12. Implements appropriate nursing interventions to help clients and support system address spiritual needs.	<ol style="list-style-type: none"> 1. Utilizes appropriate technique of communication when identifying needs of client for spiritual care. 2. Provides the client with appropriate environment and materials for praying. 3. Offers opportunities for performance of religious activities based on client's religion. 4. Refer to an appropriate religious agency for further spiritual support.
2.4.13. Manages client load to ensure health program/service coverage.	<ol style="list-style-type: none"> 1. Conducts case detection, tracking, tracing and monitoring surveillance. 2. Conducts health programs and services in the home, clinic, school, and work settings. 3. Carries out strategies to ensure health program/service coverage based on health programs objectives/targets, through health resource availability, access, and/or use, especially among marginalized/vulnerable risk groups. 4. Determines adequacy of health program/service coverage based on updated caseload registries by type of client, health program or health problem (e.g. Client lists for Prenatal/Postpartum Care, Client List for At-risk Children, Family Registry of Priority Cases)

COMPETENCIES	PERFORMANCE INDICATORS
	<ol style="list-style-type: none"> 5. Carries out interventions for effective and efficient care of clients in the caseload based on assigned geographical coverage. 6. Adheres to institutional safety policies and protocols to prevent injuries/accidents and infection. 7. Refers client for appropriate management and assistance for health and medical-related benefits. 8. Reports notifiable/reportable disease based on protocol.

11. PROVIDING HEALTH EDUCATION IN CHRONIC CARE

Providing patients with information is one aspect of meeting their needs. It is meant to empower patients and their carers in making informed decisions and managing their health needs. All people with chronic disease need to manage their illness. To assist patients to become good self-managers, two major skills are required of health professionals: information-giving and collaborative decision making. However, the manner in which this information is provided, matters. Lecturing patients about the importance of changing behaviors even when patients agree, but are, in fact, struggling with poor health self-management skills, is not effective. On the other hands, reworking actions plans, even when patients would not follow up, is also ineffective. The goal of patient education is larger than simply making the patient comply with the regimen, and neither is it to empower patients who eventually turn out to reject direction. Neither of these two directions is capable of supporting highly successful best practice in chronic care. The best combination of patient education is that which empowers the patient to make informed decisions and still be amenable to making improvements in behavior through coaching.

The scope of patient education in chronic care is also important. Patient education in this patient population should include (1) techniques to deal with problems and frustration, fatigue, pain, and isolation; (2) appropriate exercise for maintaining and improving strength, flexibility and endurance; (3) appropriate use of medications; (4) communicating effectively with family, friends, and health professionals; (5) nutrition; (6) decision-making, and' (7) how to evaluate new treatments.

In chronic care, patient education has to be designed to enhance regular treatment and disease-specific education such as Better Breathers, cardiac rehabilitation, or diabetes instruction. Since many chronic disease patients have more than one condition, it is especially helpful to give them the skills to coordinate all the things needed to manage their health, as well as to keep them active in their lives.

Patient education needs to encourage self-efficacy, the confidence that one has that he/she can master a new skill or affect one's own health, also called self-management. Self-management education includes, not only traditional patient education, but also involves helping patients to set achievable goals and learn techniques for problem-solving that will improve their outcomes and quality of life. Traditional patient education is disease-specific, working with patients to provide knowledge about their condition and to teach skills needed to keep their condition under control. Goal-setting and problem-solving skills are not disease-specific.

For example, information giving alone does not improve glycemic control in diabetes. An additional factor is needed. That additional factor turns out to be collaborative decision-making and goal-setting. There is evidence that patient participation in decision-making increases the concordance of health care professional and patient goals, understanding of the disease regimen, and self-efficacy. More on this participatory and

collaborative relationship in patient education can be found in the references.

Assessing patient understanding of instructions by asking him/her to restate instructions, a method called “closing the loop,” was found to improve patient comprehension and disease management outcome. The Master Trainer needs to emphasize this point.

The ideal chronic disease self-management program must concern itself with nurses having the competency to engage the patient in making collaborative decision and setting collaborative goals, in addition to information giving. A specific strategy for collaborative decision-making is the planned visit where the agenda for each visit is negotiated. See reference. If the patient has something in mind that is not on the agenda, he/she probably will not be open to hearing what the nurse has to say. While the physician can encourage patients to engage in self-management skills, frequently, they do not have the time to get involved in the lengthy process of agreeing on goals and doing follow-up. Nurses are especially qualified to engage in the collaborative process of assessing readiness (both importance and confidence), discussing action plans, and conducting follow-up. For examples of collaborative goal-setting dialogues, see the Bodenheimer & Holman reference.

Table 5.4.9 Providing Health Education in Chronic Care	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community).	
2.5.1. Determines the health education planning models appropriate to target clientele/ expected objectives and outcomes.	<ol style="list-style-type: none"> 1. Specifies the characteristics of each health education planning model. 2. Selects appropriate health education planning model.
2.5.2. Utilizes health education process to accomplish the plan to meet identified client's learning needs.	<ol style="list-style-type: none"> 1. Assesses the needs of the target population. 2. Prioritizes the learning needs/problems in partnership with client partner. 3. Formulates appropriate goals and objectives 4. Designs a comprehensive health education plan. 5. Implements the health education plan utilizing appropriate teaching strategies 6. Evaluates the results of client's learning experiences using the evaluation parameters identified in the health education plan.

12. EVALUATING OUTCOMES IN CHRONIC CARE

Evaluating the effectiveness of nursing care is necessary for developing a sound knowledge base to guide practice. More importantly, evaluation of processes must now shift to evaluation of outcomes. The effectiveness of nursing care or interventions must be shown to produce the desired outcomes.

The outcomes must reflect the direct benefits of nursing care. When nurses use their chronic care skills appropriately, improvement in patient outcomes should include: glycemic control for diabetes patients, dramatic increase in follow-up for patients with depression; decreased rates of hypertension among patients with cardiovascular disease, overwhelming success in providing asthmatic patients with daily preventive medicines, and decreasing health care costs even while increasing the number of patient visits (Wagner et. al., 2001). If nursing care is effective, the client's condition or well-being should improve.

In chronic disease management, patients play an active role in defining and evaluating healthcare, because it is them who provide the majority of care in day-to-day management of their illness.

The Patient Assessment of Care for Chronic Conditions (PACIC) measures specific actions or qualities of care, congruent with CCM, that patients report they have experienced. The PACIC was designed to assess the implementation of the CCM from the patient perspective that focuses on the receipt of patient-centered care and self-management behaviors. The PACIC has 5 subscales addressing the following domains: patient activation, delivery system design, goal setting, problem solving, and follow-up/coordination. The survey also includes 3 sets of measures related to self-management behaviors over the past 6 months (use of self-management services, performance of self-management behaviors, medication adherence) and 2 patient-centered outcomes (quality of health care, quality of life). A copy of the PACIC is available through the link in the References section.

There is an excellent resource on developing an effective teaching style when teaching patients. Follow the link in the references section.

Table 5.4.10 lists the performance indicators for evaluating outcomes in chronic care.

Table 5.4.10 Evaluating Outcomes in Chronic Care	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.6. Evaluates with the client the health status/competence and/or process/ expected outcomes of nurse-client working relationship.	<ol style="list-style-type: none"> 1. Utilizes participatory approach in evaluating outcomes of care. 2. Specifies nature and magnitude of change in terms of client's health status/competence/processes and outcomes of nurse-client working relationship. 3. Monitors consistently client's progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools (e.g. critical pathway, nurse sensitive indicators, quality indicators, client competency indicators, hospital and community scorecard) in collaboration and consultation with the client 4. Revises nursing care plan based on outcomes and standards considering optimization of available resources.

13. NNCCS IN DOCUMENTING CHRONIC CARE

Clinical care is judged on the basis of medical record documentation. It is the documentation that supports

or fails to support a clinician about the necessity of care. Documentation is paramount in chronic care to ensure continuity of care. In chronic care, it is not just the patient chart that is updated. The nurse working in chronic care uses written information like registers, treatment plans, and written information for patients to document, monitor, and remind. Written information helps the patient and all health professionals involved in the care to remember the Treatment Plan, monitor and evaluate progress, remember when it is time for a follow-up appointment and facilitate response to missed appointments, transfer pertinent information to others, and arrange for supportive care from community resources.

In chronic care, written or pictorial information helps patients remember the plan and monitor their self-management. So, the following should be provided for the patient: written or pictorial summary of the plan to take home, self-monitoring tools such as a calendar or chart, and a review of patient self-monitoring tools at each hospitalization episode/ visit.

Written nursing process notes, assessment flow sheets and information shared between nurses and among the team communicate a patient's progress toward meeting expected outcomes and goals for the nursing plan of care.

The Master Teacher should refer to the performance indicators in Table 5.4.11 to determine how documentation is assessed. Emphasize the need to document patient teaching. Good documentation helps maintain continuity of care and avoids duplication. It also serves as evidence of the fulfillment of care plan requirements.

The references will have excellent resources for documentation.

Table 5.4.11	Documenting Chronic Care
Responsibility 2	Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care
COMPETENCIES	PERFORMANCE INDICATORS
2.6. Documents client's response/ nursing care services rendered and processes/outcomes of the nurse client working relationship	<ol style="list-style-type: none"> 1. Accomplishes appropriate documentation forms using standard protocols. 2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness and timelines of documentation. 3. Utilizes acceptable and appropriate terminology according to standards.

FINAL WORD

All the competencies learned in the above exercises must come together in a case study. Try to work on the case in the Geriatric Care section using the Chronic Care Model and illustrate the nurse competencies required to help this patient achieve optimum outcomes. Implementation Facilitators will be especially helped by the references below.

Given that the use of the Chronic Care Model (CCM) has been found to translate to better health outcomes in chronically ill patients, it is imperative that nurses are trained in its use. The traditional health care delivery models are no longer effective in the care of this patient population. As Master Trainers, you are at the forefront of culture change pertaining to chronic care. What an exciting place to be in!

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Care of the Acutely Ill Adult Client

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INTRODUCTION

The complexity of caring for adult patients who become acutely ill or have deteriorated can be an overwhelming challenge for entry level nurses. It is therefore important that an approach to comprehensive understanding of acute care scenarios combined with concepts of pathophysiology, pharmacology and nursing care in simulated clinical settings be provided as an engaging resource for developing competencies in acute care practice.

To guide the development of competencies among entry level nurses in the field of critical care, you as the Master Trainer must possess qualifications that will encourage the former to consistently demonstrate clinical skills in the care of the acutely ill adult client that are professional and safe. The practice of the beginning nurse is evidence-based and in line with the current 2012 National Nursing Core Competency Standards' (NNCCS) statements and performance indicators.

It is your responsibility as a Master Trainer to promote a positive learning environment that will support the entry level nurses to demonstrate competencies as they are stated in the 2012 NNCCS by grounding their knowledge and understanding of the care of acutely ill adult clients. As a Master Trainer, you must be able to highlight learning opportunities to enable the entry level nurses to demonstrate complete assessment within a recommended and appropriate time frame thus enabling these entry level nurses to set realistic and achievable action/care plans. Likewise, as a Master Trainer you will assist in developing entry level nurses in demonstrating competencies through the utilization of the nursing process in the interdisciplinary care of the acutely ill adult clients.

This self-instructional module will provide you as the Master Trainer with recommended teaching-learning strategies that will promote critical thinking, and engage entry level nurses in an active learning process that will achieve the goal of situating the NNCCS and nursing practice in caring for the acutely ill adult clients not just in the Intensive Care Unit (ICU) setting but in various settings including the emergency department and immediate post-operative areas. The module will contain instructional activities with appropriate practice tools, guidelines and/or frameworks that will help develop the competencies of entry level nurses in providing care to acutely ill adult clients.

MODULE OBJECTIVES

At the end of the module, you as the master trainer will be able to:

1. Define specific sets of competencies in the NNCCS on the care of the acutely ill adult client.

2. Select learning activities that will enable the learners to implement the NNCCS on the care of the acutely ill adult client.
3. Apply nursing tools, guidelines and / or frameworks in the care of the acutely ill adult client.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the care of the acutely ill adult client.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of the acutely ill adult will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS in the acute care units / critical care units.

CRITICAL THINKING IN INQUIRY – BASED LEARNING APPROACH

Critical thinking is the disciplined, intellectual process of applying skillful reasoning as a guide to belief or action (Paul, 1990, Ennis & Norris, 1989). In nursing, critical thinking is the ability to think in a systematic and logical manner with the openness to question and reflect on the reasoning process used to ensure safe practice nurse and quality care (Heaslip, 2008).

On the other hand, inquiry-based learning approach (IBLA) is a learner-directed approach that begins with the curiosity of the learner. The IBLA utilizes strategies that will promote the learners' voice and choice, collaborative work, interactive activities, investigations and explorations, utilization of multiple resources and performance and self-assessment evaluation.

Through critical thinking in inquiry-based approach, the standards of nursing practice for safe and quality care are enshrined (Maglaya, 2013). This module intends to facilitate your ability as Master Trainers to utilize critical thinking in inquiry-based approach to find and use a variety of sources of information and ideas that will help increase the students or nurse-trainees' understanding of the NNCCS as applied to the care of the acutely ill adult clients.

The following recommended references will provide additional insights on critical thinking and inquiry-based approach that will expound on these concepts. Hence, facilitate your ability as a Master Trainer in the selection of appropriate teaching strategies, learning resources and tools that will enable the students or nurse-trainees to demonstrate the NNCCS in the care of the acutely ill adult clients.

Recommended Resources

- Callister, L., Matsumura, G. Lookinland, S, Mangum, S & Loucks, C. (2005). Inquiry in Baccalaureate nursing education: Fostering evidence-based practice. *Journal of Nursing Education*, 44 (2), 59-64.
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THE NURSING PRACTICE FRAMEWORK FOR THE CARE OF THE ADULT ACUTELY ILL CLIENT

As a Master Trainer, you are expected to play role model or coach the learners in the translation of the NNCCS to practice in the care of the acutely ill adult clients. Therefore, as a Master Trainer you must have a deep understanding of the foundational elements of 2012 NNCCS statements that are essential to delivering safe, effective care. You must be able to focus on the most important nursing techniques and concepts for learners to understand the care of the acutely ill adult client establishing the groundwork learners need to become increasingly effective and capable of implementing NNCCS in the care of this highly vulnerable population.

The WFCCN Topical Index of Web Based Resources for Critical Care Nursing Education (http://wfccn.org/assets/edu_web_list.pdf) can help you to select appropriate nursing practice guidelines for safety and evidence-based practice; and be able to ensure greater attention to nursing actions associated with collaborative care for the acutely ill adult patients.

TEACHING-LEARNING STRATEGIES

(Case-based application of NNCCS Responsibility 2)

Adopted from: A Simple Five-step Method for Teaching Clinical Skills by John H. George, PhD; Frank X. Doto, MS (Fam Med 2001;33(8):577-8. Retrieved from <http://www.stfm.org/fmhub/fm2001/sep01/ftobtofm.pdf>)

Here is a Simple Five-step Method that you can use in developing clinical skills related to care of the acutely ill adult client:

1. Provide an overview: The learner must understand why the skill is needed and how it is used in the delivery of care.
2. Demonstrate: The Master Trainer should demonstrate the skill exactly as it should be done without explaining the steps of the procedure giving the learner the mental picture of what the skill should be like when it is done correctly
3. Repeat the demonstration of the procedure: The Master Trainer should repeat the demonstration of the procedure but this time the Master Trainer should take time to describe in detail each step in the process allowing students to ask questions and seek clarification.
4. Student talk through the skill. Ask the learner to describe step by step how to do the skill. This will ensure that the learner understands and remembers each step in the sequence.
5. The learner performs the skill: The Master Trainer/implementer should observe and provide feedback or coaching as needed. Learners are allowed to practice until they reach a certain level of proficiency.

Case – Based Scenario:

Clinical simulation using case-based scenario has been recognized as a teaching method using learning exercises that closely resemble real-life situations. The scenarios that are created will allow the learners to learn in a safe environment and provide opportunity to immerse them in a representative patient-care scenario with sufficient realism to allow learners to suspend disbelief.

Note: Case-based scenarios can be supported with a Dart Sim program in an iPad to provide moderate fidelity simulation. This is a program that can be downloaded from Apple Application.

Case-Based Scenario

The case scenario of Mang Pedro discussed in the Module “Introduction to the Cluster and Case Report” will be used as an exemplar for Responsibility 2: Utilizing the Nursing Process in the Interdisciplinary Care of the Acutely Ill Adult Client. This case showed the following data:

“On Day three (3) in the hospital, afternoon shift, the nurse reported the following physical examination findings of Mang Pedro that prompted several in-house referrals: HR = 102 beats/min. with occasional skipped beats; RR = 28 cycles/min, fast and shallow, orthopneic, use of accessory muscles for breathing, pronounced crackles on both lower lung fields; BP = 100/60 mmHg; cool and clammy skin; edema of the lower extremities.”

RESPONSIBILITY 2 – UTILIZES THE NURSING PROCESS IN THE INTERDISCIPLINARY CARE OF CLIENTS THAT EMPOWERS THE CLIENTS AND PROMOTES SAFE QUALITY CARE

A patient can become unstable, as a result of the sudden change in their condition at any point in time. As a Master Trainer, you should be able to emphasize to the learners the importance of understanding that many family members of acutely ill patients become very anxious about their patient’s condition. The family demonstrates their worries by staying in the hospital day and night wanting to know as much as possible about the patient’s condition and wanting to visit the patient frequently or stay with the patient constantly. Stressful relationships between nurses and family members have occurred. If unresolved, stress can affect how family members cope with and support the patient (Titler, 1991). Family support has been found to play a significant part in promoting the patient’s recovery and progress (Alpen, 1991; Leske, 1986; Molter, 1979).

Therefore, it becomes imperative that nurses must understand the family needs and have the competencies that will ensure an acceptable working relationship not just with the acutely ill adult client but also with the family based on trust, respect and shared decision making. The references below will help you as a Master Trainer to articulate the NNCCS related to understanding the acutely ill adult clients’ family needs. Likewise, the required competency on working with the family can be demonstrated through the stated indicators of these competencies as shown in Table 5.5.1.

Recommended Resources

- Alpen, M.A. & Halm, M.A. (1991). Family needs: an annotated bibliography. *Critical Care Nurse*, 12(2), 32, 41-50.
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Table 5.5.1 presents the list of performance indicators of NNCCS 2.1.(The beginning nurse ensures a working relationship with the client and/or support system based on trust, respect and shared decision making.)

2.1. The Beginning Nurse ensures a working relationship with the client and/or support system based on trust, respect and shared decision making.

Table 5.5.1	NNCCS on Establishing Working Relationship with the Client-family
COMPETENCIES	PERFORMANCE INDICATORS
2.1.1. Establishes rapport with the client and/or support system ensuring adequate information about each other as partners in a working relationship	<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner. 2. Addresses with respect and trust client-partner's concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship.
2.1.2. Formulates with the client-partner the objectives and expectations the nurse-client working relationship	<ol style="list-style-type: none"> 1. Explains nature and purpose of the client-partner working relationship. 2. Prepares with the client a list of objectives and expectations.
2.1.3. Maintains shared decision making and client participatory capability throughout the nurse-client working relationship.	<ol style="list-style-type: none"> 1. Assesses client's participatory capability. 2. Determines strategies to ensure shared decision making and client's participation throughout the working relationship. 3. Carries out appropriate strategies to ensure continued participation of the client.
2.1.4. Enhances client-partner's readiness for taking over/being in-charge when objectives and expectations of the working relationship have been achieved.	<ol style="list-style-type: none"> 1. Assesses client-partner's readiness for taking charge of the condition or situation. 2. Uses strategies to prepare the client for being in-charge/taking over charge when objectives and expectations have been achieved or when the situation necessitates termination of the nurse-client-family's relationship. 3. Supports client as he/she takes charge of maintaining health or managing the condition/ situation (e.g. taking over self-care or implementation of prevention and control measure).

2.2. Assesses the clinical health status acutely ill adult client with family and other members of the health team

Acute illness can lead to critical illness which is a life-threatening multisystem process that without prompt medical intervention can result in significant morbidity or mortality. It may be the product of one or more underlying pathophysiological processes; however, the end result is a multisystem progression that ultimately involves respiratory, cardiovascular and neurological compromise. In most patients, critical illness is preceded by a period of physiological deterioration; but evidence suggests that the early signs of this downward shift are frequently missed. Early-warning systems are important resources that can help identify patients at risk of deterioration and serious adverse events. Assessment of the critically ill patient should be undertaken by an appropriately trained clinician and follow a structured ABCDE (airway, breathing, circulation, disability and exposure) format. This facilitates correction of life-threatening problems by priority

and provides a standardized approach between professionals. Good outcomes rely on rapid identification, diagnosis, through prompt data gathering and analysis, which can lead to definitive treatment.

In the event that the patient is too sick to contribute to fulfill a comprehensive assessment process (example, patient's physical status before the critical event), the nurse must be competent to collect these data from the family of the acutely ill patient.

Prompt assessment of the deranged physiology and immediate establishment of complete clinical diagnosis through history and further diagnostic studies should be achieved. Likewise, careful monitoring of the patient's condition and response to treatment are imperatives in the on-going assessment of the client during this acute and critical phase.

Going back to the case of Mang Pedro on his 3rd day of admission, the student can demonstrate competency in analyzing the assessment data using assessment tools such as the Modified Early Warning Score (MEWS). This will give a score to the clinical assessment made. The score of five or more in MEWS is statistically linked to increased likelihood of death or admission to an intensive care unit.

The references identified below can guide you as Master Trainer in ensuring that the teaching strategies are used for prompt data gathering and analysis of the multisystem assessment of the acutely ill adult patient. Likewise, the required competency on data gathering and analysis of the multi system assessment can be demonstrated through the stated indicators of these competencies as shown in Table 5.5.2.

Recommended Resources

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Table 5.5.2	Data–gathering and Analysis in the Assessment of the Acutely Ill Adult Client
COMPETENCIES	PERFORMANCE INDICATORS
2.2. Assesses with the client (individual, family, population group, and / or community) one's health status / competence.	
2.2.1. Develops the data gathering plan with the client, specifying methods and tools.	1. Uses strategies to develop/enhance the skills of the client to participate in developing/specifying the methods and tools for data gathering.
2.2.2. Obtains assessment data utilizing appropriate data gathering methods and tools guided by type of client and work setting requisites.	1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework. 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by the work-setting requisites. <ul style="list-style-type: none"> 2.1. Individual as client – obtains assessment data through nursing history taking, physical/ developmental/psychosocial assessment and other assessment protocols, laboratory and diagnostic procedures 2.2. Family/population group/community as a client– obtains assessment data through family health history, assessment of the home and environment, records review and other assessment protocols such as laboratory and diagnostic procedures/reports, epidemiologic and social investigations and assessment of client competence, risk factor assessment, screening of vulnerable risk groups, and assessment of issues of vulnerability (health risks, limited control, powerlessness, disenfranchisement, victimization and disadvantaged status).
2.2.3. Analyzes data gathered.	1. Groups assessment data by condition or category using appropriate assessment framework by type of client. 2. Relates data with each other to determine patterns, recurring themes and processes. 3. Compares data, patterns and recurring themes with norms/standards, clinical health indicators or research findings using algorithms and standard protocols.

COMPETENCIES	PERFORMANCE INDICATORS
2.2.4. Synthesizes data gathered.	<ol style="list-style-type: none"> 1. Interprets data gathered. 2. Draws inferences from data gathered by specifying the nature, magnitude/extent and sources of/ reasons for the alterations (e.g. pathophysiology, psychopathology), gaps, deficiencies and/or barriers to opportunities for change or improvement, health promotion/wellness, disease prevention, problem/ disease management, rehabilitation.
2.2.5. Specifies client's status/ condition/problems to be addressed identifying reasons (etiology) for the existence of that condition or problem.	<ol style="list-style-type: none"> 1. Identifies the factors associated with the condition/s or reasons for the existence of the problem. 2. States nursing diagnosis or nursing problems. 3. Seeks concurrence with the client regarding problems identified.

2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities

The American Association of Critical Care Nurses (AACN, 2010) stated that “the professional practice of the acute and critical care nurse is characterized by the application of relevant theories, research, and evidence-based guidelines to explain human behavior and related phenomena. These theories, standards and guidelines provide a basis for nursing intervention and evaluation of patient-oriented outcomes. It is recognized that acute and critical care nurses require resource materials in their practice settings, support for and access to continuing education programs, and a philosophy that is congruent with research and evidence-based practice” (AACN, 2010).

The following skill sets form the foundation of the plan of care for the acutely ill adult clients:

- I. Acting During Emergency Situations
- II. Demonstrating Specific Knowledge and Skills
 - A. Pulmonary Care
 - B. Cardiovascular Care
 - C. Neurological Care
 - D. Renal Care
 - E. Gastrointestinal Care
 - F. Endocrine Care
 - G. Perioperative Care
 - H. Trauma Care
 - I. Burn Care
 - J. Organ Transplantation Care
 - K. Pain Management
 - L. Prevention and Control of Infection
 - M. Psychosocial and Spiritual Care
- III. Common Critical Illnesses
 - A. Shock Syndrome
 - B. Acute Respiratory Failure
 - C. Chronic Respiratory Failure
 - D. Infections
 - E. Renal Failure

- F. Neurologic Conditions
- G. Bleeding and Clotting
- H. Multisystem Organ Failure
- IV. Routine Standards of Care in Critical Care setting
 - A. At Admission
 - B. Routine Monitoring and Identification of risk of deterioration
 - C. Patient Safety and Preventing Complications
 - D. Transfer from ICU to Ward
- V. Communication in Acute (Critical Care) Setting
 - A. Situation, Background, Assessment, Recommendation (SBAR)
 - B. 24-hour Flow Sheets

The following references may be helpful to the Master Trainer in formulating a plan of care for the acutely ill adult patient to address the health conditions, needs, problems and issues based on priorities. Likewise, the required competency on formulating a plan of care for the acutely ill adult can be demonstrated through the stated indicators of these competencies as shown in Table 5.5.3.

Recommended Resources

- AACN Standards and Scope of Practice. (2008). In *American Association of Critical-Care Nurses*. Retrieved December 19, 2013, from http://www.aacn.org/wd/practice/docs/130300-standards_for_acute_and_critical_care_nursing.pdf.
- American Heart Association 2010 Guidelines on Resuscitation. (2010). In *American Heart Association*. Retrieved December 19, 2013, from http://circ.ahajournals.org/content/122/18_suppl_3.toc.
- CCNAPI Standards for the Care of the Critically Ill Patients Retrieved December 19, 2013, from <http://www.ccnapi.org>.
- Guideline for Inter and Intra-hospital Transport of the Critically Ill Patient. (n.d.). In *Society of Critical Care Medicine*. Retrieved December 19, 2013, from <http://www.learnicu.org/Docs/Guidelines/Inter-IntrahospitalTransport.pdf>.
- Perrin, K.O. (n.d.). Understanding the essentials of critical care. In *Pearson Education*. Retrieved December 19, 2013, from http://wps.prenhall.com/chet_perrincriticalcare_1/98/25165/6442472.cw/index.html.
- Practice Guidelines for VAP, CLABSI, CAUTI. (n.d.). In *Centers for Disease Control and Prevention*. Retrieved December 19, 2013 from <http://www.cdc.gov/hai>.
- Stroke Guidelines. (n.d.). In *The Stroke Society of the Philippines*. Retrieved December 19, 2013, from <http://www.strokesocietyphil.org/>.
- Topical Index of Web Based Resources for Critical Care Nursing Education. (2011). In *World Federation of Critical Care Nurses*. Retrieved December 19, 2013, from <http://wfccn.org/wp-content/uploads/WFCCN-Educational-Websitr-Listing-final1.pdf>.
- Vashisht, S. (n.d.). Assessment and Stabilization of the Critically Ill Patient (pdf). In *The Hillingdon Hospitals*. Retrieved December 19, 2013, from http://www.thh.nhs.uk/documents/_Departments/Undergraduates/additional/Assessment_and_Stabilisation_Critically_III_Patient.pdf

Table 5.5.3 Plan of Care for the Acutely Ill Adult Client

COMPETENCIES	PERFORMANCE INDICATORS
2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities.	<ol style="list-style-type: none"> 1. Sets priorities among a list of conditions or problems. 2. Specifies goals, objectives and expected outcomes of care maximizing client's competencies. 3. Selects appropriate interventions/strategies enhancing opportunities for health promotions, wellness response, prevention of problems/complications, and eliminating gaps/deficiencies. 4. Uses methods/tools to maximize client/family participation in planning appropriate interventions/strategies. 5. Develops with the client an evaluation plan specifying criteria/indicators, methods and tools. 6. Collaborates with the client and the inter-professional healthcare team in developing the plan of care. 7. Modifies plan of care according to one's judgment, skill or knowledge as client's needs change.

2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues.

An interdisciplinary team consists of practitioners from different professions who share the care of a common patient population and common patient care goals, such as that of the acutely ill adult patient. The interdisciplinary team has the responsibility for complementary tasks. The team is actively interdependent, with an established means of ongoing communication among team members and with patients and families to ensure that various aspects of patients' health care needs are integrated and addressed.

A process of learning to understand the roles and responsibilities of other professionals is necessary to function effectively in a team. According to Grant et al (1995), while training and legal scopes of practice largely determine team members' roles, the skills of various primary care practitioners overlap to some extent. Several professionals including nurses, for example, have expertise in patient interaction, development of care plans, and patient education.

Consequently, division of tasks among team members may be based more on individual patient problems and needs than on traditional role definitions. In practice settings with fewer resources and a limited number of professionals, additional blurring of traditional distinctions may occur (Grant et al., 1995).

Recommended Resources

Grant RW, Finocchio LJ, California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration. Interdisciplinary collaborative teams in primary care: a model curriculum and resource guide. San Francisco, California: Pew Health Professions Commission, 1995. As cited in the Module 4: Interdisciplinary in Health Care. Retrieved from <http://www.med.unc.edu/epic/module4/m4to.htm>

Table 5.5.4	Implementation of an Interdisciplinary Safe and Quality Interventions for Acutely Ill Adult Clients	
COMPETENCIES	PERFORMANCE INDICATORS	
<p>2.4.1. Implements appropriate psychosocial/ therapeutic interventions to render holistic nursing care in any setting.</p> <p>References: Peris A, Bonizzoli M, et al. (2011). Early intra-intensive care unit psychological intervention promotes recovery from post-traumatic stress disorders, anxiety and depression symptoms in critically ill patients. <i>Critical Care</i>, 15(1), R41. doi: 10.1186/cc10003 Retrieved December 19, 2013, from http://www.ncbi.nlm.nih.gov/pubmed/21272307 http://ccforum.com/content/15/1/R41</p> <p>Papathanassoglou , E.D.E. (n.d.). Psychological support improves outcomes of critically ill patients. In <i>International Hospital</i>. Retrieved from http://www.ihe-online.com/feature-articles/psychological-support-improves-outcomes-of-critically-ill-patients/.</p>	<ol style="list-style-type: none"> 1. Addresses with respect, trust, and concern for safety, client's needs, issues or problems related with psychosocial adaptation using appropriate communication/interpersonal techniques/strategies. 2. Utilizes therapeutic interventions appropriate to psychosocial phenomena/maladaptive behavior patterns/problems identified. <ol style="list-style-type: none"> 2.1. Utilizes therapeutic use of self (e.g. Uses self-awareness techniques/strategies; determines appropriate strategies to achieve the goals of the nurse-patient relationship, seeks consensual validation with client). 2.2. Implements psychosocial/therapeutic interventions (e.g. Nurse-client relationship therapy, Relaxation exercise/therapy, Behavioural / Cognitive therapy, Coping Assistance, Mental Health counseling /education, Social support intervention, Environmental structuring/Milieu therapy, Psycho-spiritual care, and Crisis intervention/Psychological stress de-briefing). 2.3. Carries out biophysical interventions (e.g. Nutritional intervention, Detoxification, Pharmaco-therapeutics). 3. Collaborates with client support system and the multi-disciplinary team in developing, implementing and evaluating the plan of care 	
<p>2.4.2. Provides appropriate evidence-based nursing care using participatory approach based on:</p> <ol style="list-style-type: none"> 1. Variety of theories and standards relevant to health and healing 2. Research 3. Clinical practice 4. Clinical preferences 5. Client and staff safety 6. Customer care standards 	<ol style="list-style-type: none"> 1. Develops competence of the client to participate in using appropriate evidence-based nursing care. 2. Refers to appropriate authority client's situations not within his/her capabilities. 3. Decides on appropriate interventions to address client's specific concerns, issues and problems based on the situation. 4. Performs autonomously a wide range of nursing interventions (action, treatments and techniques) in accordance with nursing standards which include promote health, prevent disease or injury, maintain and restore health, promote rehabilitation, and provide palliation. 	

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.3. Applies safety principles, evidence-based practice, infection control measures and appropriate protective devices consistently, when providing nursing care and preventing injury to clients, self, and other health care workers and the public.</p>	<ol style="list-style-type: none"> 1. Performs evidence-based nursing procedures safely and effectively. 2. Uses appropriate technology to perform safe and efficient nursing interventions. 3. Applies consistently principles of infection control in practice. 4. Uses appropriate personal protective equipment. 5. Ensures that the members of the health care team and visitors perform infection control measures accordingly. 6. Requests change in assignment when his/her competence level does not meet the client's care needs.
<p>2.4.4. Implements strategies related to the safe preparation and administration of medications based on institutional policies and protocol.</p>	<ol style="list-style-type: none"> 1. Prepares medication according to standard procedures. 2. Check on the medication to be administered three times. 3. Avoids interruptions during the preparation and administration of medication. 4. Performs the 2-patient identifier checks before administering the medication. 5. Reviews appropriate laboratory results, assessment findings and other pertinent information prior to administration of medication. 6. Withholds the medication when appropriate. 7. Informs the physician of side effects and adverse reactions to the medication. 8. Completes the adverse drug reaction (ADR) documentation appropriately. 9. Collects data/statistics to manage and reduce risks related to medication administration. 10. Modifies techniques of medication administration in a variety of setting based on standards.
<p>2.4.5. Applies evidence-based practices on pain prevention and management of clients using pharmacologic and non-pharmacologic measures.</p>	<ol style="list-style-type: none"> 1. Selects appropriate assessment and intervention tools and techniques based literature review, consultation with colleagues and other resources. 2. Carries out evidence-based practices with the client on pain prevention and management using pharmacologic and non-pharmacologic interventions. 3. Uses a framework to structure the use of analgesia in the pharmacologic management of pain (e.g. WHO Pain Ladder which includes: assesses symptoms comprehensively, identifies common, expected and unexpected symptoms, relieves symptoms through a variety of strategies, evaluates intervention for effectiveness of symptom-relief, and revises the symptom management plan as needed).

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.6. Implements safe, adequate, evidence-based care of client during the pre, intra, and post-diagnostic and treatment procedures.</p>	<ol style="list-style-type: none"> 1. Explains to the client the diagnostic and treatment procedure. 2. Prepares adequately the client prior to the procedure (e.g. NPO, enema, informed consent). 3. Chooses evidence-based interventions pre, intra, post diagnostic and treatment procedures. 4. Performs evidence-based interventions pre, intra, post diagnostic and treatment procedures. 5. Monitors for adverse reactions and complications post procedure. 6. Reports adverse reactions and complications post procedure. 7. Reviews diagnostic and treatment procedure results using a specific effective communication model (e.g. the SBAR format – Situation, Background, Assessment, Recommendation). 8. Relays diagnostic procedure results to the physician. 9. Recommends further diagnostic procedures and/or treatment options for adverse reactions and complications in coordination with a senior member of the nursing team.
<p>2.4.8. Applies appropriate and evidence-based nursing interventions for physiologic and related psychosocial needs of patients/clients to preserve physiologic integrity and prevent complications of problems of oxygenation (ventilation, transport, perfusion); fluid and electrolyte imbalance and acid-base imbalances; nutrition and metabolism; gastrointestinal (indigestion, digestion, absorption, elimination); urinary function; perception, coordination, and altered sensation; inflammation, infection and immune responses; cellular aberration, altered genetic conditions; and reproductive problems</p>	<ol style="list-style-type: none"> 1. Generates adequate assessment data according to level of prescribed/ needed care. 2. Uses appropriate assessment techniques with least discomfort to patients. 3. Recognizes and prioritizes emerging problems in a timely manner. 4. Provides substantial pathophysiologic reasoning for problems and changing patient situations. 5. Integrates plans for immediate and subsequent patient care. 6. Provides for patient's hygiene and comfort continuously. 7. Incorporates appropriate safety indicators and interventions to reduce anxiety where peri-operative care is needed. 8. Demonstrates skill in performing basic and advance nursing interventions and rehabilitation care. 9. Follows correct procedures and collaborates appropriately in the administration of medications related to IV fluids, blood, and blood products. 10. Demonstrates caring and compassionate care, especially to vulnerable patients. 11. Has the ability to anticipate changing patient situations. 12. Communicates with the health team constantly, as well as with the client and his/her family.

COMPETENCIES	PERFORMANCE INDICATORS
	<ol style="list-style-type: none"> 13. Uses complimentary, alternative and behavioral therapies appropriately. 14. Maintains holistic perspective and spiritual care. 15. Ensures appropriate presence of significant others when end-of-life care is needed. 16. Exercises good intentions and safe care practices when performing nursing interventions.
<p>2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access within the context of Primary Health Care.</p>	<ol style="list-style-type: none"> 1. Determines appropriate participatory and empowerment strategies related to health promotion, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation and protection and health resource generation, use or access. 2. Creates opportunities to develop client's competence for promotion of health, healthy life style/adaptation, wellness, disease management, environmental sanitation and protection and health resource generation, use or access. 3. Executes appropriate participatory and empowerment strategies.
<p>2.4.9.1. Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resources access or use and safe environment conducive to health maintenance among its members.</p>	<ol style="list-style-type: none"> 1. Develops the competence of the family to recognize opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease/problem management and environmental sanitation and protection by: <ul style="list-style-type: none"> - Analyzing the factors affecting health, human response, the environment and its resources/realities. - Determining the relationships among these factors - Specifying the health and related conditions/problems which need to be addressed 2. Carries out the strategies / interventions to help the family decide to take appropriate action on each health condition/ problem identified. 3. Implements competency-building intervention options to help the family provide appropriate care to the dependent, at-risk, vulnerable, sick and/or disabled member/s. 4. Develops the competence of the family to provide a home environment conducive to health maintenance and personal development. 5. Carries out participatory and empowerment strategies to enhance the family's competence to use community resources for health care and health maintenance.

COMPETENCIES	PERFORMANCE INDICATORS
2.4.12. Implements appropriate nursing interventions to help clients and support system address spiritual needs	<ol style="list-style-type: none"> 1. Utilizes appropriate technique of communication when identifying needs of client for spiritual care. 2. Provides the client with appropriate environment and materials for praying. 3. Offers opportunities for performance of religious activities based on client's religion. 4. Refer to an appropriate religious agency for further spiritual support.
2.4.13. Manages client load to ensure health program/ service coverage.	<ol style="list-style-type: none"> 1. Conducts case detection, tracking, tracing and monitoring surveillance. 2. Conducts health programs and services in the home, clinic, school, and work settings. 3. Carries out strategies to ensure health program/service coverage based on health program objectives/targets, through health resource availability, access, and/or use, especially among marginalized/vulnerable risk groups. 6. Adheres to institutional safety policies and protocols to prevent injuries/accidents and infections. 7. Refers client for appropriate management and assistance for health and medical-related benefits. 8. Reports notifiable /reportable disease based on protocol.
2.4.13.1. Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resources access or use and safe environment conducive to health maintenance among its members.	<ol style="list-style-type: none"> 1. Develops the competence of the family to recognize opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease/problem management and environmental sanitation and protection by: <ul style="list-style-type: none"> - Analyzing the factors affecting health, human response, the environment and its resources/realities. - Determining the relationships among these factors - Specifying the health and related conditions/problems which need to be addressed 2. Carries out the strategies / interventions to help the family decide to take appropriate action on each health condition/ problem identified. 3. Implements competency-building intervention options to help the family provide appropriate care to the dependent, at-risk, vulnerable, sick and/or disabled member/s. 4. Develops the competence of the family to provide a home environment conducive to health maintenance and personal development 5. Carries out participatory and empowerment strategies to enhance the family's competence to use community resources for health care and health maintenance.

2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community).

Table 5.5.5	Health Education for the Client and Family of the Acutely Ill Adult Client	
COMPETENCIES	PERFORMANCE INDICATORS	
2.5.1. Determines the health education planning models appropriate to target clientele/expected objectives and outcomes.	1. Specifies the characteristics of each health education planning model. 2. Selects appropriate health education planning model.	
2.5.2. Utilizes health education process to accomplish the plan to meet identified client's learning needs. Reference: Understanding the Option: Planning care for critically ill patients in the Intensive Care Unit. (2009). In Ottawa Hospital Research Institute. Retrieve from http://decisionaid.ohri.ca/docs/das/Critically_Ill_Decision_Support.pdf .	1. Assesses the needs of the target population. 2. Prioritizes the learning needs/problems in partnership with client partner. 3. Formulates appropriate goals and objectives. 4. Designs a comprehensive health education plan. 5. Implements the health education plan utilizing appropriate teaching strategies. 6. Evaluates the results of client's learning experiences using the evaluation parameters identified in the health education plan.	

2.6. Evaluates with the client the health status/competence and/or process/expected outcomes of nurse-client working relationship.

Table 5.5.6	Evaluation of the Outcomes of Care for the Acutely Ill Adult Clients	
COMPETENCIES	PERFORMANCE INDICATORS	
2.6. Evaluates with the client the health status/competence and/or process/expected outcomes of nurse-client working relationship.	1. Utilizes participatory approach in evaluating outcomes of care. 2. Specifies nature and magnitude of change in terms of client's health status/competence/processes and outcomes of nurse-client working relationship. 3. Monitors consistently client's progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools (e.g. critical pathway, nurse sensitive indicators, quality indicators, client competency indicators, hospital and community scorecard) in collaboration and consultation with the client 4. Revises nursing care plan based on outcomes and standards considering optimization of available resources.	

2.7. Documents client's response/nursing care services rendered and processes/outcomes of the nurse client working relationship.

Table 5.5.7	Documentation of Nursing Care and Client Outcomes	
COMPETENCIES	PERFORMANCE INDICATORS	
<p>2.7. Documents client's response/nursing care services rendered and processes/outcomes of the nurse client working relationship</p> <p>Note: Include technology at the bedside with electronic documentation interface; SBAR / RSVP approach and 24-hour Flow chart.</p> <p>References: SBAR (Situation Background Assessment Recommendation). (2008). In <i>NHS Institute for Innovation and Improvement</i>. Retrieve from http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html</p> <p>RSVP (Reason-Story-Vital Signs-Plan). (2009, March 31). In <i>Nursing Times</i>. Retrieve from http://www.nursingtimes.net/whats-new-in-nursing/acute-care/reducing-harm-from-deterioration/2007666.article</p>	<ol style="list-style-type: none"> 1. Accomplishes appropriate documentation forms using standard protocols. 2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness and timelines of documentation. 3. Utilizes acceptable and appropriate terminology according to standards. 	

EVALUATION

Critical Thinking Questions using performance indicators during case-based scenarios will evaluate learner/nurse trainee's performance in the use of the NNCCS. Checklist will supplement the evaluation of learners in demonstrating competencies. Debriefing will be used to reinforce the learner's behavior during the case scenario. This will be supported with video coverage and will observe ethical considerations.

SELF-ASSESSMENT QUESTIONS AND ANSWERS

1. What teaching-learning strategies/activities will you use?

The teaching-learning strategy such as simulated case-based scenarios will provide interactive activity to enhance the students/nurse-trainees' ability to assess the acutely ill adult client. The critical thinking in inquiry-based learning grounds the NNCCS assessment.

2. What assessment tools and methods will you use?

The assessment and method that may be used by the Master Trainer to supplement training of the principles for prompt data gathering and analysis of the multisystem assessment of the acutely ill adult patient will include the structured ABCDE (airway, breathing, circulation, disability and exposure) format. This facilitates correction of life-threatening problems by priority and provides a standardized approach between professionals.

3. What nursing assessment tools may be used to develop skills of the learner caring for acutely ill adult patient?

The following assessment tools can be used by the Master Trainer in supplementing for the need to emphasize prompt data gathering and analysis of the multisystem assessment of the acutely ill adult patient:

- 2010 American Heart Association Resuscitation Guidelines
- Cincinnati Pre-hospital Stroke Scale
- Glasgow Coma Scale
- Modified Ranking Scale

4. How do you plan to cascade what you have learned to the “end-learner”?

APPLICATION

The application of the NNCCS Competency 2 is most useful in:

1. Education: To meet requirement of CMO No. 14 for elective subject on adult acutely ill person (Critical Care Nursing)
2. Hospital Setting: To meet requirement of DOH AO 2012-0012 Rules and Classification governing Hospitals and Other Facilities in the Philippines
3. Policy Administration: Philippine Nursing Law
4. Research Implication: Documentation of Data gathered utilizing nursing process

SUMMARY

In summary, this module focusing on acutely ill adult person will highlight contents that focus on the physiological needs to help the learner identify and prioritize their plan of care.

The Master Trainer will employ appropriate teaching-learning strategies that will promote critical thinking, engaging the entry level nurses in an active learning process that will achieve the goal of situating the NNCCS and nursing practice in caring for the adult patients in acute care (critical care) settings including the emergency department and immediate post-operative areas.

Simulation case-based scenario will facilitate critical thinking opportunities guided by the Master Trainers' formulated questions to evaluate the knowledge, skills and behavior (K-S-B) of the learner in appreciating and utilizing the nursing process in the care of the acutely ill adult person.

Rehabilitation Nursing of Adult and Older Persons

CARMELITA C. DIVINAGRACIA, RN, PhD

INTRODUCTION

The scenario in the Philippine setting has tremendously changed in terms of health care. Individuals seen in health care institutions with cardiovascular, pulmonary, neurological disorders and other variety of problems suggest that there is a need for them to learn and adjust again to their usual functions as human persons. Likewise, situations brought about by vehicular crash, earthquakes, fires, tsunamis and other natural disasters that bring about disabilities to the total well-being of the person will equally require intervention in the form of Rehabilitation.

Rehabilitation Nursing is gaining impetus in the field of health care. Its unique role and expertise is enabling patients and family members come up with creative measures that will help them adapt in order for them to achieve maximum function and improve quality of life. Early literature records showed that the concept of rehabilitation started as early as Florence Nightingale's era in 1854 by using rehabilitation principles and hygiene to decrease the mortality rate of soldiers wounded during the Crimean War. Through the years, this pioneering work gained popularity for its key role which was for individuals to regain quality of life after a disability.

The role of the health professionals working as a team from assessment of functional health patterns, actual onset of the incident and continuity of care from the health facility to the community calls for a mutually acceptable goal between the patients and the health care professionals.

The philosophy of rehabilitation is quite different from the care of individuals who are suffering from acute illness. Patients under this condition depend a lot on the assistance of the nurses in carrying out activities of daily living while in rehabilitation. The health care provider focuses on how to maximize the self-worth of the individual by providing the necessary knowledge and skills for him to achieve the process of dependency at the early part of his disability to independence and restoration of health.

New nurses need to be prepared to practice safely, accurately and compassionately in varied settings where knowledge and innovation increase at an astonishing rate. Nurses must draw on nursing science with inquiring minds and can apply logical thinking based on the fundamental principles of the nursing process.

The NNCCS and Performance Indicators are situated in this module. There are teaching guides for this module and other strategies for the learners to improve and appreciate the competencies as they apply it to actual situation. The purpose of the module is to enhance principles and concepts related to rehabilitation into the academe and practice.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the care of adult and older persons undergoing rehabilitation.
2. Select learning activities that will enable the learners to implement the NNCCS on the care of adult and older persons undergoing rehabilitation.
3. Apply nursing tools, guidelines and/or frameworks in the care of adult and older persons undergoing rehabilitation.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the care of adult and older persons undergoing rehabilitation.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of adult and older persons undergoing rehabilitation will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on the care of adult and older persons undergoing rehabilitation.

In this module development, there are four (4) basic components of the module on Rehabilitation to align with the NNCCS under Responsibility 2 which focuses on the use of the nursing process from assessment to the documentation phase. Annexes are available for you as the Master Trainer as an additional guide for disseminating information to the learners.

TOPIC OUTLINE

1. Related Nursing Theories and Models
 - Orem's Self-Care Deficit Theory
 - Roy's Adaptation Model
 - WHO International Classification of Functioning, Disability and Health Model
2. Scope of Rehabilitation and Rehabilitation Nursing
 - Framework of Rehabilitation and Rehabilitation Nursing
3. Rehabilitation Nursing of Adult and Older Persons using the Nursing Process
 - Assessment Phase of Rehabilitation
 - Building a Therapeutic Relationship with Clients undergoing Rehabilitation
 - Assessment with Focus on the Functions and Disabilities
 - Nursing Assessment for Special Population Groups
 - Data Analysis and Nursing Diagnosis Phase
 - Therapeutic Plans and Interventions Phase
 - Evaluation and Documentation Phase
4. Application of Rehabilitation Nursing in Different Practice Settings
 - Acute Care Setting
 - In-Patient Nursing Care for Patients undergoing Rehabilitation
 - Discharge Plan for Patients undergoing Rehabilitation
 - Out-Patient (Early Phase) for Patients undergoing Rehabilitation
 - Community and Home Setting
5. Role of the Family in Rehabilitation

MODULE CONTENT

1. RELATED NURSING THEORIES AND MODELS FOR REHABILITATION AND REHABILITATION NURSING

A vital component of the Master Trainer's function on the NNCCS in the concept of Rehabilitation and Rehabilitation Nursing specifically on adult cardiac patients is the use of nursing models which can challenge, guide and direct the nurse to be more systematic and organized in performing one's role in any practice setting. A number of relevant nursing models and theories are useful guiding tools for rehabilitation nursing. In this section, there will be a brief discussion of selected theories from nursing and how this will be useful in rehabilitation nursing.

- **Orem's Self-Care Deficit Theory.** This theory of self-care by Orem was first introduced in 1959. This was further developed and composed of three sub theories; the theory of self-care, the theory of self-care deficit, and the theory of nursing system. Utilizing this theory in rehabilitation, a nurse must keep in mind that a patient undergoing rehabilitation needs special assistance to maintain optimal functioning and help the patient to become independent to the best of his/her capability in self-care.
- **Roy's Adaptation Model.** The Roy's Adaptation Model is one of the widely applied nursing models in nursing practice, education and research. The goals of this model as related to nursing are to promote adaptation for individuals and groups in the four adaptive modes; physiological, self-concept, interdependence, and role function, thus contributing to health and quality of life. The rehabilitation nurse must assess the patient's capabilities, behaviours and other factors that will influence the patient's adaptive ability in the rehabilitation process. For example, a patient who has Buerger's Disease due to chronic smoking developed complication and will be amputated; the nurse must prepare the patient for this sudden change not only physically but as well as psychologically and emotionally. The nurse should assist the patient to undergo rehabilitation and teach the patient to cope utilizing his adaptive ability so he can live a quality of life.
- **The World Health Organization's (2001) International Classification of Functioning, Disability and Health (ICF) Model** was developed discussing individual function as a relationship between health conditions and circumstantial factors. It also addresses how disability becomes the consequence of vigorous interaction between collapse in health domains and individual contextual factor. Figure 5.6.1 presents this explanation.

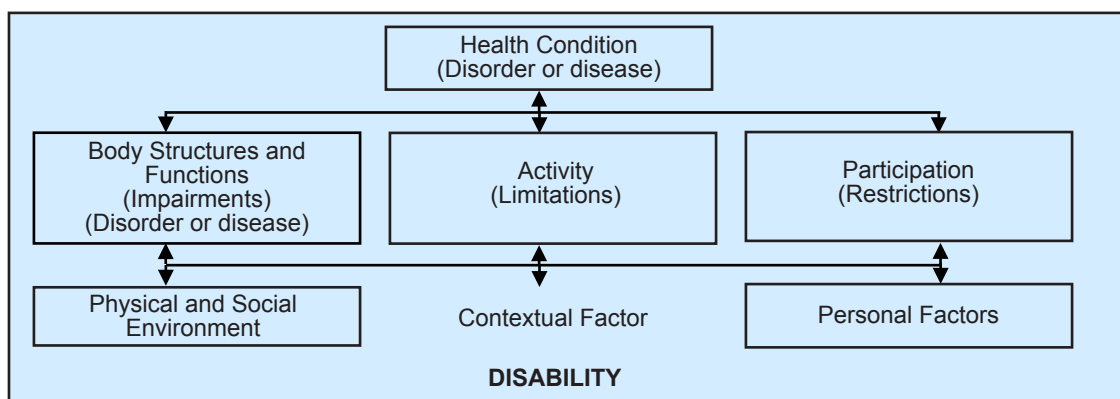


Figure 5.6.1 Interactions between the consequences of disease and contextual factors (WHO ICF, 2001)

Learning these important and relevant theories and models, the rehabilitation nurse can use these models to provide a theoretical basis for rehabilitation nursing care. Likewise, these selected models will serve as a background for this module.

This module contains basic information on concepts, principles of rehabilitation, intervention and outcomes of care. This particular module focuses on the rehabilitation of adult and older persons. Clinical cases that pertain to rehabilitation of cardiac patients are included for you as the Master Trainer (MT) to use as a critical method for reflection and analysis of care.

2. SCOPE OF REHABILITATION AND REHABILITATION NURSING

Framework of Rehabilitation and Rehabilitation Nursing

Rehabilitation Nursing is defined as a specialty practice of professional nursing. Rehabilitation nursing is the diagnosis and treatment of human responses of individual and groups of actual or potential health problems relative to altered functional ability and lifestyle (ARN, 2000). The goals of rehabilitation nursing are maximizing potential, learning, ability, quality of life, family-centered care, wellness, culturally competent care, and community reintegration.

Traditionally, rehabilitation nursing follows three phases which are: (1) Disease-Organ Impairment, (2) Person-Disability, and (3) Societal-Handicap. The practice guidelines of rehabilitation nursing are the competency standards of assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

With this model in comparative evaluation, the rehabilitation nurse is then guided and able to collaborate with other allied health professionals that comprise the rehabilitation team. The members of the team are the client, physician, occupational therapist, physical therapist, speech therapist, social worker, and vocational counselor. Rehabilitation teams may work in a multidisciplinary, interdisciplinary or transdisciplinary manner; and to ensure that the team will succeed in rehabilitating a patient; they need the factors of communication, trust, goal, decision making, clarification of roles, and conflict management. Please read Attachment M for the Framework of Rehabilitation and Rehabilitation Nursing.

As a jumpstart, you can come up with an overview of some significant information about Rehabilitation nursing. Provide the learners a framework with the use of a handout (See Annex M) that can guide him/her better with a broader perspective in assuming his/her role for providing rehabilitation services that begins with preventive care up to the restoration of function of individuals with disabilities.

Self-Assessment Questions

The following are some Self-Assessment Questions (SAQ) that you can use to guide the Learner in analyzing the framework:

1. What is the meaning of Rehabilitation and Rehabilitation Nursing?
2. What are the Goals of Rehabilitation?
3. Describe the phases of Rehabilitation?
4. What are the roles and responsibilities of Rehabilitation Nurses and the members of the Rehabilitation team?
5. Identify the types of Rehabilitation teams and its members.

3. REHABILITATION NURSING OF ADULT AND OLDER PERSONS USING THE NURSING PROCESS

Assessment Phase of Rehabilitation

Building a Therapeutic Relationship with Patients Undergoing Rehabilitation

Assessment is a basic component of cardiac rehabilitation. This is a helpful guide for the nurse to establish a baseline data whether there are existing deviations in the physical, social, psychological, mental well being of the person. This is also a basis for comparing future changes or improvements brought about by the interventions done by the rehabilitation team. Since assessment is the initial encounter of the nurse with the patient and the family members, it is important that rapport and trusting relationships must be established within the health care delivery system.

Table 5.6.1 presents the list of performance indicators of the NNCCS on creating a functional relationship to promote client's participation in rehabilitation.

Table 5.6.1	NNCCS on Creating a Functional Relationship with the Client	
Responsibility 2	Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES		PERFORMANCE INDICATORS
2.1.1. Establishes rapport with client and/or support system ensuring adequate information about each other as partners in a working relationship.		<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner 2. Addresses with respect and trust client-partner's concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship.
2.1.2. Formulates with the client-partner the objectives and expectations of the nurse-client working relationship.		<ol style="list-style-type: none"> 1. Explains nature and purpose of client-partner working relationship. 2. Prepares with the client a list of objectives and expectations.
2.1.3. Maintains shared decision making and client's participatory capability throughout the nurse-client working relationship.		<ol style="list-style-type: none"> 1. Assesses client's participatory capability. 2. Determines strategies to ensure shared decision making and client participation throughout the working relationship. 3. Carries out appropriate strategies to ensure continued participation of the client.
2.1.4. Enhances client-partner's readiness for taking over/being in-charge when objectives and expectations of the working relationship have been achieved.		<ol style="list-style-type: none"> 1. Assesses client-partner's readiness for taking charge of the condition or situation. 2. Uses strategies to prepare the client for being in-charge/taking over when objectives/expectations have been achieved or when the situation necessitates termination of the nurse-client relationship. 3. Supports client as he/she takes charge of maintaining health or managing the condition/situation (e.g. taking over self-care or implementation of prevention and control measures).

Establishing rapport is a process of creating goodwill and trust. It can begin with a greeting or self-introduction accompanied by nonverbal gestures such as a smile, a handshake, and a friendly manner (Berman & Snyder, 2012). A nurse must build rapport to the patient in rehabilitation to gain his trust and this will boost the client's self-esteem and participate willingly in rehabilitation process. Interaction with the family members is important in the rehabilitation process of the client, this will allow encouragement and support for the client.

Suggested Teaching-Learning Strategies for the Learners

1. **Video presentation** - Show video presentation on Cardiac Assessment. It is available at <http://www.youtube.com/watch?v=H3LiTHn35BE>. After the presentation, ask the learners to summarize what essential concepts they have learned from the video. You may ask the learners to return-demonstrate cardiac assessment with peers.

2. **Case Scenario:**

This case has been presented earlier in the module on Introduction to the Cluster and Case Report which will now be presented applying Rehabilitation principles.

Mang Pedro is a fisherman, who lives in the coastal town of a nearby island. He lives with his wife for 40 years, Zenaida. His wife of the same age, is a retired elementary school teacher. They enjoy a peaceful life in a fishing community. Whatever share he gets is being sold in the inland market by his wife and married daughter, in their market stall. They also are in the business of making dried fish, and this adds to their economic support.

Mang Pedro is 67-years old, tall but is on the heavy side. He was previously (about 10 years ago) diagnosed with hypertension, but seems to have missed medical follow-ups in the Rural Health Clinic. His reason is- he does not feel any symptom at all. He feels good, until recently. His wife noted less fishing days and that Mang Pedro verbalized increasing episodes of fatigue, which he attributes to the hot weather. There were times that the usual walking around the village seemed difficult, and he didn't have that much interest to meet his friends for their usual drinking session, where they talk about politics, incomes, families, anything.

His eldest son, a seaman of several years, came home for vacation from an overseas contract and noted his father's behaviour. He convinced Mang Pedro for a medical consult in the nearby city where a medical center is located. This is also where his son and family maintain their home. This time, Mang Pedro verbalized shortness of breath on activity, and had difficulty performing activities of daily living, and had to be always assisted by his wife. Mang Pedro was admitted and was confined in a small private room. Aling Zenaida had some confidence about hospitalization, because she was a PhilHealth member, and his son is helping them. The admitting medical impression was 'Hypertension Stage 2, uncontrolled; Diabetes Mellitus Type 2 uncontrolled, and for cardiac work-up'. His ECG findings showed myocardial ischemia of the anterior wall. This sort of confirmed the small chest discomforts that he was experiencing. He did not know about his diabetes, and was not taking any medication for hypertension. This made Mang Pedro somewhat depressed, more so, when informed that he had to stay in the hospital for a while. He was constantly asking how soon can he be back to his own home.

Suggested Teaching-Learning Strategies for the Learners (Continued)

On Day three (3) in the hospital, afternoon shift, the nurse reported the following physical examination findings that prompted several in-house referrals: HR = 102 beats/minute with occasional skip beats; RR = 28 cycles/minute, fast and shallow, orthopneic, use of accessory muscles for breathing, pronounced crackles on both lower lung fields; BP = 100/60 mmHg; cool and clammy skin; edema of the lower extremities.

That evening, the attending physician conferred with Mang Pedro's family, and explained to them the possible medical management processes that may take place. This included the management of developing heart failure, and once resolved the possibility of having a coronary angiogram and a coronary artery bypass surgery.

The nursing care plan for Mang Pedro was planned by the nursing staff, to include discharge plan and rehabilitation.

The outcomes of care included full recovery for Mang Pedro, self-care skills, functional capacity to perform close to usual activities, psychosocial adaptation given his chronic illness, and social support for psychosocial integration as an older person in the community, together with his wife.

The outcome for the nurse includes demonstration of his/her beginning role in patient/client care, beginning nurse manager/leader, and beginning researcher.

Self-Assessment Questions

Considering that the manifestations of Mang Pedro are typical example of Coronary Artery Disease (CAD), you can post the following Self Assessment Questions to the Learners as part of the critical thinking exercise in dealing with the case scenario:

1. What is the prevalence of heart disease in the Philippines?
2. What are the significant findings supporting that Mang Pedro is a candidate for cardiac rehabilitation? Identify the different assessment data i.e. history, Physical Examination (PE) and laboratory tests.
3. In your discharge plan, what modification should be emphasized as part of lifestyle and practices?
4. What are the cardiac rehabilitation programs that you can design for Mang Pedro during the in-patient, and out-patient phase and as well as in the community setting?

Assessment with Focus on Functions and Disabilities

Functional assessment and evaluation instruments are designed to capture domains and constellation of domains involved in an independent life. The framework represents impairments, disability, and participation. Every tool provides validated scales that have met standards for measurement in rehabilitation setting. Each has descriptive and evaluative properties in the clinical setting.

The utility of these instruments is that they provide a description of overall functioning and can be appropriately used to follow broad measures of all clinical courses. These instruments expand across disease categories and physical impairments to address the resultant disability targeted by rehabilitation efforts. Because many assessment measures are available, chosen tools must undergo extensive testing and validation in the rehabilitation field.

Table 5.6.2 presents the NNCCS competency and performance indicators on the assessment phase of the nursing process with the client in rehabilitation.

Table 5.6.2 NNCCS on the Assessment Phase of the Nursing Process	
COMPETENCIES	PERFORMANCE INDICATORS
2.2.1. Develops the data gathering plan with the client, specifying methods and tools	1. Uses strategies to develop/enhance the skills of the client to participate in developing/specifying the methods and tools for data gathering.
2.2.2. Obtains assessment data utilizing appropriate data gathering methods and tools guided by type of client and work setting requisites.	1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework. 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by work-setting requisites. 2.1. Individual as client – obtains assessment data through nursing history taking, physical/developmental/psychosocial assessment and other assessment protocols, laboratory and diagnostic procedures 2.2. Family/population group/community as a client – obtains assessment data through family health history, assessment of the home and environment, records review and other assessment protocols such as laboratory and diagnostic procedures/reports, epidemiologic and social investigations and assessment of client competence, risk factor assessment, screening of vulnerable risk groups, and assessment of issues of vulnerability (health risks, limited control, powerlessness, disenfranchisement, victimization and disadvantaged status).

In this module only a sample of selected instruments from Centers for Medicare and Medicaid Services (CMMS); Minimum Data Set (MDS); Outcome and Assessment Information Set (OASIS); Older American Resources and Services Scale (OARSS); and Philadelphia Geriatric Center Instrumental Role Maintenance Scale (PGCIRMS) had been adopted as an example. Barthel Index (Mahoney & Barthel, 1965) is a widely used assessment instrument in rehabilitation specifically for the screening and monitoring of the progress of patients for cardiac rehabilitation. It consists of 10 items, and adapts measures of basic activities of daily living (ADLs). This captures the assessment of the bladder, feeding, grooming, dressing, transfer, toilet use, mobility, use of the stairs and bathing.

The other instrument that is useful is the Function Independence Measure (FIM) (Granger, 1986). This measures physical and functional communication, subscores for motor function and cognition. The domains included are self-care, sphincter control, transfer, locomotion, communication and social cognition.

Nursing Assessment for a Special Population Group

Before you proceed to the case study, the learner must be able to review the essential elements of assessment for patients with heart conditions. Risk factors must be identified and be agreed upon with the patient on how to control them. Baseline physical assessment include heart and lung sounds, peripheral pulses, strength and flexibility of muscles, blood pressure and cardiac strips and patient's self care capability. Likewise, psychological well being, family social adjustments and ability to return to work are also essential information that should be included.

Additional Resource

Hoeman, S. (2008). Rehabilitation Nursing, Prevention, Intervention and Outcomes (p. 681)

In addition to the physical assessment you have conducted, there are also additional assessment questions that can be incorporated in the baseline data you will gather using the selected assessment instruments. There is a summary of education-related variables and assessment questions in the book of Hoeman.

Data Analysis and Nursing Diagnosis Phase

After sorting and analyzing your data based on your interview with the needed information related to Mang Pedro's rehabilitation and physical assessment, there are nursing diagnoses which you as the Master Trainer can extract from the assessment questions and provide guidance in the formulation of nursing diagnosis.

The critical thinking process guides you on how to create teaching-learning environment in helping the learners in analyzing the assessment data and developing nursing diagnoses appropriate for the client in rehabilitation.

Table 5.6.3 presents the NNCCS competencies and performance indicators in data analysis.

Table 5.6.3	NNCCS on Data Analysis and Nursing Diagnosis	
	COMPETENCIES	PERFORMANCE INDICATORS
	2.2.3. Analyzes data gathered	<ol style="list-style-type: none"> 1. Groups assessment data by condition or category using appropriate assessment framework by type of client. 2. Relates data with each other to determine patterns, recurring themes, or processes. 3. Compares data, patterns, recurring themes with norms/ standards, clinical/health indicators or research findings using algorithms and standard protocols.
	2.2.4. Synthesizes data gathered	<ol style="list-style-type: none"> 1. Interprets data gathered. 2. Draws inferences from data gathered by specifying the nature, magnitude/extent and sources of/reasons for the alterations (e.g., pathophysiology, psychopathology), gaps, deficiencies and/or barriers to opportunities for change/improvement, health promotion/ wellness, disease prevention, problem/disease management, rehabilitation.

Suggested Teaching-Learning Strategies for the Learners

1. The Learners will have to go back to the given case of Mang Pedro and do the following:
 - a. Analyze data gathered.
 - b. Group assessment data.
 - c. Synthesize data gathered.
 - d. Recognize and prioritize emerging problems with the least discomfort to patients.
 - e. Provide substantial pathophysiologic reasoning for problems and changing patient situation.
 - f. The learner will identify nursing problems-diagnosis based on the assessment questions (Jillings, 1988)
 - g. Identify three priority problems

Therapeutic Plans and Interventions Phase

After careful analysis of data and formulation of the nursing diagnosis, you will now help the learners in developing a plan of care uniquely designed for the patient on rehabilitation.

The purpose of planning is to design the strategy for achieving the established goals of the interdisciplinary rehabilitation team. Nursing care plan is established to assist the nurse in providing direct care, identifying the desired outcomes of care, and measuring the effectiveness of team interventions. Goals help team members in promoting the retention and transfer of skills learned in therapy session to the nursing unit during inpatient care, and to the community settings.

A variety of schemes have been proposed to conceptualize nursing process goals. Theoretically speaking, goals are statements of desired outcomes. In rehabilitation, setting goals are set for the client, and the nursing interventions would include strategies or actions taken by the nurse to assist the client in reaching the goal.

The following principles will help you in this phase of the nursing process:

1. Applies appropriate and evidence-based nursing interventions for physiologic and related psychosocial needs of patients to preserve physiologic integrity and prevent complications of problems
2. Performance indicator: Demonstrates skill in performing appropriate basic and advance nursing interventions and rehabilitation care

In developing plan of care, a client on rehabilitation needs special interventions in maintaining his optimal functioning. It includes not only the physiologic and physical capabilities but also the psychological, emotional and spiritual well-being. Table 5.6.4 shows the NNCCS competencies and performance indicators in guiding the rehabilitation nurse in developing a plan of care and interventions for the client.

Table 5.6.4 NNCCS on Developing Therapeutic Plan of Care and Interventions	
COMPETENCIES	PERFORMANCE INDICATORS
2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities.	<ol style="list-style-type: none"> 1. Sets priorities among a list of conditions or problems. 2. Specifies goals, objectives and expected outcomes of care maximizing client's competencies.

COMPETENCIES	PERFORMANCE INDICATORS
	<ol style="list-style-type: none"> 3. Selects appropriate interventions/strategies enhancing opportunities for health promotion, wellness response, prevention of problems/complications, and eliminating gaps/deficiencies. 4. Uses methods and tools to maximize client/family participation in planning appropriate interventions/strategies. 5. Develops with the client an evaluation plan specifying criteria/indicators, methods and tools. 6. Collaborates with the client and the inter-professional health care team in developing the plan of care. 7. Modifies plan of care according to one's judgment, skill, or knowledge as client's needs change.
2.4.9.3. Enhances the competencies of specific population groups to ensure wellness, healthy lifestyle/adaptation, disease prevention, management, rehabilitation and vulnerability reduction or prevention.	<ol style="list-style-type: none"> 1. Develops the competence of specific population groups/support systems to analyze the relationship of factors or patterns, home and community realities affecting health, human response and the environment. 2. Implements effective strategies to develop/enhance the competence of specific population groups/support system for decision making on appropriate actions for healthy lifestyle adaptation, disease prevention, management and rehabilitation. 3. Carries out empowerment strategies to develop the competencies of specific population groups and support systems for health care, healthy lifestyle/adaptation, use of health service and health resource access or use.

Suggested Teaching-Learning Strategies for the Learners

1. Assign the learner to design a Nursing Care Plan (Independent, Dependent, and Collaborative Functions) for the identified three priority nursing problems.
2. Interventions must contain rationales and evidences from readings taken from literature and research findings. Likewise, theories and conceptual models for rehabilitation can be included (e.g. Roy's Adaptation Model, Orem's Self Care Theory, King's Open System Framework).

Additional Resource

Mauk, K.L. (2012). Rehabilitation Nursing A Contemporary Approach to Practice (p.29)

Evaluation and Documentation Phase

Cardiac Rehabilitation is essential to determine the effectiveness of patient care and quality improvement strategies. You as the Master Trainer will now discuss to the Learners the process of evaluation and

documentation. Evaluation and documentation are the final steps in the nursing process. This phase will determine whether the client's condition and wellbeing improves. The rehabilitation nurse evaluates the progress towards the goal. If regression occurred then the rehabilitation nurse must change the plan of care accordingly.

Table 5.6.5 presents the NNCCS competencies and performance indicators of the evaluation and documentation phase of the nursing process.

Table 5.6.5 NNCCS on the Evaluation and Documentation Phase of the Nursing Process	
COMPETENCIES	PERFORMANCE INDICATORS
2.6. Evaluates with the client the health status/competence and/or process/expected outcomes of nurse-client working relationship.	<ol style="list-style-type: none"> 1. Utilizes participatory approach in evaluating outcomes of care. 2. Specifies nature and magnitude of change in terms of client's health status/competence/processes and outcomes of nurse-client working relationship. 3. Monitors consistently client's progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools (e.g. critical pathway, nurse sensitive indicators, quality indicators, client competency/indicators, hospital and community scorecard) in collaboration and consultation with the client. 4. Revises nursing care plan based on outcomes and standards considering optimization of available resources.
2.7. Documents client's responses/ nursing care services rendered and processes/outcomes of the nurse client working relationship.	<ol style="list-style-type: none"> 1. Accomplishes appropriate documentation forms using standard protocols. 2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness and timeliness of documentation. 3. Utilizes acceptable and appropriate terminology according to standards.

Suggested Teaching-Learning Strategies for the Learners

1. You as the Master Trainer will require the learners to compare present patient condition based on the objectives and standards of care. A nursing outcome classification guideline is recommended for the learner to utilize in the evaluation phase of patient's rehabilitation.
2. Clinical Activity
Assign the learner to a cardiac patient enrolled in a rehabilitation program and ask the learner to make a nursing care plan for the three (3) identified priority nursing problems. Incorporate applicable nursing theories, evidences from literature and research findings in the justification for the interventions. Make a teaching plan to cover the areas for rehabilitation in a patient with cardiac disorders and make the learner evaluate the effectiveness of interventions as planned and their outcomes.

4. APPLICATION OF REHABILITATION NURSING IN DIFFERENT PRACTICE SETTINGS

This module tries to capture how the Master Trainer can assist the learner appreciate the importance of the NNCCS in the performance of the future professional roles in rehabilitation and rehabilitation nursing while the patient is in the hospital, outpatient as well as in the community and home setting. Likewise, the role of the family in rehabilitation has also been included. The following are some of the highlights on how the learners can apply the previous content of this module.

Acute Care Setting

In-Patient Nursing Care for Patients undergoing Rehabilitation

1. In the Acute Cardiology Unit, the learner assesses the health status and condition of the person with congestive heart failure. Through interview, the nurse obtains personal data, cardiac and rehabilitation status using the GCS, MMSE, Barthel Index, FIM, OARSS, CES-D, MOS-FS, MDS, and/or OASIS. Functional assessment and evaluation instruments are designed to capture domains involved in an independent life. Use of these instruments provides a description of the overall functioning of patients, and can be appropriately used to follow the clinical pathways for rehabilitation.

A good rapport with the client is important for the learner to be able to obtain personal data like preferences, insights, level of sexual activity, lifestyle, stress management and coping strategies, diet history, etc. Moreover, establishing a good rapport will encourage and foster trust and cooperation of the patient.

Focused physical assessment is done to include the extent of affectation caused by the cardiac condition; these includes, but not limited to, level-of-consciousness, mental status, ability to perform ADLs, depression, etc.

The learner should evaluate the following factors to decide who is appropriate for cardiac rehabilitation. These factors include age, precardiac event physical capacity, treatments and bed rest during the event, fluid volume, left ventricular dysfunction, residual myocardial ischemia, skeletal muscle performance, autonomic function, peripheral vascular status, pulmonary status, and other illnesses, such as orthopedic conditions that limit mobility (Mauk, 2012).

2. While the patient is being admitted to the hospital, the learner will be assigned to be a member of the rehabilitation team who will periodically visit the patient and evaluate the progress or deterioration of his condition. As part of the in-patient rehabilitation phase, the learner is expected to educate the cardiac patient regarding the disease and the recovery process. Psychological and interpersonal interventions are also beneficial to the patient to ensure compliance to the cardiac rehabilitation program; this can be achieved through personal encouragement and inclusion of the family members in classroom and group meetings (Singh, Schocken & William, 2008).
3. During referral to the rehabilitation section, the learner will collaborate with the physical therapist for the provision of appropriate and prescribed exercises.
4. The modification of the patient's health seeking behavior is also another activity the learner should implement, like recognition of the signs and symptoms, do's and don't's for home care and medication instruction.

Discharge Plans for Patients undergoing Rehabilitation

1. At the rehabilitation facility, the learner will initiate the next phase of the rehabilitation program based on the results of the exercise testing. The supervised exercise training program is usually prescribed three times a week, with each session lasting from 30 to 60 minutes, which includes warm-up of at least 10 minutes, while the intensity is relative to the patient's target heart rate. The learner will implement an exercise program starting from aerobic conditioning during the first few weeks and followed by strength training with perceived exertion rate of 13 to 15 based on the Borg Scale (Mauk, 2012).
2. The learner, as part of the cardiac rehabilitation program will coordinate with the physician to formulate the level of exercise necessary to meet an individual patient's needs. This monitored ambulatory outpatient activity as well as use of exercise electrocardiograms must be done with medical supervision.
3. The patient will also be enrolled to different programs that are designed to improve lifestyle which includes stress management and effective coping strategy sessions, smoking cessation seminars, lipid management lectures, weight management counseling, reduction or elimination of alcohol intake, blood pressure control and diabetes management. The learner should also make plans for referrals to the respective institutions.

Out-Patient (Early Phase) for Patients undergoing Rehabilitation

1. After the patient returns home from the hospital, the learner, in collaboration with the rehabilitation team, works with patients and their families while doing home visit in the related learning experiences for community health nursing subject. The focus of the home visit is to keep the heart healthy and strong, and to monitor patient's medical status and continuing recovery and offer reassurance as the patient recovers, which usually lasts for 2 to 6 weeks.
2. Outpatient referral to a physical therapy clinic is also part of the learner's care plan; this can be achieved by including low-level exercise and physical activity as well as instruction regarding changes for the resumption of an active and satisfying lifestyle (Singh et al., 2008).

Community and Home Setting

1. The learner in the community should coordinate with the out-patient nurse and receive endorsement for continuity of care for the patient enrolled to a cardiac rehabilitation program. The community health nurse should carry out the referral and follow-up the patient's compliance to the lifetime maintenance programs. Exercise programs are still being implemented usually three times a week and may include types of exercises that the patient enjoys, like walking, bicycling, or jogging with the supervision of the nurse.

5. Role of Family in Rehabilitation

1. Rehabilitation involves the successful and productive interdisciplinary interactions and one of these stakeholders is the patient and the family (Mauk, 2012). It is said that a patient with high resilience, helpful family, and flexible and supportive job will likely cope with a disabling condition better than a person with ineffective coping and very minimal family or social aid (Mauk, 2012). Thus, the patient and family should all be involved in planning the patient's rehabilitation together with the cardiac specialist, nurses, and the rest of the cardiac rehabilitation team (National Heart Foundation of Australia, & Australian Cardiac Rehabilitation Association (2004). Retrieved from <http://www.heartfoundation>.

com.au)

2. Both patient and family need to receive advice and education for them to adjust and cope with potential psychological and emotional problems that usually develop after a cardiac event, often provoking stressful response. As a group, patients and families tend to inquire of almost the same concerns. Rehabilitation nurses who are able to identify these frequently expressed concerns that are able to offer anticipatory guidance that enable patients and families to resist or eliminate stressors.
3. When selecting educational materials, assess the patient and family concerning the following: diagnosis and health status; education and socioeconomic background; interest in material and mode of presentation; availability of computers, internet access, Compact Disks and Digital Video Disks or other devices; cultural or religious preferences; literacy level, primary language; visual, auditory, or other sensory impairments; functional abilities; and age or developmental factors.

SUMMARY

The preparation of this module has been designed to understand better the importance of integrating the National Nursing Core Competency Standards (NNCCS) in the care of adult and older persons in rehabilitation in order to provide the ground work in integrating it in the academe, hospital and community setting. The module, all in all, contains the principles and topics of rehabilitation and rehabilitation nursing. Major topics covered by this module include the rehabilitation nursing of adult and older persons using the nursing process and the different practice settings in rehabilitation such as in Acute-Care, Community and Home Setting.

ANSWERS TO SELF-ASSESSMENT QUESTIONS

SAQ 1. What is the meaning of Rehabilitation and Rehabilitation Nursing?

A specialty practice area of professional nursing. Rehabilitation Nursing is the diagnosis and treatment of human responses of individual and groups of actual or potential health problems relative to altered functional ability and lifestyle (ARN, 2000).

SAQ 2. What are the Goals of Rehabilitation?

- | | |
|-------------------------|------------------------------|
| 1. Maximizing Potential | 5. Family-Centered Care |
| 2. Learning | 6. Wellness |
| 3. Ability | 7. Culturally Competent Care |
| 4. Quality of Life | 8. Community Reintegration |

SAQ 3. Describe the phases of Rehabilitation?

1. Disease – organ impairment
2. Person-disability
3. Societal-handicap

SAQ 4. What are the roles and responsibilities of Rehabilitation Nurses and the members of the Rehabilitation team?

Core Competencies

Responsibility 2 - Utilizes the nursing process in the interdisciplinary care of clients that empowers the clients and promotes safe quality care.

Competency:

Resp. 2.1.1. Establishes rapport with client and or support system ensuring adequate information about each other as partners in a working relationship.

Resp. 2.2. Assesses with the client one's health status/competence.

Resp. 2.2.2. Obtains assessment data utilizing appropriate data gathering methods/tools guided by type of client and work setting requisites.

Resp. 2.4.7. Implements safe and quality nursing interventions addressing health needs, problems and issues affecting patient undergoing cardiac rehabilitation

SAQ 5 Identify the types of Rehabilitation teams and its members.

Type of Rehabilitation Teams:

1. Multidisciplinary
2. Interdisciplinary
3. Transdisciplinary

Members of a Rehabilitation Team:

1. Client
2. Physician
3. Occupational therapist
4. Physical therapist
5. Speech therapist
6. Social worker
7. Vocational counselor

SAQ 6. What is the prevalence of heart disease in the Philippines?

Please refer to Prevalence Rate of Coronary Disease. (2012, April 11). In *Philippine Statistics Authority*. Retrieved from http://www.nscb.gov.ph/sexystats/2012/SS20120411_heart.asp#tab1.

SAQ 7. What are the significant findings that support that Mang Pedro is a candidate for cardiac rehabilitation? Identify the different assessment data.

Table 5.6.6 Assessment Data of Mang Pedro	
SUBJECTIVE DATA	OBJECTIVE DATA
<ul style="list-style-type: none"> - 67 y/o - Fisherman - Increasing episodes of fatigue - Shortness of breath on activity - Difficulty performing ADL 	<ul style="list-style-type: none"> - BP 100/60, HR 102/min, RR 28 - Cool and clammy skin - Edema of the lower extremities - ECG myocardial ischemia of the anterior wall - Hypertension Stage 2 Uncontrolled - DM Type 2 Uncontrolled

SAQ 8. In your discharge plan, what modification should be emphasized as part of lifestyle and practices?

- Stop smoking
- Diet rich in vegetables, fruits, whole-grain and high-fiber foods, fish, lean protein and fat-free or low-fat dairy products. And to maintain a healthy weight, coordinate diet with physical activity level
- Engage in exercise
- Reduce stress

SAQ 9. What are the cardiac rehabilitation programs that you can design for Mang Pedro during the in-patient, out-patient, and community setting?

Table 5.6.7 Cardiac Rehabilitation Programs	
REHABILITATION PHASE	CARDIAC PROGRAMS
In-Patient	Exercise that is progressive in nature Health seeking behavior modification: Recognition of signs and symptoms Do's and don'ts for home care Medication instruction
Out-Patient Early Phase	Low level exercise and physical activity Changes for resumption of an active and satisfying lifestyle
Out-Patient	Exercise and physical activity according to a prescribed program Stress management and effective coping strategies Smoking cessation and exposure to secondary smoke Lipid management Weight management Reduction or elimination of alcohol intake Blood pressure control Diabetes management
Community Setting	Maintenance of physical fitness and additional risk-factor reduction

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Care of Clients with Problems on Psychosocial Adaptation/Adjustment

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INTRODUCTION

Psychosocial adaptation is a medical term used in the fields of psychology and rehabilitation. Adapting may be difficult but can be accomplished with the right coping. The adjustment process includes a search for meaning in the experience and an attempt to regain control and self-determination over events that affect one's life. Regardless of the nature of loss, a variety of reactions may take place while the end attempts to make needed adaptations and changes. Most definitions of this construct (psychosocial adaptation) involve the ability of the person affected by a serious health setback to emotionally cope with their conditions so they can maintain some quality of life. As individuals begin to approach their condition realistically, they examine the limitations it imposes and its associated limitations along with realistic appraisal and implementations of strengths. As they accept their conditions, they attain their maximal functional capacity. The amount of time the individual needs to reach acceptance is dependent on personality, reaction of family and significant others, life circumstances, available resources and types of challenges that confront an individual.

Researches show that people who achieve psychosocial adaptation possess certain traits which help them cope. Maladjustment and non-acceptance are characterized by immobility, marked dependency, continued anger and hostility, prolonged mourning or participation in detrimental or self-destructive activities. Just as coping mechanisms are vital parts of human nature, serving to protect against stress, decrease anxiety and facilitate the adjustment process, overuse or maladaptive use of coping mechanisms can postpone or inhibit adjustment/ adaptation.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the care of clients with psychosocial problems and/or maladaptive disorders.
2. Select learning activities that will enable the learners to implement the NNCCS on the care of the client/s with problems on psychosocial adaptation.
3. Apply nursing tools, guidelines and/or frameworks in the care of clients with problems on psychosocial adaptation.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the care of clients with psychosocial problems and/or maladaptive disorders.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of clients with psychosocial problems/psychosocial behaviors will be assessed with appropriate methods

- and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on the care of clients with psychosocial problems/psychosocial behaviors.

SPECIFIC OBJECTIVES

Using the nursing process, the master trainer should be able to:

1. Do complete psychosocial assessment of client
2. Define psychosocial nursing diagnosis or human response patterns with NANDA diagnosis
3. Plan a care for clients with problems on psychosocial adaptation
4. Carry out appropriate actions/strategies for specific needs/problems of clients both non-pharmacological and pharmacological interventions.
5. Evaluate client's response to interventions both non-pharmacological and pharmacological interventions.
6. Record accurately findings/observations/interventions done in charting, nursing care plans, process recordings, behavioral/thematic analyses and other paper requirements/documentations.

There are two (2) parts of this module. Part 1 deals with the basics of psychosocial adaptation. This refers to concepts of stress and coping, stress vulnerability, motivation and lifestyle, and handling feelings and other coping mechanisms, strengths and weaknesses as part of self-awareness. Part 1 relates more on mental health promotion, and mental illness prevention. This is generally applied to normal coping/adaptation across client's type.

Part 2 is more of maladaptive coping relating to psychiatric disorders, its treatment, and rehabilitation. It included the use of the nursing process from assessment using interview, mental status examination and treatment through pharmacological and non-pharmacological interventions up to documentation and evaluation using process recording, behavioral analyses and guided by the standards of nursing practice in mental health psychiatric nursing.

There are annexes for the details of the discussion, however this module does not intend to give the full content of the topic but to guide the Master Trainer as to how to disseminate and embed this at the level of implementation as guided by the **CORE COMPETENCIES** specified.

TOPIC OUTLINE

1. Working Relationship: Basis for Psychosocial Assessment
2. Data Gathering on Psychosocial Assessment
3. Formulating the Nursing Care Plan
4. Implementing the Nursing Care Plan
5. Evaluating Process and Outcome of Psychosocial Care
6. Documenting Client's Psychosocial Care

1. WORKING RELATIONSHIP: BASIS FOR PSYCHOSOCIAL ASSESSMENT

This relationship is not an ordinary or social relationship. Its framework is on the therapeutic use of self. Nurse and the client come together for a reciprocal purpose. This one on one relationship has an end result of a series of planned purposeful interactions between a nurse and a client. It is a learning experience for both, a series of experiences, during which both participants change and develop increased interpersonal competencies. The nurse and the client enter a relationship that is unique to both. Each is affected by and

affects the thoughts, feelings and behavior of, the other person. Each encounter is unique and original. Though unique, all interactions proceed through several general phases, which are not discrete, but may overlap with the other. This is not a social relationship. This relationship requires trust, accepting attitude, non-judgmental, empathy and sympathy, maturity development. It is deliberate and purposeful.

There are factors determining the progress through these phases like the nurse's knowledge and her ability to use it, the ill person's willingness or capacity to respond to the nurse's efforts and the kind of problem experienced by the ill person. This is a therapeutic relationship.

Table 5.7.1 NNCCS on Working Relationship with the Client	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care.	
COMPETENCIES	PERFORMANCE INDICATORS
2.1. Ensures a working relationship with the client and/or support system based on trust, respect and shared decision making.	
2.1.1. Establishes rapport with the client and/or support system ensuring adequate information about each other as partners in a working relationship.	<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner. 2. Addresses with respect and trust the client-partner's concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship.
2.1.2. Formulates with the client partner the objectives and expectations of the nurse client working relationship.	<ol style="list-style-type: none"> 1. Explains nature and purpose of the client-partner working relationship. 2. Prepares with the client a list of objectives and expectations.
2.1.3. Maintains shared decision making and client's participatory capability throughout the nurse-client working relationship.	<ol style="list-style-type: none"> 1. Assesses client's participatory capability. 2. Determines strategies to ensure shared decision making and client participation throughout the working relationship. 3. Carries out appropriate strategies to ensure continued participation of the client.
2.1.4. Enhances client-partner's readiness for taking over/ being in-charge when objectives and expectations of the working relationship have been achieved.	<ol style="list-style-type: none"> 1. Assesses client-partner's readiness for taking charge of the condition or situation 2. Uses strategies to prepare the client for being in-charge/taking over when objectives/expectations have been achieved or when the situation necessitates termination of the nurse-client relationship. 3. Supports client as he/she takes charge of maintaining health or managing the condition/situation (e.g. taking over self-care or implementation of prevention and control measures).

2. NNCCS ON PSYCHOSOCIAL ASSESSMENT

As a nurse, you will be the data processor who pulls together all bits of information. You need to integrate all these and apply the multiple theories you know about normal and abnormal physiological, psychological and social functioning to formulate a list of the client's problems. According to National Conference on Nursing Diagnosis, 2/3 of the disorders that nurses are capable of independently diagnosing and treating are in the psychosocial categories. e have the potential to identify clients who are beginning the process of psychosocial maladaptation to physical illness or any life events. With astute nursing assessment, the pre-crisis types of maladaptive processes like depression, anxiety and other signs of inadequate and maladaptive coping can be reversed.

In assessing a client, you always start with an interview. Before interview, take the time to explain that one of your responsibilities as a nurse is to understand how one is feeling about and reacting to one's illness in order to help him/her during recovery. This helps the client to feel understood. It can give one a sense of security at a time when one feels apprehensive and alone. He has to appear strong in front of his family. This approach will give a professional stamp to your questions, some of which are very professional. Use techniques that promote trust and openness. Your approach should primarily be that of a non-judgmental listener. Try to reflect and be skilled in using therapeutic communication techniques (*see Annex N for details*). Usually the patient is looking for your acceptance, not your opinion. Regardless of what you say, the level of anxiety will often prevent one from fully hearing your response. Follow this interview using the psychosocial assessment rating scale by Patricia Barry 1984.

As a trainer, you should be keen on the areas of stress and coping, interpersonal relationship, motivation and lifestyle, support system of the clients.

The integration of varied etiological explanations for psychosocial maladaptation is important. This integration should help the nurse to appreciate several models used to explain psychopathology. It will assist one to draw connections and arrive at a framework which will give the direction for interventions. Realizing that there is no one best cause/explanation for psychosocial problems/concerns, the nurse appreciates the team approach and multidisciplinary roles in assisting a client with such needs. Putting together results of observations, interview and use of some methods and tools backed up by nurse's knowledge on different theories will help shape the kind of nursing diagnosis and needed nursing actions.

To interpret data requires a fund of knowledge and understanding concerning the nature of the data perceived. To acquire this data/knowledge it is necessary to develop varied cognitive skills and the ability to use and apply concepts to data. This is the difficulty encountered at the interpretive level. Interpretation consists of explanation of raw data and what was observed into a meaningful whole. Interpretation may range from an unsubstantial "opinion" to tentative working hypothesis which is related to a body of theory. To validate conclusions, one has to use interview, do mental status examination and psychological tests to gain insight into patient's perception of himself and others. Nurses in a one-on-one relationship, are concerned with the present reality, with the here and now interpretations of the possible meanings of the client's behavior and the relevancy of these meanings for nursing interventions.

Very important prior to interviewing a client is to get his/her trust. What are the indicators that you have already established rapport? First, find out if the client is comfortable sharing his/her life experiences, and initiatives, if client is interested to know something personal e.g. where you live, what school you belong, and province you come from, etc. When he/she starts to develop concerns for you e.g. asking you if you preferred to sit and rest from continuous working, or find shade or a better place for exchange so you are not under the sun and many more.

After this, you can start to be sensitive to one's feelings and listen attentively. Your techniques of therapeutic

communication can help you. There are helpful hints on what to do and what not to do when having an exchange with the client. Please see *Annex O* for more. After trust has been established and you both feel comfortable with each other, more in depth information can be shared. You can use the “Psychosocial Assessment Rating Scale” as guide which is more specific and complete. This includes level of stress, mental status, personality style and other psychological issues/concerns. Please see Annex P.

TO DO – be guided by:

Thus in your assessment, make sure you do the following:

- a) Get some information/data from secondary sources.
- b) Meet the patient for initial encounter and see him/her personally.
- c) Do contract setting considering schedule, time, purpose, expectations, confidentiality and others.
- d) For succeeding sessions, be sure you have mastery of therapeutic techniques of communication.
- e) Be guided further by the helpful hints/tips given in the annex when relating with client.

Table 5.7.2 shows the competency and performance indicators for these nursing diagnoses.

Table 5.7.2 NNCCS on Data Gathering in Psychosocial Assessment	
COMPETENCIES	PERFORMANCE INDICATORS
2.2. Assesses with the Client (individual, family, population group, and/or community) one's health status/competence.	
2.2.2. Obtains assessment data utilizing appropriate data gathering methods and tools guided by the type of client and work setting requisites.	1. Uses strategies to develop/enhance the skills of the client to participate in developing/specifying the methods and tools for data gathering.
2.2.1. Develops the data gathering plan with the client specifying methods and tools.	<ol style="list-style-type: none"> 1. Conducts comprehensive & systematic nursing assessment of clients within an interdisciplinary framework. 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by work setting requisites <ol style="list-style-type: none"> 2.1 . Individual as client – obtains assessment data through history taking, physical/developmental/psychosocial assessment and other assessment protocols, laboratory and diagnostic procedures.

COMPETENCIES	PERFORMANCE INDICATORS
	2.2. Family/population group/community as a client – obtains assessment data through family health history, assessment of the home and environment, records review and other assessment protocols such as laboratory and diagnostic procedures/reports, epidemiologic and social investigations and assessment of client competence, risk factor assessment, screening of vulnerable risk groups and assessment of issues of vulnerability (health risks, limited control, powerlessness, disenfranchisement, victimization, disadvantaged status).
2.2.3. Analyzes data gathered.	<ol style="list-style-type: none"> 1. Groups assessment data by condition or category using appropriate assessment framework by type of client. 2. Relates data with each other to determine patterns, recurring themes or processes. 3. Compares data, patterns, recurring themes with norms/standards, clinical/health indicators or research findings using algorithms and standard protocols.
2.2.3. Synthesizes data gathered.	<ol style="list-style-type: none"> 1. Interprets data gathered. 2. Draws inferences from data gathered by specifying the nature, magnitude/extent and sources of/reasons for the alterations (e.g. pathophysiology, psychopathology), gaps, deficiencies and/or barriers to opportunities for change/ improvement, health promotion/wellness, disease prevention, problem/disease management, rehabilitation.
2.2.5. Specifies client's status/ conditions/problems to be addressed identifying reasons (etiology) for the existence of the condition or problem.	<ol style="list-style-type: none"> 1. Identifies the factors associated with the condition/s or reasons for the existence of the problem. 2. States nursing diagnosis/nursing problem. 3. Seeks concurrence with the client regarding problems identified

The use of nursing diagnosis in the nursing process necessitates astute psychosocial assessment based on a sound theory. This is affirmed by the fact that the majority of nursing diagnoses categories developed by the North American Nursing Diagnosis Association (NANDA) are psychosocial. Knowledge of psychosocial assessment theory is mandatory, if we are to support our client's adaptation. There are eight major psychosocial factors that nurses should be able to predict with a good level of accuracy on how a person will be able to adapt to a sudden change in health status. This includes social history, level of stress during the year before admission, normal coping pattern, neuro-vegetative changes, patient's understanding of illness, mental status, personality style, major issues of illness.

Further in NANDA typology, it was defined that nursing is the “diagnosis and treatment of human responses to actual or potential health problems”. There are many ways to assemble information to formulate nursing diagnosis. One is to make a list of problems the patient is now experiencing. Another list can be developed containing areas of functioning where the client could be at risk of maladaptive trends, continue or begin to occur and areas of possible needs that require further data to substantiate interventions. Another way is to review Gordon’s health response patterns with the appropriate diagnostic labels categorized within each pattern. *See Annex Q.*

3. FORMULATING THE NURSING CARE PLAN WITH CLIENTS HAVING PSYCHO-SOCIAL PROBLEMS IN ADAPTATION/ADJUSTMENT

The nurse’s purpose in developing a care plan is to provide for oneself a basis to provide guidance to the client. He/she encourages the client to identify certain behaviors as adaptive or maladaptive. The nurse may attempt to create a climate either within the nurse-client relationship or within a specific milieu, where the client may practice changed behavior.

The plan of care must be based on a solid theoretical framework and not on “intuition” or “this worked before”. The theoretical framework, as a means to explain and predict behaviors will help the nurse on maintaining a reasoned, consistent approach and help him/her from falling prey to feeling of hopelessness and inadequacy. The plan of care is concerned with the nurse and nurse’s behavior as factors that will influence desired results.

Nursing care planning is a judgment process that calls on all aspects of nursing knowledge to identify the plan of nursing actions that will restore clients to their optimum health status. Carpenito (1987) describes the purpose of care plan asserting that it aims to communicate to the nursing staff the specific problem of client and the prescribed interventions for directing and evaluating the care given. Different terms used to describe the process of care planning are: defining characteristics, etiology, evaluation and intermediate client goal. Nursing care plan involves five steps of the nursing process (assessment, nursing diagnosis, care planning, interventions and evaluation). Care plans include two outcome criteria for evaluation. These are inter-mediate client goals and specific measurable outcomes describing the optimum behavioral or physiological state related to clients’ identified problems.

Table 5.7.3

NNCCS on Formulating the Nursing Care Plan with Clients Having Problems on Psychosocial Adaptation/Adjustment

COMPETENCIES	PERFORMANCE INDICATORS
2.3. Formulates with the client a plan of care to address the health conditions, needs, problems and issues based on priorities.	<ol style="list-style-type: none"> 1. Sets priorities among a list of conditions or problems 2. Specifies goals, objectives and expected outcomes of care maximizing clients’ competencies. 3. Selects appropriate interventions/strategies enhancing opportunities for health promotion, wellness response, prevention of problems/complications and eliminating gaps/deficiencies. 4. Uses methods and tools to maximize client/family participation in planning appropriate interventions/strategies. 5. Develops with the client an evaluation plan specifying criteria/indicators, methods and tools. 6. Collaborates with the client and inter-professional health care team in developing plan of care. 7. Modifies plan of care according to one’s judgment, skill or knowledge as the client’s needs change.

As a whole, the nursing care plan includes series of steps as a process. This helps ensure the collaborative planning with the client, the client's family, health care team at the appropriate points as needed. Please see guide for plan of nursing care. (See *Annex R*).

4. IMPLEMENTING THE NURSING CARE PLAN WITH CLIENTS HAVING PSYCHOSOCIAL PROBLEMS IN ADAPTATION/ADJUSTMENT

When the stress of illness is too great for the ego to respond in an adaptive manner, one or more types of maladaptive responses can occur. However, these initial maladaptive responses do not always evolve into maladaptation. The ego can, through adaptive efforts, reverse the process. Perceptive caregivers, intervening when maladaptive responses begin to occur can also help reverse the process. Some of the most common types of maladaptive responses are unusual levels of anxiety and depression, suicidal thinking, sexual dysfunction, over dependency, lack of motivation and non-compliance. The degree of emotional stress that occurs as the result of inadequate ego defenses depends on the client's normal personality style and coping ability, his/her perception of the illness, the degree of threat involved and the availability and strength of a support system which includes hospital caregivers in addition to family members and friends.

Interventions for clients and psychosocial problems are numerous. In general there are the non-pharmacological and pharmacological ones, theory-driven interventions, psychosocial reactions, specific interventions and global clinical interventions. As nurses, we ought to have full grasp of these and see for ourselves what we can maximize based on our expertise and experiences. Most often, interventions can be a combination of any of them. However, the pharmacological intervention is crucial because this will help our clients become manageable for our non-pharmacological categories of interventions (e.g. one on one or nurse-patient relationship).

The nurse begins the implementation of the care plan by beginning at the level of attention, but this is difficult when the client has a short attention span. Lack of attention will be identified easily by the nurse as the client constantly jumps from one subject to another. At this point, the nurse may need to set firm limits with the client to gain his/her attention. Setting limits can be a serious problem for some nurses. They consider it as a breach of contract. Therefore, the nurse must decide that in order to meet the major aspect of being therapeutic or helping, the client's inattentiveness must be reduced, which is probably pathological, by setting limit. The problem of attentiveness may actually be the major difficulty stated in the care plan. Success will be interpreted as gaining and increasing the attentive level with some response on the part of the client. Attentiveness may be limited if the client is so severely depressed that his/her thinking is totally self-centered and one is unable to move his/her thoughts from a repetitive sequence of guilt, remorse and hopelessness. It is needed in a therapeutic nurse-client relationship to attend to the response level as well as to other events occurring at the attention level. Much of nurse's work at this point has been concerned with the attention and response level. After a mutual identification of problem area, the relationship moves into the exploratory level, which is an exciting time between the nurse and the client. Identification of problem gives a feeling of success for both, a sense of direction and purpose.

The next level is that of social dimension and is most anxiety provoking for the emotionally disturbed and the area with least understanding for both. This social level focuses on personal and interpersonal relations, societal factors, the ordinarily acceptable social behavior, all of which maybe a complete enigma to many people. The final level in implementation stage is the mastery level. Here the nurse functions chiefly as an observer, encourager and listener. As mastery is achieved, nurse begins to move toward termination by encouraging greater independence by the client. As the client achieves mastery in his/her own area of difficulty, the nurse is also achieving mastery of nursing skills. Constant evaluation, attention, responding to one's own evaluation, exploring ways of guiding the client and identifying the practical and social aspects of his/her functioning lead one to some degree of mastery of the complex skills required in therapeutic nursing. Table 5.7.4 illustrates the competency and performance indicators during the process of implementation

with a client having problem in psychosocial adaptation. The discussion prior to Table 5.7.5 shows the uniqueness of intervening with these types of clients.

Table 5.7.4	NNCCS on Implementing Safe and Quality Interventions with the Client Having Psychosocial Problems in Adaptation/Adjustment to Address the Health Needs, Problems and Issues
COMPETENCIES	PERFORMANCE INDICATORS
2.4. Implements safe and quality interventions with the client to address the health needs, problems and issues	
2.4.1. Implements appropriate psychosocial/therapeutic interventions to render holistic nursing care in any setting.	<ol style="list-style-type: none"> 1. Addresses with respect, trust and concern for safety, client's needs, issues or problems related with psychosocial adaptation using appropriate communication/interpersonal techniques/strategies. 2. Utilizes therapeutic interventions appropriate to psychosocial phenomena/maladaptive behavior patterns/problems identified. <ol style="list-style-type: none"> 2.1. Utilizes therapeutic use of self, e.g. Uses self awareness techniques/strategies; determines appropriate strategies to achieve the goals of the nurse-patient relationship; seeks consensual validation with client. 2.2. Implements psychosocial/therapeutic interventions (e.g. Nurse-client relationship therapy, Relaxation exercises/therapy, Behavioral/Cognitive Therapy, Coping Assistance, Mental health counselling education, Social support intervention, Environmental structuring/Milieu therapy, Psycho-spiritual care and Crisis Intervention/ Psychological stress debriefing). 2.3. Carries out biophysical interventions (e.g. Nutritional intervention, Detoxification, and Pharmacotherapeutics). 3. Collaborates with client support system and the multi-disciplinary team in developing, implementing and evaluating the plan of care.

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/ adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access within the context of Primary Health Care.</p>	<ol style="list-style-type: none"> 1. Determines appropriate participatory and empowerment strategies related to promotion of mental health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation and protection and health resource generation, use or access. 2. Creates opportunities to develop client's competence for mental health disease management environmental sanitation and protection and health resource generation, use or access 3. Executes appropriate participatory and empowerment strategies
<p>2.4.9.1. Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resource access or use and safe environment conducive to health maintenance among its members.</p>	<ol style="list-style-type: none"> 1. Develops the competence of the family to recognize opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease/problem management and environmental sanitation and protection by: <ol style="list-style-type: none"> a) Analyzing the factors affecting health, human response, the environment and its resources realities. b) Determining the relationships among these factors. c) Specifying the health and related conditions/problems which need to be addressed. 2. Carries out strategies/interventions to help the family decide to take appropriate action on each health condition/problem identified. 3. Implements competency-building intervention options to help the family provide appropriate care to the dependent, at-risk, vulnerable, sick and/or disabled member/s. 4. Develops the competence of the family to provide a home environment conducive to health maintenance and personal development. 5. Carries out participatory and empowerment strategies to enhance the family's competence to use community resources for health care and health maintenance.
<p>2.4.9.3. Enhances the competencies of specific population groups to ensure wellness, healthy lifestyle/adaptation, disease prevention, management, rehabilitation and vulnerability reduction or prevention.</p>	<ol style="list-style-type: none"> 1. Develops the competence of specific population groups support systems to analyze the relationship of factors or patterns, home and community realities affecting health, human response and the environment. 2. Implements effective strategies to develop/enhance the competence of specific population groups/support system/s for decision making on appropriate action/s for healthy lifestyle/adaptation, disease prevention, management and rehabilitation.

COMPETENCIES	PERFORMANCE INDICATORS
	<ol style="list-style-type: none"> 3. Carries out empowerment strategies to develop the competencies of specific population groups and support systems for health care, healthy lifestyle adaptation, use of health service and health resource access or use.
2.4.13. Manages client load to ensure health program/ service coverage.	<ol style="list-style-type: none"> 1. Conducts case detection, tracking, tracing and monitoring surveillance. 2. Conducts health programs and services in the home, clinic, school and work settings. 3. Carries out strategies to ensure health program/service coverage based on health program objectives/ targets through health resources availability, access and or use especially among marginalized/vulnerable risk groups. 4. Determines adequacy of health program/service coverage based on updated caseload registries by type of client, health program or health problem (e.g. Client Lists for Prenatal/Post-partum Care, Client List for At-Risk Children, Family Registry of Priority Cases). 5. Carries out interventions for effective and efficient care of clients in the caseload based on geographical coverage. 6. Adheres to institutional safety policies and protocols to prevent injuries/accidents and infection. 7. Refers client for appropriate management and assistance for health and medical-related benefits. 8. Reports notifiable/reportable diseases based on protocol.

5. EVALUATING PROCESS AND OUTCOMES OF PSYCHOSOCIAL CARE OF CLIENTS

Evaluation is a procedure followed throughout the nurse-patient relationship to enable the nurse to conduct activities in a purposeful and therapeutic manner. A final evaluation gives the nurse a comprehensive view of the client, and progress and what encouraged or impeded progress. It helps establish guidelines for future nursing activity as it provides an experimental basis to complement theoretical background already acquired.

There are three (3) sections when evaluating the nurse-patient relationship. The first is the descriptive and is designed to compare the mental health status of the client during orientation, working and termination stages. The second part is an assessment of the learning acquired by the nurse. Assessment guides require the nurse to assess his/her learning during each of the stages in the nurse-patient relationship. The third is the overall outcome of the Nurse-Patient relationship both from patient and the nurse.

Each guide indicates specific learning dimension e.g., attending, responding, exploratory, social and mastery. Mastery of skills is unique in varied stages e.g. during orientation period, the nurse assesses his/her skills to observe, report and interpret data. At the working phase, she assesses her ability to develop and implement nursing care plan. During the terminal phase, he/she assesses her ability to complete the

grief work required for both oneself and the client.

Table 5.7.5	NNCCS on Providing Health Education	
COMPETENCIES	PERFORMANCE INDICATORS	
2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community).		
2.5.1. Determines the health education planning models appropriate to target clientele/expected objectives and outcomes.	<ol style="list-style-type: none"> 1. Specifies the characteristics of each health education planning model. 2. Selects appropriate health education planning model. 	
2.5.2. Utilizes health education process to accomplish the plan to meet identified client's learning needs.	<ol style="list-style-type: none"> 1. Assesses the needs of the target population. 2. Prioritizes the learning needs/problems in partnership with client partner. 3. Formulates appropriate goals and objectives. 4. Designs a comprehensive health education plan. 5. Implements the health education plan utilizing appropriate teaching strategies. 6. Evaluates the results of client's learning experiences using the evaluation parameters identified in the health education plan. 	

Health Education relating to psychosocial adaptation is more focused on prevention of mental illness and promotion of adaptive coping. Because stress is an automatic response and cannot be avoided, we should learn to conserve our adaptive energies. Because energy supply is limited, coping measures using minimal amount of energy are called adaptive measures. These are measures which deal directly with the stressful event or its symptoms. Health education relating to stressful events include utilizing support system, relaxing, problem solving, changing behavior and developing more realistic goals.

Well-adjusted people use internal and external resources to conserve energy by making realistic problem solving. They recognize and accept situations that cannot be changed, and find alternative actions for those that can be changed. Nurses owe it to themselves and their clients to follow rules of good health to prevent physical illness. Physically ill persons have less ability to cope. A nurse who is unable to handle one's own stress adequately cannot help others. Nurses should get adequate rest, proper nutrition, plenty of exercises and engage in wholesome and enjoyable activities. They should work to strengthen their own adaptive methods. This framework is extended not only to clients but to client's families as well. The significance of psychoeducation has evidence in a lot of researchers or studies.

Table 5.7.6 NNCCS on Evaluating Process and Outcomes of Psychosocial Care with Clients

COMPETENCIES	PERFORMANCE INDICATORS
2.6. Evaluates with the client the health status/competence and/or process/expected outcomes of nurse-client working relationship.	<ol style="list-style-type: none"> 1. Utilizes participatory approach in evaluating outcome of care. 2. Specifies nature and magnitude of change in terms of client's health status/competence/processes and outcomes of nurse-client working relationship. 3. Monitors consistently client's progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools (e.g. critical pathway, nurse sensitive indicators, quality indicators, client competency indicators, hospital and community scorecard) in collaboration and consultation with the client. 4. Revises Nursing Care Plan based on outcomes and standards considering optimization of available resources.

6. DOCUMENTING CLIENT'S PSYCHOSOCIAL CARE

Documentation is one area that is mostly not attended by nurses. Nurses should choose a systematic method of collecting data regarding their plan, structure and evaluating nursing intervention. The process record is probably the most frequently used form of data collection. It is a guide as to what verbatim the client used to identify symptoms and behaviors. To use the tool effectively, the nurse must understand the purpose for which it was designed. It is recommended that instructors and supervisors explain well the need to invest time, energy and effort required to assist the learner the importance of making them. This tool helps improve the quality of nursing care. Writing and analyzing process records are experiences which assist the nurse to plan, structure and evaluate interventions. The process record helps the nurse become increasingly cognizant of ways to improve clinical practice. The writer begins to develop an increased awareness of the verbal and non-verbal communication patterns and feelings relating to self and others. Learners increase their ability to identify nursing problems and gain some degree of skill in solving it on top of consciously applying theory to practice. *Please see Annex S for details.*

Another important documentation is the behavioral analyses. This tool utilizes the nursing process in care of clients. It assesses one's capacity to analyze care given based on behavioral patterns demonstrated by the client. As nurses, our role is to detect human responses/pattern to conditions of health and illness. *Please see Annex T for more details.*

Documentation of the nursing process is required in any state and is needed to meet standards for nursing care. This documentation should be done according to expected format of the institution/work setting in which the nurse worked or is employed. These standards pertain to professional nursing activities that are demonstrated by the nurse through the nursing process. It involves assessment, diagnosis, outcome identification, planning, implementation and evaluation. The nursing process is the foundation of clinical decision making and encompasses all significant actions taken by nurses providing psychosocial and psychiatric mental health care to all clients.

"Standards of Professional Performance" describe a competent level of behavior in the professional roles, including activities to quality of care, performance appraisal, education, collegiality, ethics, collaboration and research. All these documents are significant in our role as professional nurses. Table 5.7.7 identifies the specific competency and corresponding performance indicators when documenting.

Table 5.7.7	NNCCS on Documenting Process and Outcomes of Psychosocial Care	
COMPETENCIES	PERFORMANCE INDICATORS	
2.7. Documents clients' responses/ nursing care services rendered and processes/outcomes of the nurse-client working relationship.	<ol style="list-style-type: none"> 1. Accomplishes appropriate documentation forms using standard protocols. 2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness & timeliness of documentation. 3. Utilizes acceptable and appropriate terminology according to standards. 	

Finally, after going through the module on “psychosocial care of client with problems on adaptation/ adjustment”, the master trainer should be able to understand fully the set objectives for this specific module. The use of nursing process in caring for clients with psychosocial concerns or mental health psychiatric problems must be appreciated. The bottomline for this module is the “therapeutic use of self”. One cannot give something to clients if one does not have it. Therapeutic use of self-is enhanced by increasing self-awareness in a nurse-patient relationship backed up by skill in therapeutic communication, dynamics of human behavior and theories. The pre-requisites for therapeutic relationship are acceptance, non-judgmental attitude, mature emotional involvement, trust and empathy.

Using the self therapeutically as you do your nursing process should be guided by the set of competencies explored in this module parallel with performance indicators. From here you can formulate and implement the instructional design. Mentoring and coaching strategies will enhance your knowledge and skill, thus assisting you to make good decisions, actions for the implementation of NNCCS on care of clients with problems on psychological adaptation/adjustment.

Suggested Resources

Listed below are tools and additional resources that may be helpful to you as a master trainer. You may check the following resources in the book *Psychosocial Nursing Assessment and Intervention* written by Patricia D. Barry.

1. Psychosocial Assessment Rating Scale (pages 160 - 163)
2. Psychosocial Nursing Diagnosis (page 171)

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Care of the Older Person

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INTRODUCTION

Review of literature shows that the increasing global population of older persons has been attributed to two major factors: falling fertility, and rising longevity. The Philippines is no exception. The varied conditions and lifestyle that the older persons go through, their characteristic life histories, environmental situations, social challenges, burdens of illness, create the need for highly individualized nursing care. These needs are in the form of total dependent care, assisted care, or promoting independence and self-care. Nursing care for the older persons provides nursing actions and services to increase health promoting behaviors; minimize and compensate for health-related losses and impairments related to aging; provide comfort through distressing and debilitating events of aging and dying and death; and facilitate the diagnosis, palliation, and treatment of disease in the older persons.

In what context or environment should we understand the application of “care of older persons?” The picture from the national data will help learners appreciate this application. The National Objectives for Health (2012-2016) of the Department of Health describes the overall goal for older persons: “quality of life among the older persons is promoted and contributes to nation building”. Within this context, nursing care is aimed at promoting healthy, productive older persons. Given the data on the leading causes of death among older persons, nurses are provided with a direction on the knowledge, skills and attitude competencies expected of the beginning nurse.

Table 5.8.1

Leading Causes of Death Among Older Persons, 2005
(Ref. National Objectives of Health 2011-2016, 2012, p109)

RANK	CAUSES OF DEATH
1	Cardiovascular diseases , all forms
2	Pneumonia
3	Malignant neoplasms, all forms
4	Chronic Obstructive Lung Disease
5	Tuberculosis, all forms
6	Diabetes Mellitus
7	Gastric, duodenal, peptic and gastrojejunal ulcers, and other diseases of the digestive system
8	Nephriitis, nephrotic syndrome, and nephrosis
9	Accidents, injuries, all forms
10	Chronic liver disease and cirrhosis

The data show that lifestyle related diseases such as diseases of the heart, hypertension, diabetes, cancers are related to the mortality of older persons, with pneumonia and TB, as the main infectious conditions. Lifestyle related diseases are so called, because factors like unhealthy diet, smoking, physical activity, obesity, stress - contribute to their development.

This module is for Master Trainers (MT). The purpose of the module is to provide the MT a guide to increase awareness and knowledge of the 2012 NNCCS. This will be the means by which the MT will “spread-out” information on the use of the 2012 NNCCS, a process before the “embedding” takes place by implementation facilitators (IF). The module covers a process of explaining the use and application of the NNCCS for courses and programs that aim to provide care for older persons. This module is an exemplar. The process is open to creativity and new ways of understanding. The process values the expertise of the MT in cascading the competencies and indicators. The module will not cover content, but rather processes, teaching-learning strategies, background information, critical thinking and inquiry, as guide for the MT.

EXPECTED COMPETENCY

At the end of the module study, the master trainer will be able to:

- Explain the use of NNCCS Responsibility 2: “Utilizes the Nursing Process in the Interdisciplinary Care of Clients: Module on the Care of Older Person.”

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the care of the older person.
2. Select learning activities that will enable the learners to implement the NNCCS on the care of the older person.
3. Apply nursing tools, guidelines and/or frameworks in the care of older person.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the care of the older person.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of older person will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on the care of older person.

TOPIC OUTLINE

1. Assessment of the Older Person
 - Assessment with Focus on Function
 - Tools for Screening and Assessment
2. Problem Identification and Nursing Diagnosis
 - Recognizing Priority Problems
 - Some Guide on How Illness Changes with Age and Their Presentation
 - Geriatric Syndromes
3. Developing the Plan of Care
 - Patient Objectives: Long-Term & Short Term
4. Selecting Appropriate Interventions
5. Evaluating the Plan of Care

MODULE CONTENT

1. ASSESSMENT OF THE OLDER PERSON

Assessment of the Older Person with Focus on Function

Good use of assessment tools guides the nurse to enhance the overall wellbeing of the older person.

Tip for Master Trainers

- Use an approach that accommodates the nursing process framework.
- Consider the work setting and the needs of the patient being served.
- Advocate for the comprehensiveness of assessment.
- Have adequate knowledge of the age-related changes in aging, as well as the skills in assessment.

Nursing Assessment of the Older Person. The purpose of nursing assessment of the older person is to identify patterns of functioning that deviate from normal or baseline or from an accepted standard. This provides the reasoning for developing the plan of care selection of appropriate nursing interventions. From the assessment proceeds the application of the nursing process.

Functional Status. Functional status refers to the person's ability to perform the activities necessary to ensure well-being. It is conceptualized as the integration of three domains of function: biological, psychological (cognitive and affective), and social. Functional assessment is derived from a system's model which recognizes the interrelationships of these domains and their interaction with the environment. (Linton & Lach, 2007, 25).

The Assessment Encounter. The nurse ensures a good working relationship with the client based on trust, respect and shared decision making. The nurse explains the nature and purpose of the client- nurse working relationship. The nurse addresses safety issues and concerns when doing assessment.

The nurse makes adequate plans for assessment. Unless there is an emergency, the nurse starts with the functional pattern of assessment, such as the use of the Gordon's Functional Pattern of Assessment.

The nurse plans for conducting the assessment in such a way that ensures the procedure will flow smoothly, and will result in the least number of position changes for the patient and considers the energy expenditure of the patient. The nurse uses the principles to ensure comfort, privacy and safety in the process of assessment.

Critical Thinking Exercise 1

The Master Trainer guides the learners/ nurses to connect ideas and draw conclusions from the assessment findings.

Case Report:

Mang Pedro De Legaspi is a 67-year old fisherman previously diagnosed with hypertension Stage 2. The family members observed that he had increasing "off- fishing" days, and would prefer to be alone. Lately, walking seemed to be a difficult activity. He verbalized shortness of breath at times and had to be assisted by his wife. Mang Pedro denies that he is sick. He claims, it is only one of those days that he felt lazy. The time came when they had to seek consult for him and was advised by the attending physician to be confined for observation.

Critical Thinking Exercise 1 (Continued)

Case Report:

The following physical examination findings were reported: HR = 102 beats/min. with occasional skip beats; RR = 28 cycles/min, fast and shallow, orthopneic, use of accessory muscles for breathing; BP = 100/60mmHg; cool and clammy skin; observable edema of the hands and feet. Mang Pedro De Legaspi's case was discussed in a case conference by the Master Trainer in a group composed of new nurses.

The following are guide questions to take-off the discussion.

1. What are the physiologic and emotional changes that happen in aging? Why would Mang Pedro prefer to be alone?
2. Assuming that Mang Pedro sought initial consultation at the Health Unit of the fishing village, what situations should have caused alarm? What actions were important?
3. What were the significant physical examination findings that support the identification of the nursing problem?
4. The Master Trainer provides at least two (2) additional trigger questions.

Approaches to the case report answers.

1. Please refer to or get hold of a reference on the "Changes in Aging". Make sure you read and get a good understanding of the physical, physiologic, and emotional changes common to aging. Mang Pedro's behavior is reflective of changes in aging. As a nurse, you will have to make decisions about whether to refer him or not for further medical evaluation. It is common for nurses to attribute signs manifested by Mang Pedro to aging. Then, what are some assessment guidelines that nurses should follow when assessing an older person?
2. The Master Trainer draws discussion for nurses to identify possible priority problems.
3. The Master Trainer synthesizes with the nurses the significant data as bases for defining the nursing problems.
4. The Master Trainer adds two (2) trigger questions and possible approaches to the answers.

Tools for Screening and Assessment

There are standardized tools for screening and assessment of the older persons. The nurse uses appropriate criteria in selecting the tools, which include the following: the purpose of the instrument, limitations in the work setting, clinical relevance, ease of use, amount of training required, equipment need and costs, appropriateness for use with older persons (Linton & Lach, 2007, 53).

The tools are broadly categorized into three (3) main domains: biological (physical and functional), psychological (cognitive and affective), and social. For purposes of the module, examples from each category will be briefly discussed.

Tools for Functional Assessment. Examples of assessment tools for functional health include:

1. "Assessment of General Health". The indicators are diagnoses, conditions present, symptoms, disabilities, categories or number of drugs taken, severity of illness, utilization of health care (number of hospital days).
2. "Pain Assessment" using the "Faces Pain Scale" and the "Visual Analog Scale" are very relevant tools. Pain is common in the older persons as a result of chronic conditions.
3. "Get-up and Go-test". This is a simpler measure of gait and balance, and can be completed in a few minutes. Several variations do exist in the use of the tool.

Measures for Functional Status Assessment identify the type and amount of assistance needed. The idea in the use of the tools is to aim for competence in physical assessment for older persons, as clients.

Self- Assessment Question (SAQ) #1

“What are the uses and advantages of the KATZ INDEX OF ACTIVITIES OF DAILY LIVING?”

Katz Index of Activities of Daily Living

It was originally developed to study treatment outcomes and the prognosis of older adults and the chronically-ill. The six (6) different functions measured are bathing, dressing, toileting, transfer ability, continence and feeding ability. Each function is rated according to the level of assistance required to complete the task, with the *choices as being independent, assistance required, or completely dependent*.

Web Resources

Katz Index of Independence in Activities of Daily Living. (2012). In *Hartford Institute for Geriatric Nursing*. Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf.
Wallace, M. & Shelkey, M. (2008). Monitoring Functional Health Status in Hospitalized Older Adults. In *Tufts Health Plan*. Retrieved from http://www.tuft-healthplans.org/providers/pdf/katz_adl.pdf.

Operational definitions. Independent means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on the actual status and not ability. A patient who refuses to perform a function, is not considered doing the function, even though, he or she is deemed able.

Bathing (sponge, shower or tub)

Independent: Assistance only in bathing a single part (back or disabled extremity) or bathes self completely.
Dependent: Assistance in bathing more than one part of the body; assistance in getting in and out of the tub; does not bathe self.

Dressing

Independent: Gets clothes from closets and drawers; puts on clothes, outer garments, braces, manages fasteners; act of tying the shoes is excluded.
Dependent: Does not dress self, or remains partly underdressed.

Going to toilet

Independent: Gets to toilet; gets on and off toilet; arranges clothes; cleans organs of excretion (may manage bed pan use at night only and may not be using mechanical supports).
Dependent: Uses bedpan or commode, or receives assistance in getting to and using toilet.

Transfer

Independent: Moves in and out of bed, and in and out of chair independently (may or may be using mechanical supports).
Dependent: Assistance in moving in and out of bed and/or chair; does not perform one or more transfers.

Continence

Independent: Urination and defecation entirely self-controlled.
Dependent: Partial or total incontinence in urination and defecation; partial or total control by enemas, catheters, or regulated use of urinals and/or bedpans.

Feeding

Independent: Gets food from plate or its equivalent.

Psychological Function: Cognitive and Affective Assessment. Psychological impairments, such as depression and dementia have been reported to be strongly correlated with decreased quality of life (QOL) and functional deficits. The social environment also needs to be assessed, alongside the cognitive aspects, as it may adversely affect the emotional state, leading to symptoms of sadness, loneliness, anxiety.

Examples of test for cognition are the:

1. Mini-Mental State Examination. It is interviewer-administered and tests orientation, registration, attention and calculation.
2. Another example is the Geriatric Depression Scale. It is a self-rated type of scale designed and focussed on the psychological aspects of depression.

Social Function. There are two (2) general directions for social function assessment, the social network and support system.

1. The social network describes the “web of social relationships that surround a person”, including the number and frequency of contacts, geographical proximity, reciprocity (mutual helping) and durability of the network.
2. Social support describes the emotional, instrumental, or financial aid that is obtained from the social network. Social networks need to be dynamic for the older persons.

Table 5.8.2 below outlines the NNCCS on Responsibility 2 on “competencies and performance indicators” for the assessment component of Responsibility 2 on the use of the nursing process.

Table 5.8.2	NNCCS on the Beginning Nurse's Function on Assessment	
Responsibility 2	Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe and Quality Care	
COMPETENCIES		PERFORMANCE INDICATORS
2.1.1. Establishes rapport with the client and/ or support system ensuring adequate information about each other as partners in a working relationship.		<ol style="list-style-type: none"> 1. Shares pertinent information about oneself as nurse-partner. 2. Addresses with respect and trust the client-partner's concerns/ needs related to sharing information about oneself to enhance the nurse-client working relationship.
2.2.1. Develops the data gathering plan with the client, specifying methods and tools.		<ol style="list-style-type: none"> 1. Uses strategies to develop / enhance the skills of the client to participate in developing /specifying the methods and tools for data gathering.
2.2.2. Obtains assessment information utilizing appropriate data gathering methods and tools guided by the type of client and work-setting requisites.		<ol style="list-style-type: none"> 1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework. 2. Generates with the client the assessment data using appropriate data gathering methods and tools guided by the work-setting requisites.

COMPETENCIES	PERFORMANCE INDICATORS
2.4.8. Applies appropriate and evidence-based nursing process requisites (assessment and interventions) for physiologic and psychosocial needs of patients / clients to preserve physiologic integrity and prevent complications, as applied to the care of older persons.	<ol style="list-style-type: none"> 1. Generates adequate assessment data according to level of prescribed/ needed care. 2. Uses appropriate assessment techniques with the least discomfort to the patients. 3. Recognizes and prioritizes emerging problems in a timely manner. 10. Demonstrates caring and compassionate care, especially to vulnerable patients, e.g. the older persons.

Self- Assessment Question (SAQ) #2

On **EVIDENCE – BASED PRACTICE:**

“Caregiver support refers to provision of the necessary information, advocacy, and support to facilitate primary patient care, by someone other than the health care personnel”. Cite an example derived from your practice that illustrates this for the care of the older person.

Critical Thinking Exercise 2

The Master Trainer needs to be equipped with background information (knowledge) that will enrich competencies of the learners. The following data on laws, policies, guidelines, issues on care of older persons are provided to help the Master Trainer gain background information about older persons.

- In the Philippines, one becomes a Senior Citizen at 60 years old (R.A. 7432/9994).
- Mandatory Retirement is at 65 years old. One qualifies for Social Security System (SSS) Pension, Government Service Insurance System (GSIS) Pension
- Issues: (Adapted from Paper presentation of Dr. Doris Camagay, NIH Institute on Aging, May 24, 2013).
 - Health care is an out of pocket expense for self-employed older persons, such as farmers, fisherfolk, and housewives who were never employed.
 - Adult-to-Adult children tensions
 - Shifting of roles from parent (caregiver) to care-recipient
 - Migration causes “skipped generation” or a physically absent middle generation
 - Abandonment
 - Abuse and Neglect
 - Disasters and natural calamities/situation
 - Accessibility Act RA 344 (BP Bilang 344)
 - Creation of the Institute on Aging UP Manila (2012)
 - DOH Administrative Order that includes in the classification of facilities to be licensed, Custodial Care - Nursing Homes (2012)

2. PROBLEM IDENTIFICATION AND NURSING DIAGNOSIS

Recognizing Priority Problems

Critical Thinking Exercise 3

The Master Trainer is expected to have working knowledge of the different levels or types of services that can be provided. The following descriptions will guide the MT to determine the competencies needed for each type or level of care.

Acute Care. In the acute care for older persons, nurses deal with life-threatening situations. The nursing goals for care include to recognize problems correctly and with speed, and participate in related critical care and holistic interventions. Examples of critical care are coronary care, neuro critical care among others.

Subacute Care. This level addresses the need for medical and rehabilitative needs of patients who have been sufficiently stabilized and no longer require acute care, but that services might be complex for interventions in conventional nursing centers. This is similar to a step-down unit.

Long-Term Care and/or Community Care. Care in long-term care is multidisciplinary. The goals are common to the members of the health care team, but for nursing care, the application of the nursing process applies to the following: 1) manage symptoms of acute and chronic conditions, 2) ensure that basic physiological, psychological, social and spirituals needs are met, 3) maintain or improve function, 4) prevent excess disability, 5) encourage autonomy, 6) support the family unit, 7) preserve dignity, 8) provide a safe environment, 9) maximize the quality of life, 10) provide compassionate end-of-life care.

End of Life Care. This is a period of care where there usually is a shift from invasive interventions at prolonging life to supportive interventions that focus on control of symptoms. Two models are common: hospice and palliative care. "Hospice is an interdisciplinary model of care that supports the patient, the family and significant others through the final phase of a life-threatening illness. Hospice care is a model of quality end-of-life care focussing on the last phase of an illness, the dying process and the bereavement period (Linton & Lach, 2007, 713)." "The palliative care model built on the hospice care model, defines an approach that improves the quality of life of patients facing life-threatening illness, and their families, through the prevention, assessment, and treatment of pain, and other physical, psychosocial, and spiritual problems (WHO, 2002)".

Symptom Experiences in Older Persons

The changes presented in the table below represent some examples of symptom experiences that older persons report. There is a need then for nurses to be cautious and discrete when assessing older patients.

Table 5.8.3 Symptom Experiences in Older Persons	
PROBLEM	PRESENTATION IN OLDER PERSONS
DEPRESSION	Classic signs may or may not be present, apathy, memory and concentration problems, psychomotor problems, increased somatic symptoms, increase sleep

PROBLEM	PRESENTATION IN OLDER PERSONS
PNEUMONIA	Cough may be productive, dry or absent; chills, fever, elevated WBC may be absent; tachypnea, slight cyanosis, confusion, anorexia, nausea and vomiting, tachycardia may be present
URINARY TRACT INFECTION	Incontinence, confusion, anorexia; dysuria often absent; frequency, urgency, nocturia,
MYOCARDIAL INFARCTION	Sometimes no chest pain, or an atypical pain location, such as jaw, neck, or shoulder; shortness of breath, tachypnea, arrhythmia, hypotension, restlessness, syncope, confusion
HEART FAILURE	May have the classic presentation, plus anorexia, restlessness, cyanosis, falls.

Geriatric Syndromes

Geriatric syndromes are subsets of problems observed to be common in older persons. They require a unique and specific type of problem-focussed assessment. Geriatric syndromes include: urinary incontinence, falls, cognitive impairments such as dementia, Alzheimer's disease, malnutrition, pressure ulcers, pain.

In managing geriatric syndromes, the nurse should be familiar with the wide range of assessment techniques, risk-factors tools, knowledge of common presentation of the problems, preventive measures, interventions, pharmacological treatments and other management strategies. Frailty is related to geriatric syndromes and requires competencies for knowledge and skills in assessment and care.

Critical Thinking Exercise 4

The module has thus far discussed assessment, problem identification, and common problems of the older persons. Common to all the concepts is the principle of practice, most especially for physical assessment, use of assessment tools, and analysis of problem situation.

In the table below are principles for teaching psychomotor skills. The Master Trainer's role in part is to supervise practice. Practice is essential in order to fix the sequential order of movements in the learner's memory. The amount of practice varies with the complexity of the skill, the learner's motivation and knowledge of related skills. Practice enables the learner to master performance skill smoothly, with better control, less wasted time and motion.

Teaching–Learning Principles for Teaching Psychomotor Skills (De Young, 2003, 206)

1. People learn psychomotor skills best using a greater number of short practice sessions rather than fewer long sessions.
2. Distributed practice is generally better than massed practice.
3. Practice must be long enough for the learner to make appreciable progress; rest periods must be short enough that forgetting does not occur.

In the next page is Table 5.8.4 on NNCCS on competency and performance indicators for the assessment component of Responsibility 2 on the use of the nursing process, assessment and problem identification.

Table 5.8.4 NNCCS on Beginning Nurse's Function on Problem Identification

COMPETENCIES	PERFORMANCE INDICATORS
2.2.3. Analyzes data gathered.	<ol style="list-style-type: none"> 1. Groups assessment data by condition or category using appropriate assessment framework by type of client. 2. Relates data with each other to determine patterns, recurring themes and processes. 3. Compares data, patterns and recurring themes with normal standards , clinical health indicators, or research findings using best practice guidelines.
2.2.4. Synthesizes data gathered.	<ol style="list-style-type: none"> 1. Interprets the data that has been obtained. 2. Draws inferences from data gathered by specifying the nature, extent, and reasons for the alterations.
2.2.5. Specifies client's condition and problems to be addressed.	<ol style="list-style-type: none"> 1. Identifies the factors associated with the conditions/or reasons for the existence of the problems. 2. States nursing diagnosis or nursing problems. 3. Seeks concurrence with the client regarding problems identified.
2.4.8. Applies appropriate and evidence-based nursing process requisites (assessment, problem identification and interventions) for physiologic and psychosocial needs of patients/ clients to preserve physiologic integrity and prevent complications, as applied to the care of older persons.	<ol style="list-style-type: none"> 3. Recognizes and prioritizes emerging problems in a timely manner. 4. Provides substantial pathophysiologic reasoning for problems and changing patient situations. 11. Has the ability to anticipate changing patient conditions.

3. DEVELOPING THE PLAN OF CARE

The nursing process is referred to as the blueprint or plan for client care. A good plan allows flexibility for use in clinical and community settings. Nurses identify clients' health care needs, define the nursing diagnosis or collaborative problem, determine priorities of care, set goals and expected outcomes of care. The use of the nursing process is a competency that has to be developed. The Master Trainer takes this into consideration in the learning process.

The following are suggested guidelines for writing goals and expected outcomes in planning care.

1. Client-centered: should reflect a client behavior, and not the nurse's goal.
2. Singular goal or outcome: address only one behavior or response at a time.
3. Observable: if changes do occur in the client's physiologic status, knowledge, perception and behavior.
4. Measurable: meaning setting standards against which to measure the client's response to nursing care.
5. Time-limited: indicating when the response is expected to occur assists the nurse to determine

if the client is making progress at a reasonable rate, and promotes accountability in the delivery and management of nursing care,

6. Mutual factors: mutual goal setting ensures that the nurse and the client agree on the direction and time limits of care, and it increases client's motivation and cooperation,
7. Realistic: setting goals and objectives that a client is able to reach, provides clients a sense of hope, and important in relation to resources in the health care facility.

Adapted from Potter, P. A. & Perry, A. G. (2009). *Fundamentals of Nursing*, 7th Edition. Mosby: Elsevier, 267.

The Master Trainer brings in experiential learning in planning care to the teaching-learning scenario, and can discuss with the learners selected cases to illustrate the plan of care.

Self-Assessment Question (SAQ) #3

Consider the following outcome statement for an older patient with pneumonia: "the client's lung will be clear to auscultation in three (3) days, and the respiratory rate will be decreased to about 22-26 breaths per minute." Is the statement correct? What are your comments?

Table 5.8.5	NNCCS on the Beginning Nurse's Function in the Plan of Care	
COMPETENCIES	PERFORMANCE INDICATORS	
2.3. Formulates with the client a plan of care to address the health conditions, needs problems and issues based on priorities.	<ol style="list-style-type: none"> 1. Sets priorities among a list of conditions or problems. 2. Specifies goals, objectives and expected outcomes of care maximizing client's competencies. 3. Selects appropriate interventions/ strategies enhancing opportunities for health promotion, well-ness response, prevention of problems/complications. 4. Uses methods to maximize client/ family participation in planning appropriate interventions. 5. Develops with the client an evaluation plan specifying criteria indicators. 6. Collaborates with the client and the inter-professional health care team in developing the plan of care. 7. Modifies plan according to one's judgement, skill or knowledge as client's need change. 	

The SPICES model (Lewis, 2011, 73) is also a recommended tool to integrate data in the care of older patients.

Web Resource

Fulmer SPICES: An Overall Assessment Tool for Older Adults. (2012). In *Hartford Institute for Geriatric Nursing*. Retrieved from http://consultgerim.org/uploads/File/trythis/try_this_1.pdf.

Critical Thinking Exercise 5

The Master Trainer applies clinical decisions in the determination of appropriate nursing diagnosis. Supporting evidences of correct assessment findings should be the guide. The following is a list of age-related physiologic changes and nursing diagnoses that may be applicable in the care of older patients (Lewis, 2011, 73).

Additional Resource

Read the Table of Nursing Diagnoses on page 73 in the book cited below:

Lewis, S.L., Dirksen, S. R., Heitkemper, M.M., Bucher, L., & Camera, I.M. (2011). *Medical-Surgical Nursing Assessment and Management of Clinical Conditions*. (8th ed.). St. Louis, Missouri: Mosby Elsevier.

4. SELECTING APPROPRIATE NURSING INTERVENTIONS

The competencies for nursing interventions are extensive and varied. What applies to general adult health nursing (medical-surgical nursing) likewise applies to the care of older persons. For purposes of this module, selected concepts are presented to guide the Master Trainer as bases for reasoning in selecting the appropriate nursing interventions.

A working knowledge on the concept of the Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC) is recommended. This will provide the master trainer a ready tool to explain nursing interventions.

Nursing interventions are treatments or actions, based upon clinical judgment and knowledge, that nurses perform to meet client's outcomes (Bulechek, Butcher, Dochterman, 2008 in Lewis, 2011, 267). During the development of care plans, nurses select interventions designed to support the client in moving from the current level of health to the level prescribed in the goals and objectives of care.

To select nursing interventions, the nurse needs to be competent in three (3) areas (Bulechek et al, 2008 in Lewis, 2011):

1. Knowing the scientific rationale for the intervention
2. Possessing the necessary psychomotor and interpersonal skills
3. Being able to function within a particular setting to use the available health care resources effectively.

There are three (3) categories of nursing interventions:

- Nurse-initiated,
- Physician-initiated, and
- Collaborative interventions.

Selection of interventions is based on the patient's/client's needs. Nurse-initiated interventions are the independent nursing interventions. These are those that do not require direction, or order from another health care professional. They are interventions based on scientific rationale.

The Master Trainer uses the CHED CMO #14 as guide for the selection of interventions accordingly when dealing with teaching-learning situation for nursing education, and practice in a health service unit.

The Master Trainer may also refer to the Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC) for purposes of this module (Iowa Intervention Project, 2003).

Care plans for the community-based settings involve the same principles of practice. There may be a need though for a more comprehensive community, home and family assessment. The plans may include: education for the client and the family about the necessary care techniques and precautions, teaching how to integrate care in the family, and guide the patient and family to take increasing responsibility for care.

Table 5.8.6	NNCCS on the Beginning Nurse Function on Implementation of Safe and Quality Interventions to Address Health Needs
COMPETENCIES	PERFORMANCE INDICATORS
2.4.1. Implements appropriate psychosocial/ therapeutic interventions to render holistic nursing care in any setting	<ol style="list-style-type: none"> 1. Addresses with respect, trust, concern for safety, client's needs, issues or problems related with psychosocial adaptation using appropriate communication/ interpersonal techniques/ strategies. 2. Utilizes therapeutic interventions appropriate to psychosocial phenomena/maladaptive behavior patterns/ problems identified e.g. such as in dementia situations.
2.4.2. Provides appropriate evidence-based nursing care using a participatory approach based on: Variety of theories and standards relevant to health and healing Clinical practice Client preferences Client and staff safety Customer care standards.	<ol style="list-style-type: none"> 3. Decides on appropriate interventions to address client's specific concerns, issues and problems based on the situation.
2.4.3. Applies safety principles, evidence-based practice, infection control measures, and appropriate protective devices consistently, when providing nursing care and preventing injury to clients, self, other health care workers and the public, preventing injury to clients, and health workers.	<ol style="list-style-type: none"> 3. Applies consistently principles of infection control in practice. 5. Ensures that members of the health care team and visitors perform infection control measures accordingly.
2.4.4. Implements strategies related to the safe preparation and administration of medications based on institutional policies and protocol.	<ol style="list-style-type: none"> 1. Prepares and administers medications according to standard procedures. 5. Reviews appropriate laboratory results, assessment findings and other pertinent information prior to administration of medications. 7. Informs the physician of side effects and adverse reactions to the medication. 8. Completes the adverse drug reaction (ADR) documentation appropriately.

COMPETENCIES	PERFORMANCE INDICATORS
2.4.5. Applies evidence-based practices on pain prevention and management of clients using non-pharmacologic and pharmacologic measures.	2. Carries out evidence-based practices on pain prevention and management using pharmacologic and non-pharmacologic measures, such as the use of biobehavioral interventions.
2.4.8. Applies appropriate and evidence-based interventions for physiologic and related psychosocial needs of patients/ clients to preserve physiologic integrity and prevent complications of problems of oxygenation (ventilation, transport, perfusion); fluid and electrolyte imbalance and acid-base imbalances; nutrition and metabolism ; gastrointestinal (indigestion; digestion, absorption, elimination); urinary function; perception; coordination, and altered sensation, inflammation, infection and immune responses; cellular aberration, altered genetic conditions and reproductive problems.	5. Integrates plans for immediate and subsequent patient care. 6. Provides for patient's hygiene and comfort continuously. 7. Incorporates appropriate safety indicators and interventions to reduce anxiety where peri-operative care is needed. 8. Demonstrates skill in performing basic and advance nursing interventions and rehabilitation care. 9. Follows correct procedures and collaborates appropriately in the administration of medications, related IV fluids blood and blood products. 10. Demonstrates caring and compassionate care, especially to vulnerable patients, such as the older persons. 11. Has the ability to anticipate changing patient situations. 12. Communicates with the health team, as well as with the client and his/her family. 13. Uses complementary, alternative and bio-behavioral therapies appropriately. 14. Maintains holistic perspective and spiritual care. 15. Ensures appropriate presence of significant others when end- of- life care is needed. 16. Exercises good intention and safe care practices when performing nursing interventions.

Critical Thinking Exercise 6

The following questions can guide the Master Trainer in supporting Teaching-Learning Situations on the selection of appropriate nursing interventions.

- What is the intervention?
- What is the scientific rationale of the intervention?
- When should each intervention be implemented?
- What changes in aging were considered important in the selection of interventions?
- How should the intervention be performed with older persons as clients? Is there a difference if the clients were younger?
- Who should be involved in each aspect of the intervention?

5. EVALUATING THE PLAN OF CARE

Evaluation is the final step in the nursing process. Evaluative measures are done to determine if the expected outcomes were met, not if the nursing interventions were completed. The process is an ongoing process. If the outcomes are met, the overall outcomes for the patient are also met.

Table 5.8.7	NNCCS on the Beginning Nurse's Function on Evaluation of Care and Documentation	
COMPETENCIES	PERFORMANCE INDICATORS	
2.6. Evaluates with the client, the health status/competence and/or process/ expected outcomes of nurse-client working relationship.	<ol style="list-style-type: none"> 1. Utilizes participatory approach in evaluating outcomes of care. 2. Specifies nature and magnitude of change in terms of client's health status/ competence, processes and outcomes of nurse-client working relationship. 3. Monitors consistently client's progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools, (e.g. critical pathway, nurse sensitive indicators, quality indicators, client competency indicators, hospital and community scorecard) in collaboration and consultation with the client. 4. Revises nursing care plan based on outcomes and standards considering optimization of available resources. 	
2.7. Documents client's responses, nursing care services rendered, and processes/ outcomes of the nurse-client working relationship.	<ol style="list-style-type: none"> 1. Accomplishes appropriate documentation forms using standard protocols. 2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness, and timeliness of documentation. 3. Uses acceptable and appropriate terminology, according to standards. 	

Self- Assessment Question (SAQ) #4

Nurse Zeta had as an objective of care for Mrs. Juana, a 70 year-old teacher who had recurring knee pain, "to reduce the pain to tolerable level". How will Nurse Zeta evaluate the outcome of her selected interventions?

APPLICATION

Questions to trigger discussion

1. What actions can be proposed for the effective implementation of the NNCCS, specific to the care of the older persons?
2. What policies should be in place for nursing education and practice with regards to the care of older persons?
3. How should nurses establish the value of nursing in the health care delivery system in the care of

older persons?

We started the module with the context and work-setting scenario given the data on the Philippine situation of the older person. Integrating into the curriculum concepts on the Strategies proposed by the Department of Health on Health of Older Persons should be considered. These include the following (Strategies, Objectives for Health 2012-2016).

- Build the capacity of human health resources toward, promotive, preventive, curative, supportive care of the older persons.
- Develop community and institution-based models of health care for older persons.
- Pursue implementation of policies for the protection and improvement of the quality of life of the older persons, such as the RA 9257, or the Expanded Senior Citizen's Act of 2003.
- Local stewardship for improving health outcomes for the older person.

Capacity building of Master Trainers, and implementers in the academe and the nursing service on the:

- Use of competency-based education for curriculum development, instructional designs, and continuing professional education programs.
- Application of teaching-learning strategies.
- Critical thinking and the application of nursing process in the different levels of care for the older persons.
- Evidence-based interventions.
- Research process to generate data on care of older persons given the cultural context of Philippine setting.

SUMMARY

The NNCCS on the nursing process and care of older person is beneficial for establishing standards of care in the Philippine setting. They are measurable and attainable for nursing education and practice and provides basis for indicators to assess nursing care delivery. It defines the value of nursing in the health care delivery system on the care of older persons.

EVALUATION

1. THE USE OF THE SELF-ASSESSMENT QUESTIONS (SAQ) AND ANSWERS TO SELF-ASSESSMENT QUESTIONS (ASAQ)

In this module, questions are placed in between content presentation as a strategy to highlight concepts that are to be emphasized. ASAQs are provided towards the end of the module. Trainers can use this strategy, when cascading the NNCCS to nurses. Trainers can develop their own SAQs and ASAQs. In this module, this is a form of a formative evaluation tool.

Answers to Self-Assessment Questions (ASAQ)

ASAQ # 1

The Katz Index of ADL is also a research instrument, and is used to assess the ability to perform self-care.

ASAQ # 2

EVIDENCE-BASED INTERVENTION: "effective", with level of evidence (LOE 1). In a Randomized Controlled Trial (RCT) of 127 caregivers of patients with Alzheimer's disease, an intervention focussed on skill building, education and problem solving, resulted in decreased days of assisting with ADL, decreased-

upset with memory-related behaviors, improved affect, and improved task-management strategies. (Gitlin, et al, 2005 In Ackley, B.J., Swan, B.A., Ladwig, G.B. & Tucker, S.J. (2008). Evidence-Based Nursing Care Guidelines Medical Surgical Interventions. Mosby : Elsevier, 149).

ASAQ #3

There are two (2) expected outcomes in the statement. What happens in three (3) days if the lungs are clear, but the respiratory rate (RR) remains increased and greater than 26 cycles/min? By splitting the objectives, the nurse is able to determine which outcomes have been achieved, and allows the nurse to modify the plan of care.

ASAQ # 4

When Nurse Zeta assesses the severity of pain, explanation on the origin of the pain, and pathophysiologic reasoning of the pain occurrence should be asked by the Master Trainer. Nurse Zeta should be able to apply the Pain Severity scale correctly and interpret whether a change has occurred and if the change is desirable.

2. EVALUATION RUBRIC

This is a reflection of a summative course evaluation tool. An illustration is provided below. The rubrics take into consideration the major activities of the course, and are determined by the course objectives on care of older person.

Table 5.8.8		Evaluation Rubric	
CONDITION	PERFORMANCE INDICATORS	MARK/GRADE EQUIVALENT (EXAMPLE)	REMARKS
Cognitive evaluation: Content/ concepts of the 1st half of the course. Content/concepts of the 2nd half of the course.	Written Examination 1	20%	The trainer decides on how many written examination to be given, based on course objectives.
	Written Examination 2	20%	
Skill development: A. Physical assessment of one older person in a given clinical setting (or a simulated setting), using an assessment guide. B. Given a patient: Assessment of the ADL	A. Physical Assessment of an Older Person: performance checklist completion.	15%	Clinical setting/ simulated setting; usually one hour/ nurse-trainee; scheduled accordingly.
	B. Assessment of the Activities of Daily Living: performance checklist	10%	

CONDITION	PERFORMANCE INDICATORS	MARK/GRADE EQUIVALENT (EXAMPLE)	REMARKS
Comprehensive Plan of Care: Given a patient care study; must have cared/ followed-up a client /older person, minimum 3 days	Comprehensive Plan of Care: case report checklist include the following components: - Patient data base, functional patterns of assessment - Process /techniques/ tools of patient assessment and data derived - Problems identified, and reflection of reasoning/pathophysiology of the problems. - Plan of care: as appropriate, whether for hospital-based or community-based setting - Evaluation of care: indicators - Insights on concepts/skills learned/ attitudes developed	25%	Appropriate setting for the case study have to be provided.
Participation/ Interaction: Use of reflective journaling	Participation /contribution to class discussion, dialogues	10%	Timeliness, valued by peers
TOTAL		100%	

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Levels of Clientele in Community Health Nursing Practice: Family, Specific Population Groups and Community

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NOTICE

Most of the content of this module were excerpted from the Author's (Salvacion G. Bailon-Reyes) book on **Community Health Nursing --- The Basics of Practice**, published by the National Book Store in 2006.

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INTRODUCTION

1. MAJOR FIELDS OF NURSING PRACTICE

Nursing practice is broadly categorized into two major fields based on **setting** or **place of work**: **Hospital Nursing** and **Community Health Nursing (CHN)**. Hospital nurses, as the name implies, work in various units of the hospital, from the Emergency Room and Outpatient Clinics to such specialized units as the Intensive Care Unit (ICU) and Dialysis Unit. They care for **sick** people in various stages of illness --- from the mild cases to the terminally ill. The main functions of hospitals are to diagnose and treat disease/pathology. Hence, hospital nurses' objective in the care of patients is to help patients to **recover from their illness**.

Community Health Nursing, on the other hand, is a field of nursing practice where services are delivered outside of purely curative institutions (i.e. hospitals) but in community settings such as the home, the school, places of work, in health centers/clinics, or in public places in the community where a client/patient* may be situated, or where health services may be delivered. Community health nurses serve people in various stages of health and illness --- from the optimally well to the dying. The objective of care is to achieve the highest possible level of health by developing and enhancing the capabilities of the client/patient to take care of their own health and effectively cope with health problems.

2. HOSPITAL NURSING VS. COMMUNITY HEALTH NURSING: AREAS OF DIFFERENCES

Community Health Nursing, as a field of nursing practice, may be better understood by comparing it with the more familiar Hospital Nursing. In a nutshell, Table 5.9.1 on the next page presents this comparison, showing six (6) areas of differences.

*The terms "client" and "patient", as used in this Module, refer to the recipient of health/nursing services, be it an individual, a family, a specific population group, or the community as a whole. The term "client" is used to denote a recipient of care on the wellness side of the health continuum, while "patient" refers to one on the illness side.

Table 5.9.1 Comparison Between Community Health Nursing and Hospital/Clinical Nursing		
AREA OF DIFFERENCE	HOSPITAL/CLINICAL NURSING	COMMUNITY HEALTH NURSING
1. Setting/Place of Practice and Activities	Hospital wards, special clinical units in hospital	Outside of hospital, in the community – home, school, health center, place of work (industrial establishments, farms, markets, etc.), outpatient clinics
2. Types of Patients Seen	Mostly sick people; maybe limited to one group of patients, e.g. maternity cases, depending on clinical area of practice	Varied patients, representing total health spectrum – from the healthy → sick → recovering from disease → terminally ill → dying
3. Scope of Concern/Range of Services Provided	Mostly curative and rehabilitative care	Total care, whole range of services – health promotion, disease prevention, curative care, rehabilitative care, development of self-reliance, capabilities in health care
4. Priority Concern	Comfort and care during illness, recovery from disease	Promotion and maintenance of health, prevention of disease
5. Unit or Focus of Care	Individual patient	The family → population groups → whole community
6. Ultimate Goal	Maximum comfort, patient independence (self-care), recovery from disease, peaceful/dignified death for terminal cases	Effective coping and self-reliance for families and the whole community in health care

INTENDED LEARNERS

1. First/Second year midwifery/nursing students taking their beginning course in Family Health Nursing;
2. Community Health Nurses working in Rural Health Units, clinics, health centers and dispensaries;
3. Nurse Supervisors of community health nurses/midwives, as a form of continuing education for them, and
4. Nurse educators/trainers in the field of Community Health Nursing, as a form of continuing education for them.

APPROXIMATE TIME NECESSARY TO COMPLETE THE MODULE

Two hours to go through the content of the module

MODULE OBJECTIVES

This Self-instructional Module (SIM) aims to improve the practice of Community Health Nursing (CHN) at each level of clientele in CHN practice, through a clear understanding of the basic concepts, principles and processes that serve as bases for competent practice. More specifically, the learner is expected to be able to do the following after a study of this SIM:

1. Differentiate the two major fields of nursing practice --- Hospital Nursing and Community Health Nursing;
2. Identify, distinguish, briefly describe and differentiate the four levels of clientele in CHN practice;
3. Be able to apply the *nursing process* in the care of individual clients/patients, families, specific population groups, and the whole community. More specifically, be able to:
 - a. Make an accurate *initial* assessment of the condition/situation of each client/patient in four levels of clientele in CHN practice;
 - b. Identify the *possible* health/nursing needs and problems of each client/patient based on an analysis of initial data gathered;
 - c. Define and state the objectives of nursing care in clear, concise and measurable terms in each of the four levels of clientele, based on the health/nursing needs/problems identified;
 - d. Identify specific appropriate nursing interventions for each level of clientele based on the objectives of nursing care, and
 - e. Make a *plan* to evaluate the outcomes of nursing care at each level of clientele with the use of appropriate sources, methods and tools for data collection.

The above module objectives are covered by the following competencies.

Table 5.9.2 NNCCS on the Beginning Nurse's Role on Client Care	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe and Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.4.9. Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access within the context of Primary Health Care.	<ol style="list-style-type: none"> 1. Determines participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation and protection and health resource generation, use or access. 2. Creates opportunities to develop client's competence for promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access. 3. Executes appropriate participatory and empowerment strategies.

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.9.1. Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resource access or use and safe environment conducive to health maintenance among its members.</p>	<ol style="list-style-type: none"> 1. Develops the competence of the family to recognize opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease/problem management and environmental sanitation and protection by: <ul style="list-style-type: none"> • Analyzing the factors affecting health, human response, the environment and its resources/realities • Determining the relationships among these factors • Specifying the health and related conditions/problems which need to be addressed. 2. Carries out strategies/interventions to help the family decide to take appropriate action on each health condition/problem identified. 3. Implements competency-building intervention options to help family provide appropriate care to the dependent, at-risk, vulnerable, sick, and/or disabled member/s. 4. Develops the competence of the family to provide a home environment conducive to health maintenance and personal development. 5. Carries out participatory and empowerment strategies to enhance the family's competence to use community resources for health care and health maintenance.
<p>2.4.9.2. Implements strategies/interventions to ensure healthy population/s in the school and work settings.</p>	<ol style="list-style-type: none"> 1. Carries out empowerment strategies to enhance competence for health promotion, healthy lifestyle/adaptation, wellness, disease and accident prevention/management among population groups in the school and work setting. 2. Performs counterparting strategies to help population groups in the school and work setting carry out activities or measures in support of environment protection and maintain a safe environment.
<p>2.4.9.3. Enhances the competencies of specific population groups to ensure wellness, healthy lifestyle/adaptation, disease prevention, management, rehabilitation and vulnerability reduction or prevention.</p>	<ol style="list-style-type: none"> 1. Develops the competence of specific population groups/support systems to analyze the relationship of factors or patterns, home and community realities affecting health, human response, and the environment. 2. Implements effective strategies to develop/enhance the competence of specific population groups/support system/s for decision making on appropriate action/s for healthy lifestyle/adaptation, disease prevention, management and rehabilitation. 3. Carries out empowerment strategies to develop the competencies of specific population groups and support system for health care, healthy lifestyle/adaptation, use of health service and health resource access or use.

COMPETENCIES	PERFORMANCE INDICATORS
<p>2.4.9.4. Implements participatory and empowerment strategies for community competence to identify and collaborate effectively in addressing needs and problems related with health resource availability, access or use, environmental sanitation, environment protection, safety and security.</p>	<ol style="list-style-type: none"> 1. Develops the competence of community work groups to: <ol style="list-style-type: none"> a) analyze population and environmental factors/ community patterns/realities which generate need to address specific health conditions/situations/patterns b) articulate commitment and opportunities for community improvement on health resource availability access/ use, environmental sanitation and protection, and safety/security. c) handle/address issues and conflicts as creative options for collaboration and shared responsibility for decision-making by generating new ways of analyzing situations/problems for multiple possibilities/effective solutions. 2. Carries out participatory and empowerment opportunities to increase community's competence for interaction, decision-making, effective implementation of actions and management of community's relationship with the larger society for environmental sanitation and environmental protection, safety, security and for creating or using appropriate and/or supplementary resources especially for the marginalized or the vulnerable risk groups.
<p>2.4.10. Implements interventions guided by prescribed context of specific health programs/ services.</p>	<ol style="list-style-type: none"> 1. Specifies the bases for choice of interventions carried out within existing policies and procedures or protocols of specific health programs and services. 2. Performs the appropriate interventions.
<p>2.4.11. Implements appropriate care to individuals, families, vulnerable groups and communities during three phases of disaster situations, such as: 1) Pre-incident phase, 2) Incident phase, and 3) Post incident phase.</p>	<ol style="list-style-type: none"> 1. Participates in the prevention and mitigation of adverse effects of a disaster. 2. Performs preparedness activities as a member of the multi-disciplinary team. 3. Executes appropriate nursing interventions in collaboration with disaster response team. 4. Provides care and support to those injured with chronic disease, maladaptive patterns of behaviour and disabilities during recovery/reconstruction/rehabilitation period.
<p>2.4.12. Implements appropriate nursing interventions to help clients and support system address spiritual needs.</p>	<ol style="list-style-type: none"> 1. Utilizes appropriate technique of communication when identifying needs of client for spiritual care. 2. Provides the client with appropriate environment and materials for praying. 3. Offers opportunities for performance of religious activities based on client's religion. 4. Refer to an appropriate religious agency for further spiritual support.

COMPETENCIES	PERFORMANCE INDICATORS
2.4.13. Manages client load to ensure health program/service coverage.	<ol style="list-style-type: none"> 1. Conducts case detection, tracking, tracing and monitoring surveillance. 2. Conducts health programs and services in the home, clinic, school, and work settings. 3. Carries out strategies to ensure health program/service coverage based on health programs objectives/targets, through health resource availability, access, and/or use, especially among marginalized/vulnerable risk groups. 4. Determines adequacy of health program/service coverage based on updated caseload registries by type of client, health program or health problem (e.g. Client Lists for Prenatal/Postpartum Care, Client List for At-risk Children, Family Registry of Priority Cases) 5. Carries out interventions for effective and efficient care of clients in the caseload based on assigned geographical coverage. 6. Adheres to institutional safety policies and protocols to prevent injuries/accidents and infection. 7. Refers client for appropriate management and assistance for health and medical-related benefits. 8. Reports notifiable/reportable disease based on protocol.
2.5. Provides health education using selected planning models to targeted clientele (individuals, family, population group or community).	
2.5.1. Determines the health education planning models appropriate to target clientele/ expected objectives and outcomes.	<ol style="list-style-type: none"> 1. Specifies the characteristics of each health education planning model. 2. Selects appropriate health education planning model.
2.5.2. Utilizes health education process to accomplish the plan to meet identified client's learning needs.	<ol style="list-style-type: none"> 1. Assesses the needs of the target population. 2. Prioritizes the learning needs/problems in partnership with client partner. 3. Formulates appropriate goals and objectives 4. Designs a comprehensive health education plan. 5. Implements the health education plan utilizing appropriate teaching strategies 6. Evaluates the results of client's learning experiences using the evaluation parameters identified in the health education plan.

COMPETENCIES	PERFORMANCE INDICATORS
2.6. Evaluates with the client the health status/competence and/or process/expected outcomes of nurse-client working relationship.	<ol style="list-style-type: none"> 1. Utilizes participatory approach in evaluating outcomes of care. 2. Specifies nature and magnitude of change in terms of client's health status/competence/processes and outcomes of nurse-client working relationship. 3. Monitors consistently client's progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools (e.g. critical pathway, nurse sensitive indicators, quality indicators, client competency indicators, hospital and community scorecard) in collaboration and consultation with the client. 4. Revises nursing care plan based on outcomes and standards considering optimization of available resources.
2.7. Documents client's response/ nursing care services rendered and processes/outcomes of the nurse client working relationship.	<ol style="list-style-type: none"> 1. Accomplishes appropriate documentation forms using standard protocols. 2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness and timelines of documentation. 3. Utilizes acceptable and appropriate terminology according to standards.

TOPIC OUTLINE

This Module covers the following topics:

- I. Module Content
 - I.1. Levels of Clientele in CHN Practice
 - I.2. An Individual as the Client/Patient
 - I.3. The Family as the Client/Patient
 - III.3.1. Basic Functions of a Family
 - III.3.2. Health Tasks of the Family
 - I.4. A Population Group as the Client/Patient
 - I.5. The Community as the Client/Patient
 - I.6. Prioritizing Health/Nursing Care at Various Levels of Clientele Through the Risk Approach
- II. Methodology for Providing Nursing Care --- The Nursing Process Applied to Various Levels of Clientele
 - II.1. What Is The Nursing Process?
 - II.2. Major Steps in the Nursing Process
 - II.2.1. Assessment of Health/Nursing Needs and Problems at Various Levels of Clientele
 - II.2.2. Nursing Interventions at Various Levels of Clientele
 - II.2.3. Evaluation of Nursing Care at Various Levels of Clientele
- III. Summary

TEACHING/LEARNING ACTIVITIES

1. Lecture discussion on the topics under **Content** conducted by a nurse educator or nurse trainer, or self-study of the Module by the Learner.
2. A two-week affiliation with a Rural Health Unit (RHU) where the Learner goes through the following experiences:
 - a. Participation in the conduct of a Clinic in the health center and providing nursing services at the individual level of clientele;
 - b. Following up a priority client/patient in his/her home and providing services at the family level of clientele;
 - c. Identifying a priority population group in the community, making an initial assessment of the group, defining possible health/nursing needs and/or problems, and making a plan of care, and
 - d. Identifying a community-wide health problem, and planning a community project problem with the whole RHU team.

EVALUATION OF STUDENT LEARNING

1. Administration of a written test --- a Short-Question, Short-Answer type --- **before** and **after** study of the Module i.e. as a **Pretest** and **Post-Test**, and comparing the two scores obtained by the student. An increase in the Post-Test score of 20 percent or more represents an acceptable **gain in learning**.
2. Review and evaluation of the student's Nursing Care Study Report on either an Individual client/patient, a family, or a specific population group, or the Report on A Plan for a Community Health Project. Among the items to be evaluated are:
 - Completeness of identifying information on the client/patient;
 - Completeness, adequacy and accuracy of initial assessment data collected;
 - Clarity and accuracy of health/nursing needs/problems identified based on assessment data gathered;
 - Clarity, appropriateness and feasibility of achievement of nursing objectives set;
 - Appropriateness of intervention measures(planned or executed) to achieve the nursing objectives set, and
 - Appropriateness and adequacy of plan to evaluate nursing care planned or implemented.

PRE ASSESSMENT

INSTRUCTIONS TO THE LEARNER --- Before you proceed to the study of the Module, please take the **Pretest** below. The purpose of the Pretest is simply to find out how much you already know about the content material to be presented in the Module. Write your answers in a separate sheet of paper. Do not write anything on the Pretest/Question Sheet.

PRETEST

INSTRUCTION: Read carefully each of the following questions, and write your answers in a separate sheet of paper.

1. Identify five (5) areas of difference between Hospital Nursing and Community Health Nursing (CHN). For each area, indicate the difference between the two major fields of nursing practice.
2. Identify the four (4) levels of clientele in CHN practice. Briefly describe each level and differentiate one from the others.

3. For each of the four (4) levels of clientele in CHN practice, identify the five (5) initial data to collect to have some idea on possible health/nursing needs/problems.
4. Enumerate five (5) basic functions of a family.
5. Enumerate five (5) health tasks of a family.
6. In no more than two (2) sentences, define the **risk approach to health/nursing care**.
7. For each of the four (4) levels of clientele in CHN practice, identify three (3) kinds of clients/patients to whom you will give priority attention based on the risk approach to health/nursing care.
8. In no more than two (2) sentences, define **Nursing Process**.
9. Enumerate the three (3) major steps in the nursing process.
10. Identify three (3) possible general objectives of nursing practice.
11. Enumerate five (5) kinds of nursing interventions in CHN practice.
12. Identify three (3) specific items to evaluate under **Structure/Resources/Inputs**, three (3) items under **Process** and three (3) items under **Outcomes** of nursing care.

CHECKING AND SCORING YOUR ANSWERS

1. Check your answers against the **Key to Correction**.
2. Score your answers according to the number of points given to each correct answer.
3. Add up your total correct answers. The Perfect Total Score is 95 points.
4. Indicate your Total Score on the upper right hand corner of your Answer Sheet.
5. Interpreting Your Score: If your total score is 80 points or higher, you are pretty knowledgeable about the subject/topics to be studied and may not need to study this Module. However, if you scored below 71 points (75%), please proceed and carefully read the succeeding text.

KEY TO CORRECTION

INSTRUCTION: Check your answers against the following correct answers. Give the stated number of points per question for every correct answer.

1. Five (5) areas of difference between Hospital Nursing (HN) and Community Health Nursing (CHN), and difference between the two major fields of nursing practice --- Any five (5) of the following:
 - a. **Setting/Place of Practice and Activities**

HN – Hospital wards and special clinical units of the hospital
CHN – Outside of hospitals, in community settings such as the home, school, place of work, health center, outpatient clinic, in the farm, market and other public places where the client/patient may be situated.
 - b. **Type of Clients/Patients Seen**

HN – Mostly sick people at various stages of illness.
CHN – Varied clients/patients representing the total health spectrum --- from the well/healthy to the sick, the terminally ill and the dying.
 - c. **Range of Services Provided**

HN – Mostly curative and rehabilitative care.
CHN – Total care and whole range of health services --- health promotion, disease prevention, curative and rehabilitative care, and development of self-reliance and capabilities in health care.
 - d. **Priority Concern**

HN – Comfort and care during illness, recovery from disease.
CHN – Promotion and maintenance of health, prevention of disease.
 - e. **Unit and Focus of Care**

HN – Individual patient
CHN – The family, specific population groups and the whole community.

f. **Ultimate Goal**

HN – Maximum comfort, patient independence in self-care, recovery from disease, and a peaceful, dignified death for terminal cases.

CHN – Effective coping and self-reliance in health care for families and the whole community.

Scoring: Give two (2) points for every correct answer. Perfect Score is ten (10) points.

2. Four (4) levels of clientele in CHN practice, and brief description of each one.

- a. **Individual Client/Patient** – The focus of care are individual persons from varying age groups and states of health and illness.
- b. **The family** as a totally functioning unit, i.e. two or more individuals joined by ties of blood, marriage or adoption who share a single household.
- c. **Specific Population Group** – Groups of people in the community who share common and unique health needs, are at risk of developing or have already developed certain defined health problems.
- d. **Community** – A unit or section of a community, e.g. a “barangay”, a barrio/village or the whole municipality or city; a group of people who share common needs, interests, ethnic or cultural ties, such as the Christian community in Mindanao, or the squatter community in Metro-Manila.

Scoring: Give two (2) points for each correct answer. Perfect Score is eight (8) points.

3. Five (5) initial data to collect for each level of clientele in CHN practice in order to have some idea of possible health needs/problems

- a. **Individual Client/Patient** – Any five (5) of the following:
 - i. Identifying Information – name, position in the family, relationship to the head of the family
 - ii. Sociodemographic Characteristics – age, sex, marital status, education, occupation, income, religion
 - iii. Physical Condition – Appearance, build, nutritional status, weight, height, body mass index (BMI), vital signs, state of orientation or consciousness
 - iv. Psychological Condition – General mood, mental/emotional state, ability to express needs, thoughts and feelings, body language, mannerisms, “abnormal” behaviour
 - v. Ability to perform activities of daily living
 - vi. Signs and symptoms of disease, injury, disability or developmental deficit, history of disease condition, if any.
 - vii. Disease condition, injury, disability or developmental deficit diagnosed by a legitimate medical practitioner, history of condition and current treatment, if any.
- b. **Family** – Any five (5) of the following:
 - i. Family size and composition – Size of household, names of members and relationship to the head of the family
 - ii. Sociodemographic Characteristics – Age, sex, marital status, education, occupation, income, religion of members
 - iii. Health status of members:
 - Members of the family with signs and symptoms of disease, injury, disability, developmental delays/deficits which need to be diagnosed and treated; history of each condition, if any.
 - Members with disease condition, injury, disability, and/or developmental deficit which have been diagnosed by a legitimate medical practitioner; history of condition, past and current treatment, if any.
 - iv. Family health habits and lifestyle – Eating/nutrition, personal hygiene, exercise and leisure/recreation of the family as a unit, any smoking, alcohol-drinking or drug use of member(s).
 - v. Family Relationship – Quality of interaction, characteristic communication pattern and relationship among members of household, presence of conflict between family members.
 - vi. Decision-makers in the family, particularly in health matters.
 - vii. Quality of housing, facilities and immediate surroundings and environment.
 - Housing – Type and ownership of house/dwelling; adequacy of living space, bedrooms/

- sleeping quarters and sleeping arrangement; lighting and cooking facilities.
 - Water Supply – Source, potability, storage
 - Food storage facility
 - Toilet – Type, sanitary condition
 - Garbage/Refuse disposal – Type, sanitary condition
 - Drainage system – Type, adequacy
 - Presence of insects and rodents
 - Presence of accident hazards in the home and immediate surroundings
- viii. Quality of neighborhood/community where family is residing
 - Kind and socioeconomic class of neighbourhood/community
 - Communication and transportation facilities available
 - Support systems, welfare and health care facilities and resources available, and services provided.
- ix. Ability to provide for basic needs of members – food, clothing, shelter and education
- x. Ability to provide nursing care to its dependent, sick or disabled members
- xi. Family utilization of available community health resources and related social and welfare services, preventive care services, curative care services, material/financial and psychosocial support systems.
- xii. Family relationship with the community and participation in community activities
- c. **Specific Population Group** – Any five (5) of the following:
 - i. Size, location and composition of the group
 - Number of members
 - Place of domicile, work, study and common place where group congregates
 - Sociodemographic characteristics of members – age, sex, marital status, education, occupation, income, religion
 - ii. Nature of health threats, hazards or risks, disease condition, disability or developmental deficit faced by the group
 - iii. Relevant health statistics for the group – morbidity and mortality rates, causes of illness and deaths.
 - iv. Community health and health-related resources available to the group, including psychosocial, material and financial support systems from government, semi-government, private and non-government agencies/institutions.
 - v. Group's utilization of available community health and health-related resources.
- d. **Community** - Any five (5) of the following:
 - i. Size and Type of Community
 - Land area
 - Geographic units (e.g. "barangays", barrios/villages), number, size, any special distinguishing characteristics
 - Type of community, e.g. rural/urban, agricultural, industrial, shanty town, etc.
 - Socioeconomic class
 - Topography and climate/weather conditions
 - Natural resources – e.g. forest, river, lake, volcano, mountain, tourist attractions/spots
 - ii. Demographic data
 - Total population; population density
 - Sex ratio
 - Age structure
 - Marital status – Number/proportion of single, married, widowed and divorced/separated among population
 - Total number of families/households; average family size
 - Religious and ethnic groups – types, number and proportion
 - iii. Socioeconomic data

- Main occupations/industries
- Average family income or GNP
- Unemployment rate
- Percentage of the population below the poverty level
- Education – percentage of the population who completed the elementary, high school, college and graduate education levels, and those with no schooling
- Literacy rate
- iv. Environmental health facilities
 - Water supply – Sources, type of distribution, quality of water
 - Waste disposal system – Types, sanitary condition
 - Refuse/Garbage disposal system - Types of collection and disposal
 - Housing – Types, condition
 - Presence of pollution – Air, water, noise, land
- v. Public health statistics and related information
 - Fertility/natality rate
 - Morbidity – rate, leading causes, endemic diseases, past epidemics
 - Mortality – rates and leading causes
 - Life expectancy at birth
 - Reports of studies on health and related matters
- vi. Health care resources – Government, private; nature, scope and quality of services provided
 - Hospitals – Location, type, bed capacity, facilities, occupancy rate
 - Health centers, dispensaries – Number, location, service programs, personnel, utilization by public
 - Private medical clinics – Number, location
 - Dental clinics – Number, location
 - X-ray and laboratories
 - Traditional health care providers
 - Traditional healers – Number and type, location
 - Traditional birth attendants (“Hilots”) – Number, location, number trained, percent of births attended
- vii. Other community resources
 - Schools – Type, number, location, number of students
 - Public transportation – Types, condition of roads and bridges
 - Communication – Types, location
 - Leisure/recreation facilities – Types, number, location
 - Electricity – Coverage
 - Public markets, commercial centers/malls, stores
 - Police/security system – Peace and order situation, crime rate and nature of crimes committed
- viii. Government and community leadership
 - Government officials, formal community leaders
 - Informal community leaders
 - Influential citizens and groups who participate in decision-making process as well as in the planning, implementation and evaluation of community health and related programs

Scoring: Give one (1) point each for every correct answer. Perfect Score is twenty (20) points.

4. Five (5) basic functions of a family – Any five (5) of the following:
 - a. Procreation, rearing and care of children.
 - b. Provision of food, clothing, shelter and other essentials of living.
 - c. Provision of education to the young.
 - d. Satisfying the family members’ psychosocial needs for love, acceptance, sense of belonging, self-

- esteem, etc.
- e. Assigning roles, tasks and responsibilities to family members.
- f. Allocation and management of family resources.
- g. Maintenance of order and discipline, establishing standards of communication, interaction, relationship and behaviour.
- h. Socialization of family members, i.e. introduction to the norms, beliefs, customs, values, traditions and culture of the family and the community.
- i. Placement of members in the larger society, fitting them into the community and its social institutions, e.g. school, church, etc.
- j. Development of a sense of family loyalty and maintenance of the family as a cohesive unit.
- k. Promoting and ensuring the well-being and overall development of the members and the family as a whole.

Scoring: Give two (2) points for every correct answer. Perfect score is ten (10) points.

5. Five (5) health tasks of a family – Any five (5) of the following:
 - a. To recognize interruptions in health development, or the presence of a health problem.
 - b. To make decisions about taking appropriate health action.
 - c. To provide nursing care to the sick, disabled and/or dependent members of the family.
 - d. To deal effectively with health and non-health crises.
 - e. To maintain a home environment conducive to health maintenance and personal development.
 - f. To maintain a reciprocal relationship with the community and its health institutions, including effective utilization of available resources for health care.

Scoring: Give two (2) points for every correct answer. Perfect score is ten (10) points.

6. The **risk approach to health/nursing care** refers to the early recognition of risk factors associated with adverse or undesirable unwanted outcomes (e.g. illness, disability or death) in individuals, families, specific population groups or community, and taking the necessary anticipatory or compensatory measures to reduce, totally eliminate or cope with the probability of occurrence of the adverse or undesirable unwanted outcome.

Scoring: Give one (1) point for the correct answer. Perfect score is one (1) point.

7. For each of the four levels of clientele in CHN practice, three (3) clients/patients to give priority attention based on the risk approach to health/nursing care.
 - a. **Individual Client/Patient** – Any three (3) of the following:
 - i. Individuals with strong genetic/hereditary predisposition to certain diseases.
 - ii. Individuals with unhealthful lifestyle, e.g. heavy smokers, alcohol drinkers, drug users.
 - iii. Individuals manifesting some signs and symptoms of disease which require proper diagnosis and treatment.
 - iv. Individuals with specific diagnosed disease/illness, including communicable and non-communicable diseases which require monitoring and supervision.
 - b. **Families** – Any three (3) of the following:
 - i. The very poor families.
 - ii. Families residing in hazardous/unhealthy environment, e.g. shanties, squatter areas, etc.
 - iii. Families who are unable to cope with certain health threats, illness states or foreseeable crisis situations within the family.
 - c. **Specific Population Groups** – Any three (3) of the following:
 - i. The very young and the very old in the population – infants, children and the elderly.
 - ii. Childbearing women
 - iii. Specific groups living or working in hazardous/unhealthful environment such as the homeless, street children, factory workers, prostitutes.
 - iv. Specific groups suffering from chronic/long-term diseases, e.g. hypertensives, diabetics, heart

disease requiring monitoring/supervision.

- v. Specific groups suffering from communicable diseases who require treatment and follow-up, and prevention of spread to others.
- vi. The physically and mentally disabled who require monitoring, follow-up and supervision.
- d. **Communities** – Any three (3) of the following:
 - i. The very poor communities lacking in such basic facilities as potable water, sanitation and primary health care.
 - ii. Communities with relatively high fertility, morbidity and mortality rates.
 - iii. Communities with high incidence and prevalence of endemic diseases, epidemics, accidental injuries, communicable and non-communicable diseases.

Scoring: Give one (1) point for every correct answer. Perfect score is twelve (12) points.

8. **Nursing Process** is a logical, systematic and organized method of providing care to clients/patients based on the scientific problem-solving approach. It consists of three major steps --- assessment, intervention and evaluation.

Scoring: Give one (1) point for the correct answer. Perfect score is one (1) point.

9. Three major steps in the Nursing Process:

- a. Assessment
- b. Intervention
- c. Evaluation

Scoring: Give one (1) point for the correct answer. Perfect score is three (3) points.

10. Three (3) possible **objectives of nursing care** – Any three (3) of the following:

- a. Promotion and maintenance of good health
- b. Prevention of disease and accidental injuries
- c. Change of lifestyle or unhealthful behaviour
- d. Improved condition of the environment, i.e. to a more healthful one
- e. Improved ability to do activities of daily living
- f. Improved physical health, e.g. nutritional status, blood pressure, etc.
- g. Improved psychological/emotional state
- h. Early diagnosis and treatment of disease
- i. Relief of symptoms
- j. Improved compliance with prescribed treatment and/or rehabilitation measures
- k. Prevention of spread of a communicable disease
- l. Prevention of complications of an existing disease or condition (e.g. pregnancy)
- m. Rehabilitation – physical, psychosocial, occupational
- n. Prolong life
- o. Comfort, freedom from pain
- p. A peaceful, dignified death for the terminally ill
- q. Increased competence in dealing with common and simple illnesses and accidental injuries
- r. Increased utilization of available health care and related resources
- s. Increased ability to perform one or more health tasks and achieve self-reliance in health care matters
- t. Reduced incidence and prevalence of illness/diseases
- u. Reduced mortality from a given illness/disease

Scoring: Give two (2) points for every correct answer. Perfect score is six (6) points.

11. Five (5) kinds of intervention in CHN practice – Any five (5) of the following:

- a. Administration of medical treatments
- b. Direct nursing care/ministration

- c. Indirect nursing care/ministration
- d. Observational measures
- e. Anticipatory guidance
- f. Health teaching/education
- g. Counseling
- h. Motivation, support, development of support system/groups/network
- i. Environmental manipulation, modification and/or improvement
- j. Referral
- k. Advocacy
- l. Community organization and development

Scoring: Give one (1) point for every correct answer. Perfect score is five (5) points.

12. Three (3) specific items to evaluate under **Structure/Resources/Inputs**, three (3) under **Process**, and three (3) under **Outcomes** of nursing care.
- a. **Structure/Resources/Inputs** – Any three (3) of the following:
 - i. Resources of the nurse – e.g. competence (knowledge, skills, attitudes), transport facility, equipment, etc.
 - ii. Resources of the client/patient – Human/manpower resources (e.g. adult/employed members of a family)
 - iii. Resources of the community – e.g. health manpower, health care facilities
 - iv. The Nursing Care Plan (NCP) – Assessment done, objectives set, activities and intervention measures planned to be done, resources used and plan for evaluating care.
 - b. **Process** – The implementation of the NCP. Any three (3) of the following:
 - i. Quantity of activities implemented and services provided
 - ii. Estimated quality of services rendered
 - iii. Quality of the nurse's performance, including involvement and participation of the client/patient in the implementation of the NCP
 - c. **Outcome/Output** – Any three (3) of the following:
 - i. Change in the physical/mental health status of individual clients/patients, families or specific population groups
 - ii. Change in fertility, morbidity and/or mortality patterns in groups and in the whole community
 - iii. Prevention of unwanted results or negative outcomes
 - iv. Change in communication, interaction and relationship patterns, or in the assumption of roles and functions, and/or overall functioning
 - v. Change in health behaviour and lifestyle
 - vi. Change in the quality of the environment
 - vii. Change in level of competence (knowledge, skills, attitudes) in matters relating to health and health care
 - viii. Satisfaction or dissatisfaction with nursing services received

Scoring: Give one (1) point for every correct answer. Perfect score is nine (9) points.

Total Perfect Score: 95 points

MODULE CONTENT

1. LEVELS OF CLIENTELE IN COMMUNITY HEALTH NURSING PRACTICE

The practice of CHN covers four levels of clientele --- an individual client/patient, a family, a specific population group, or a community. The nurse sees and serves individual clients/patients in the clinic/health center, at home during a home visit, in the work place and other community settings where a client/

patient may be situated. Families are usually seen during home visits. Specific population groups and the community at large are served in the process of implementing special programs directed at certain groups or the community as a whole.

This Module focuses on basic concepts, principles and methodology of providing nursing care to the various levels of clientele in CHN practice.

2. AN INDIVIDUAL AS THE CLIENT/PATIENT

At the individual level of care the focus is a person, and the objective of nursing care is either promotion and maintenance of health, prevention of disease, early diagnosis and treatment of a suspected ailment, recovery and/or rehabilitation from illness, eventual self-reliance in personal care, or a peaceful, dignified death.

Individual clients/patients served are in various conditions of health and illness --- from the healthy/well to the dying --- and all age groups from birth to senescence. The nurse provides professional nursing services based on the client's/patient's needs which were previously assessed, and in various community settings --- in the clinic/health center, at home, in the school, in the work place, or anywhere where a client/patient may be situated at the time the nurse is called for help, e.g. at the roadside to a victim of vehicular accident, or by a river bank to a drowning accident victim, or in the market to a woman who suddenly fainted. The scope of service varies from simple first-aid, to basic, and to comprehensive nursing care.

An individual client/patient, however, is not viewed in isolation, but within the context of the family, group or community to which he/she belongs. Assessment of the client's/patient's needs and problems, therefore, includes an assessment of his/her family, group and community situation, as continuing care, if needed, will be based on, among others, capabilities and resources available to implement the prescribed measures.

3. THE FAMILY AS THE CLIENT/PATIENT

The family is the basic unit, the primary social group and the fundamental institution of human society that provides the physical and psychosocial environment for the natural development and fulfillment of all its members. As the basic unit of society the family is part of a larger system encompassing community and cultures. A family is a member of a community, an ethnic group, a culture and a race. It is the primary mediating agent between the individual and his society, through its teachings, examples and sanctions. The young are socialized into the habits, customs, beliefs, values and traditions of the culture.

The family is the unit of care in CHN practice. At this level of care, the focus is the family as a total functioning unit which is more than the sum of its parts. Individual members with certain defined or medically-diagnosed health problems are seen as features or part of the situation in a given family.

A **family** refers to two or more individuals joined or related by ties of blood, marriage or adoption, and who constitute a single household, interact with each other in their respective familial roles, and who create and maintain a common culture.

The basic traditional family unit is the **conjugal** or **nuclear** family which is comprised of the husband and wife and children. An **extended** family is formed when a nuclear family shares living quarters with relatives or friends. Various types of family structures are found in different societies and cultures. In recent times, there is an emergence of quasi-family forms, among them the communal or "group" family, the single-parent family, homosexual marriages and consensual unions without the benefit of marriage.

The family, like an individual, has a natural history and undergoes a life cycle of **formation** (starts with

marriage and ends with the birth of the first child), **growth** (begins with the birth of the first child and ends with the birth of the last child), **contraction** (starts when the first child leaves home and ends with the departure of the last child), and **dissolution** (starts when the first spouse dies and ends with the death of the surviving spouse).

3.1. Basic Functions of a Family

The family undertakes certain basic functions in all social classes and cultures through changing times and throughout the family life cycle. These functions, which are carried out by the roles family members play in interaction, include the following:

1. Procreation, rearing and care of children until they are mature and ready to start lives of their own;
2. Provision of food, clothing, shelter, health care and other essentials of living;
3. Provision of education to the young, including religious instruction;
4. Satisfying the family members' psychosocial needs for love, acceptance and belonging, self-esteem, encouragement, motivation and morale, self-fulfillment or self-actualization, resolving personal and family crises and problems;
5. Assigning roles, tasks and responsibilities to family members to ensure effective operation of the household and the well-being of the members;
6. Allocation and management of family resources to meet family needs, care and maintenance of family possessions;
7. Maintenance of order and discipline, establishing standards of communication, interaction, relationships and behaviour, regulating behaviour of members and administering sanctions for infraction of rules and norms of conduct;
8. Socialization of family members, i.e. introduction of children to the norms, customs, beliefs, values and tradition of the culture to which the family belongs, and transmitting the culture across family generations;
9. Placement of members in the larger society, fitting them into the community and its social institutions such as the school, church, social, political and economic organizations, and protecting family members from undesirable influences;
10. Development of a sense of family loyalty and maintenance of the family as a cohesive unit through family activities and rituals, and
11. Promoting and ensuring the well-being and over-all development of the members and the family as a whole.

3.2. Health Tasks of the Family

Ruth B. Freeman* identified tasks in the area of health care which a family must be able to perform in order to effectively **cope** with health problems. These tasks are the following:

1. To recognize interruptions in health development, or the presence of a health problem;
2. To make decisions about taking appropriate health action;
3. To provide nursing care to the sick, disabled and/or dependent members of the family;
4. To deal effectively with health and non-health crises;
5. To maintain a home environment conducive to health maintenance and personal development, and
6. To maintain a reciprocal relationship with the community and its health institutions, including effective utilization of available resources for health care.

At the family level of care, the fundamental function of the community health nurse is to develop or strengthen the ability of families to effectively perform the above health tasks.

Family health nursing is the basic and core component of CHN practice. Care to individual clients/

*Freeman, Ruth B. (1970). Community Health Nursing Practice. Philadelphia, Toronto, London: W.B. Saunders Co., 115-117.

patients is provided within the context, maximum involvement and participation of the family.

4. A POPULATION GROUP AS THE CLIENT/PATIENT

At this third level of care, community health nurses direct and focus their activities to certain population groups with common unique health needs, are at risk of developing or have already developed certain defined health problems, and to whom the nurse delivers health-promotive, preventive, curative or rehabilitative nursing services. Examples of population groups given priority attention in public health work are childbearing women, infants and pre-school age children, school children and workers in industrial establishments. Midwifery/Maternal and Child Health, School Health Nursing and Occupational Health Nursing are subspecialties in CHN practice. Other population groups with particular health needs and problems include the elderly population, out-of-school youths and street children, communicable disease cases (e.g. patients with tuberculosis or HIV/AIDS), chronic disease cases (e.g. diabetes, heart disease), and the disabled, e.g. the blind, paraplegics, and the physically or mentally retarded.

In the care of specific population groups the nurse utilizes the group approach, identifying the common health and nursing needs/problems of the members and addressing them for the whole group. For example, the nurse may organize and conduct a Meal Planning Workshop for Diabetics, a Mother's Class for Primigravidas, or a rehabilitation program for stroke victims.

5. THE COMMUNITY AS THE CLIENT/PATIENT

Collections of families constitute a community. The term “**community**” has both geographic and socio-cultural connotations. On the basis of geography, a community can be viewed as a place with spatial boundaries, physical and environmental characteristics, and natural and man-made resources. In this context, a community can be a “barangay”, a village/barrio, a town/municipality, a city, a district, a province, a region, or the whole country. A community can also refer to a group of people who share common needs, interests, ethnic or cultural ties, and are committed to the group's well-being. Examples of these are the squatter community in Metro-Manila, the Chinese community in the Philippines and the Christian community in Mindanao. The world is a “community of nations”, sharing the same aspirations of peace, development and progress, and working together to achieve these goals.

Communities, like individuals and families, are different from each other. Each community has its own physical individuality, distinctive cultural characteristics, peculiarities, problems and needs which may change through time, as well as its own set of values, relationships and ways of behaving that may have significant effects on its own state of health. And communities, like individuals and families, also go through stages of growth and development towards “maturity”. Thus, we have “primitive” and “progressive” communities, communities which are underdeveloped, developing or fully developed, as well as healthy and unhealthy/sick communities.

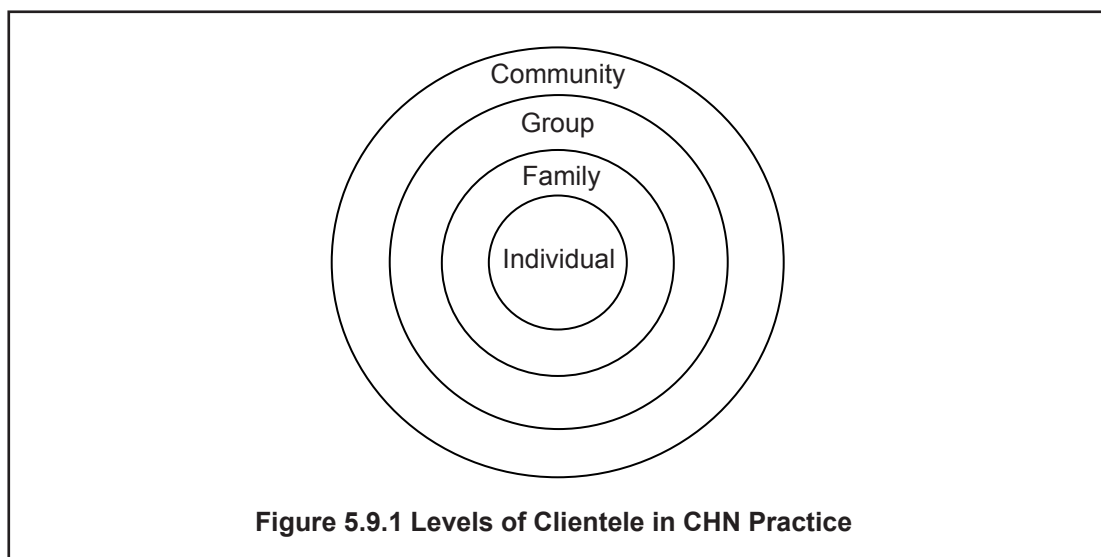
As with individuals and families and specific population groups, the health of a community is influenced by many factors --- physical, biological, social, cultural, economic and political factors. Mortality and morbidity statistics are broad indicators of a community's state of health.

A community health nurse assigned in a particular community, such as a town or municipality, has the whole community as her client/patient. While many of the services are delivered to individuals, families and specific population groups, the health needs and problems of such individuals, families and groups are seen collectively, including their import and impact on total community health. When establishing priorities for care in the face of limited resources, the nurse maintains the perspective of and orientation to the health of the total population or the community as a whole, the greatest good for the greatest number and impact on community health rather than solely the needs of an individual patient, a family or group. To use an

analogy, the nurse views the whole forest instead of a few individual trees.

When a particular condition or situation poses a risk or hazard to total community health, or when a disease threatens or actually afflicts a significant number of a community's population, such situation, condition or disease becomes a community health problem that calls for community-wide intervention measures. Examples of these are epidemics of communicable diseases, problems in the environment such as air pollution, contaminated water supply, unhygienic condition and dirty food handling practices in the public markets and eating establishments. Corrective intervention measures to community-wide health problems come in the form of specific programs or special projects which are implemented with the participation of various members of the health team, including the community health nurse.

Figure 5.9.1 below schematically presents the levels of clientele in CHN practice, each level viewed as part of and in relation to the next higher level. Healthy individual members make up a healthy family or population group, and healthy families make up a healthy community. A community health nurse maintains this perspective and never loses sight of the broader and ultimate goal of community health development.



Source: Bailon-Reyes, Salvacion G. **Community Health Nursing --- The Basics of Practice**. National Book Store, 2006, p. 10.

6. PRIORITIZING HEALTH/NURSING CARE SERVICES IN VARIOUS LEVELS OF CLIENTELE THROUGH THE RISK APPROACH

It is not possible for a community health nurse to serve every individual, family or group in the community. The needs and demands for health/nursing services are almost always greater than the resources available. In view of this, there has to be some prioritization to ensure that services are delivered to those who need them most in order to have some impact on total community health. The **risk approach to health care** is one way of establishing priorities in the care of individual clients/patients, families, specific population groups and communities.

The **risk approach** to health care refers to the early recognition of risk factors associated with adverse or undesirable unwanted outcomes in individuals, families, specific population groups or communities, and taking the necessary anticipatory or compensatory measures to reduce, totally eliminate or cope with the probability of occurrence of the adverse or undesirable unwanted outcome.

The **adverse or undesirable unwanted outcome** can be any of the following: death, disability, disease/illness, accidental injury, decline in quality of life, natural or man-made disaster, or negative effects on human relationships, family, group or community health and health-related problems of individuals, families, specific population groups or the community at large.

The risk approach is applicable to the care of individual clients/patients, families, specific population groups and communities at large. Given a specific problem, risk factors at these various levels of care can be identified. It requires identifying and concentrating care on those who are at greatest risk in relation to a particular unwanted outcome or problem. For example, to control an increasing incidence of diabetes, obese people are those at greatest risk of developing the disease; for the HIV/AIDS pandemic, drug users and prostitutes are the groups most vulnerable to acquire the disease.

Certain common defining factors make up for corresponding risks to health. Table 5.9.3 shows these factors, the ensuing vulnerable or high-risk population groups and the health programs which are addressed to reduce the chance of undesirable unwanted outcomes to occur.

Table 5.9.3 Vulnerable/High-risk Groups According to Certain Common Defining Factors and Corresponding Health and Health-Related Programs to Meet Their Health Needs		
COMMON DEFINING FACTOR	VULNERABLE/HIGH-RISK POPULATION GROUPS	HEALTH PROGRAMS
A. Age	1. Infants (0 - 1 year)	Child Health Program
	2. Pre-School Children (1 – 6 years)	
	3. School-age children (7 – 14 years)	School Health Program
	4. The elderly (60 years and over)	Geriatric Program
B. Sex/Biological Function	Child bearing women/ women in their reproductive years	Maternal and Child (MCH) Program
C. Socioeconomic status	1. Squatters/residents of shanty town 2. The homeless 3. Street children 4. Beggars 5. Orphans 6. Out-of-school youth	Health promotive and preventive programs, rehabilitative and welfare programs
D. Unhealthful behaviour or lifestyle	1. Cigarette smokers 2. Alcohol/drug users 3. Homosexuals 4. Prostitutes 5. Overweight/obese people	Health education, health promotive, preventive and rehabilitative programs
E. Disease/Illness state a. Communicable diseases	1. Tuberculosis patients 2. People with sexually transmitted diseases, including HIV/AIDS 3. Malaria patients 4. Lepers 5. Polio patients/victims	Communicable Disease Control Program

Table 5.9.3 Continued:		
COMMON DEFINING FACTOR	VULNERABLE/HIGH-RISK POPULATION GROUPS	HEALTH PROGRAMS
b. Chronic non-communicable disease	<ol style="list-style-type: none"> 1. Hypertensives 2. Diabetics 3. Heart disease patients 4. Cancer patients 	Follow-up and monitoring program to prevent complications and premature death
F. Disability/ Developmental Deficit	<ol style="list-style-type: none"> 1. Physically handicapped/disabled – blind, deaf, lame, post-polio and post-stroke patients 2. Mentally retarded 	Rehabilitation, follow-up and monitoring program
G. Hazardous Occupation	<ol style="list-style-type: none"> 1. Jeepney, bus and truck drivers 2. Factory workers 	Occupational Health Program

The risk approach is in accord and consistent with the principles of equity and need-based care in primary health care, the same care for all but more to those with greater need. The greater risk, the more need for care. Risk screening increases coverage as it identifies individuals, families, specific population groups and communities who require health/nursing services.

Table 5.9.4 presents, in general, the clients at each level of care who are at risk of developing health problems and should receive priority for health/nursing services.

Table 5.9.4 Clients At Risk Who Should Receive Priority for Nursing Care			
INDIVIDUALS	FAMILIES	SPECIFIC POPULATION GROUPS	COMMUNITIES
<ol style="list-style-type: none"> 1. Individuals with strong genetic/ hereditary predisposition to certain diseases, e.g. breast cancer, diabetes. 2. Individuals with unhealthful lifestyle, e.g. heavy smokers, alcohol drinkers, drug users. 3. Individuals manifesting some signs and symptoms of disease which require proper diagnosis and treatment. 	<ol style="list-style-type: none"> 1. The very poor families. 2. Families residing in hazardous/unhealthy environment, e.g. shanties, squatter areas. 3. Families who are unable to cope (i.e. perform the family health tasks) with respect to certain health threats, illness states or foreseeable crisis situations within the family due to: <ol style="list-style-type: none"> a. Lack of or inadequate will, knowledge and/or skills; 	<ol style="list-style-type: none"> 1. The very young and the very old in the population – infants, children, the elderly. 2. Childbearing women 3. Specific groups living or working in hazardous/unhealthful environment, e.g. the homeless, street children, factory workers. 4. Specific groups suffering from chronic/ long-term diseases (e.g. hypertensives, diabetics, heart disease cases) requiring monitoring and follow-up. 	<ol style="list-style-type: none"> 1. The very poor communities lacking in such basic facilities as potable water, sanitation and primary health care. 2. Communities with relatively high fertility, morbidity and mortality rates. 3. Communities with high incidence and prevalence of endemic diseases, epidemics, accidental injuries, communicable and non-communicable diseases.

Table 5.9.4 Continued:

INDIVIDUALS	FAMILIES	SPECIFIC POPULATION GROUPS	COMMUNITIES
4. Individuals with specific diagnosed disease/illness (includes communicable/non-communicable diseases, acute as well as chronic or long-term conditions) requiring monitoring and follow-up.	b. Lack of or inadequate resources; c. Negative beliefs and/or attitudes, e.g. fear, denial, complacency, lack of trust/confidence in health professionals and/or health care system.	5. Specific groups suffering from a communicable disease who require treatment and follow-up, and prevention of spread to others. 6. The physically and mentally disabled who require monitoring, follow-up and health supervision.	

METHODOLOGY FOR PROVIDING NURSING CARE --- THE NURSING PROCESS APPLIED TO VARIOUS LEVELS OF CLIENTELE

1. WHAT IS THE NURSING PROCESS?

The nursing process is a logical, systematic, organized and dynamic method of providing care to clients, whether the client/patient is an individual, family, a specific population group or a whole community. It is a methodical and orderly approach to the planning and delivery of nursing care that is utilized to systematize the helping process and standardize the nurse's approach to her clients/patients in an attempt to effect improvement in the latter's health status, as well as increase his capabilities to cope with health problems.

The nursing process is basically the application of the scientific problem-solving to nursing care, and is used to identify client/patient problems, to systematically plan and implement nursing care and to evaluate the results of that care. It is action-oriented but requires a great deal of judgment as the nurse makes decisions based on a consideration of a number of factors and variables, and from a synthesis of knowledge, ideas, principles, methodologies and techniques from nursing and related disciplines. In its totality, the nursing process is an integration of the intellectual, interpersonal and technical skills of the nurse.

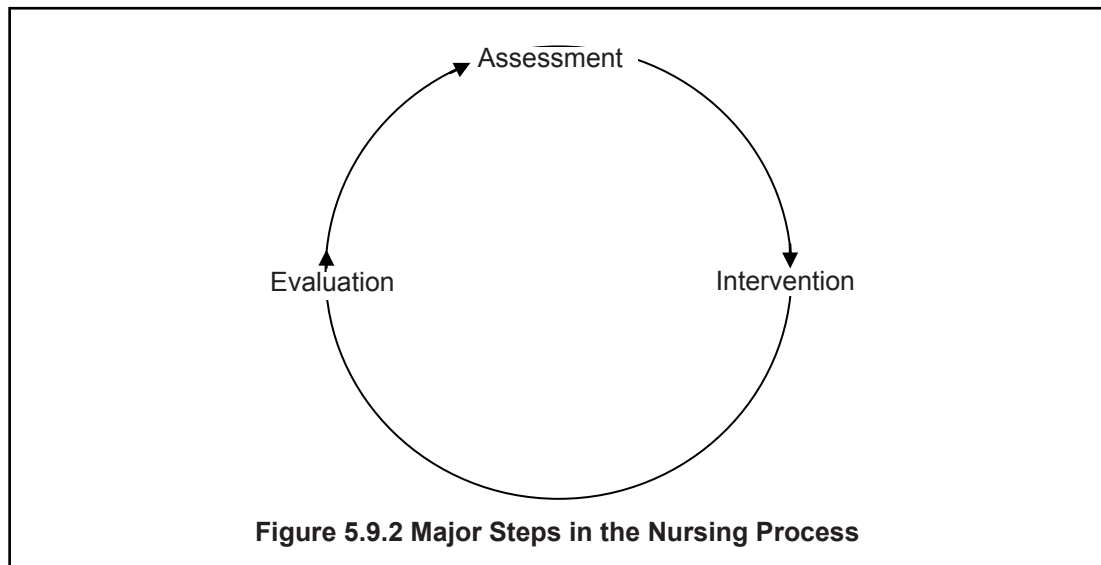
2. MAJOR STEPS IN THE NURSING PROCESS

The nursing process consists of the following steps:

1. Assessment of the health/nursing needs of a client/patient, be it an individual, a family, a specific population group or the community as a whole;
2. Intervention – the identification and implementation of appropriate intervention measures to meet the nursing needs and/or solve the health problems which were determined during the assessment phase, and
3. Evaluation of goal achievement – the process of determining whether the intervention measures done were effective in meeting the nursing needs and resolving the health problems identified. Based on the results of the evaluation, the nurse conducts a reassessment of the client's/patient's condition through continuous data collection and analysis.

The above major steps of the nursing process must be viewed as a continuing circular process as shown

in Figure 5.9.2 below.



Source: Bailon-Reyes, Salvacion G. **Community Health Nursing --- The Basics of Practice**. National Book Store, 2006, p. 96.

2.1. Assessment of Health and Nursing Needs and Problems at Various Levels of Clientele

Assessment is the first step in the nursing process. It is a crucial step as it determines the accuracy of the nursing diagnosis and the appropriateness of the ensuing nursing intervention. Adequate assessment involves the collection of **relevant** and **significant** data that alert the nurse and the whole health team to the early warning signs of trouble, data that clarify problems, contribute to the development of insight regarding what needs to be done, as well as provide some direction or bases for action. There is also a need to be discriminating and to be able to verify the veracity and validity of the sources, and the accuracy of the data collected.

The types of data to collect, their sources, the methods and tools for data collection vary according to the level of clientele, i.e. whether the client/patient is an individual, a family, a specific population group, or the whole community. Table 5.9.5 presents the initial data to collect, their sources, the methods and tools for data collection when assessing an individual client/patient, Table 5.9.6 for a family, Table 5.9.7 for a specific population group and Table 5.9.8 for a community.

Table 5.9.5

Assessment at the Individual Level of Care – Data to Collect, Sources of Data, Methods of and Tools for Data Collection

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ol style="list-style-type: none"> 1. Name, position in the family, relationship to the head of the family. 2. Sociodemographic characteristics – Age, sex, marital status, education, occupation, income, religion. 3. Physical condition – appearance, build, nutritional status, weight, height, body mass index (BMI), vital signs (temperature, pulse, respiration, blood pressure), state of orientation and consciousness. 4. Psychological condition – general mood, mental/emotional state, ability to express needs, thoughts and feelings, body language, mannerisms, “abnormal” behaviour. 5. Ability to perform activities of daily living. 6. Signs and symptoms of disease, injury, disability, and/or developmental deficit; history of condition, if any. 	<ol style="list-style-type: none"> 1. Client/Patient 2. Responsible family member 3. Friends/Neighbors 4. Medical records and reports 5. Verbal or written reports of other members of the health and intersectoral teams who have had previous contact with and/or provided service to the client/patient 	<ol style="list-style-type: none"> 1. Physical examination of the client/patient: <ol style="list-style-type: none"> a. Inspection b. Palpation c. Auscultation d. Vital signs, weight, height measurements. 2. Direct observation of verbal and nonverbal communication style, mannerisms and behaviour of client/patient 3. Interview of client/patient 4. History-taking of a health or health-related problem 5. Interview of responsible family member 6. Review of health agency records and reports, including laboratory examination results and radiological exam results. 7. Interview of relevant members of the health and intersectoral teams 8. Interview of relevant and close friends and/or neighbors 	<ol style="list-style-type: none"> 1. Physical examination tools – thermometer, blood pressure apparatus, stethoscope, tape measure, weighing scale, height sale. 2. Clinical history record forms 3. Interview schedule or questionnaire

Table 5.9.5 Continued:

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<p>7. Disease condition, injury, disability and/ or developmental deficit diagnosed by a legitimate medical practitioner; history of condition and current treatment, if any.</p> <p>8. Personal health habits and lifestyle – eating/nutrition, exercise, personal hygiene, leisure/ recreation, smoking, drinking alcohol, drug use.</p> <p>9. Personal and family resources available, including support system.</p> <p>10. Utilization of available community health resources for:</p> <p>a. Preventive care/ services</p> <p>b. Curative care/ services.</p>			

Table 5.9.6

Assessment at the Family Level of Care – Data to Collect, Sources of Data, Methods of and Tools for Data Collection

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ol style="list-style-type: none"> 1. Family size and composition – size of household, names of members and relationship to the head of the family. 2. Sociodemographic characteristics of members – Age, sex, marital status, education, occupation, income, religion. 3. Health status of members: <ol style="list-style-type: none"> a. Member(s) of the family with signs and symptoms of disease of illness, injury, disability, developmental delays/deficits which need to be diagnosed and treated; history of each condition, if any. b. Member(s) with disease condition, injury, disability and/or developmental deficit which have been diagnosed by a legitimate medical practitioner; history of condition, past and current treatment, if any. 4. Family health habits and lifestyle – Eating/nutrition, personal hygiene, exercise and leisure/recreation of family as a unit; any smoking, alcohol-drinking or drug use of member(s). 	<ol style="list-style-type: none"> 1. Head of family/ household and other responsible family members 2. Close and relevant friends and neighbors 3. Other members of the health and/or intersectoral teams who have had previous contact or provided services to the family. 4. Health agency records and reports 5. Community leaders – formal and informal 	<ol style="list-style-type: none"> 1. Interview of the health of the family, the spouse and other responsible members. 2. Physical examination of members of the family. 3. Direct observation of family interaction and relationship. 4. Inspection of home environment and surrounding premises. 5. Interview of close and relevant relatives, friends and/or neighbors 6. Review of health agency records and reports 7. Interview of relevant members of the health and intersectoral teams 8. Interview of relevant formal and informal community leaders 	<ol style="list-style-type: none"> 1. Physical examination tools – thermometer, blood pressure apparatus, stethoscope, tape measure, weighing scale, height scale. 2. Clinical history/ record forms 3. Interview schedule or questionnaire 4. Observation schedule

Table 5.9.6 Continued:

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<p>5. Family relationship – Quality of interaction, characteristic communication pattern and relationship of members of household; presence of conflict between family members.</p> <p>6. Decision-makers in the family, particularly in health matters.</p> <p>7. Quality of housing, facilities and immediate surroundings/ environment</p> <p>a. Housing – Type and ownership of house/dwelling; adequacy of living space, bedrooms/ sleeping quarters and sleeping arrangement; lighting facility, cooking facility</p> <p>b. Water supply – source, potability and storage</p> <p>c. Food storage facility</p> <p>d. Toilet – type, sanitary condition</p> <p>e. Garbage/refuse disposal – type, sanitary condition</p> <p>f. Drainage system – type, adequacy</p> <p>g. Presence of insects and rodents</p> <p>h. Presence of accident hazards in the home and immediate surroundings</p>			

Table 5.9.6 Continued:

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ul style="list-style-type: none"> i. State of cleanliness and order in the home and yard/ surroundings. 8. Quality of neighborhood/ community where family is residing <ul style="list-style-type: none"> a. Kind and socioeconomic class of neighbourhood/ community b. Communication and transportation facilities available c. Support systems, welfare and health care facilities and resources available; services provided <ul style="list-style-type: none"> i. Government ii. Semi-government iii. Non-government 9. Ability to provide for basic needs of members – food, clothing, shelter and education 10. Ability to provide nursing care to its dependent, sick or disabled members 11. Family's utilization of available community health resources and related social and welfare services; preventive care services, curative care services, material/financial and psychosocial support systems 12. Family's relationship with the community and participation in community activities 			

Table 5.9.7

Assessment at the Group Level of Care – Data to Collect, Sources of Data, Methods of and Tools for Data Collection

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ol style="list-style-type: none"> Size, location and composition of group <ol style="list-style-type: none"> Number of members Place of domicile, work, study and/or common place where group congregates Sociodemographic characteristics of members – age, sex, marital status, education, occupation, income, religion Nature of health threats, hazards or risks, disease condition, disability or developmental deficit faced by group. Relevant health statistics for the group – morbidity and mortality rates, and causes of illness and deaths. Community health and health-related resources available to the group, including psychosocial, material and financial support systems. <ol style="list-style-type: none"> Government Semi-government Non-government/ private Group's utilization of available community health and health-related resources. 	<ol style="list-style-type: none"> Leaders and/or responsible members of the group Individual group members Health agency records and reports Other members of the health and/or inter-sectoral teams who have knowledge and/or experience with the group. Formal and informal community leaders. 	<ol style="list-style-type: none"> Survey of whole group. Physical examination or health screening of members of the group. Interview of group's leader(s) or responsible members. Direct inspection of group's common environment (domicile, work, study, recreation or place of congregation) Review of health agency's records and reports, including public health statistics relevant to the group. Interview of relevant members of the health and/or intersectoral teams Interview of relevant formal and informal community leaders. 	<ol style="list-style-type: none"> Survey forms Physical examination and/or health screening tools Interview schedule or questionnaire Health record forms Community map to pinpoint group's location or spatial distribution Observation schedule

Table 5.9.8

Assessment at the Community Level of Care – Data to Collect, Sources of Data, Methods of and Tools for Data Collection

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ol style="list-style-type: none"> 1. Size, and type of community <ol style="list-style-type: none"> a. Land area b. Geographic units (e.g. barrios/vilages, “puroks”, “barangays”) – number, size, any special distinguishing characteristics. c. Type of community – e.g. rural/urban, agricultural/ industrial, shanty town, etc. d. Socioeconomic class (In the Philippines, ranges from Class I to VI) e. Topography and climate/ weather conditions f. Natural resources – e.g. forests, rivers, lakes, volcano, mountains, tourist spots, etc. 2. Demographic Data <ol style="list-style-type: none"> a. Total Population b. Population density c. Sex ratio d. Age structure – percentage of population: <ol style="list-style-type: none"> i. 0-1 year (Infants) ii. 1-6 years (Preschool) iii. 7-16 years (Elementary and high school age) iv. 17-21 years (college age group) v. 22-60 years (working group) vi. 61 and over (elderly) e. Marital status <ol style="list-style-type: none"> i. Single ii. Married iii. Widow/widower iv. Divorce/separated f. Total number of families/ households ; average family size 	<ol style="list-style-type: none"> 1. Bureau of Census and Statistics 2. Municipal and/or provincial government office – relevant or appropriate officials, records and reports 3. Informal community leaders 4. Officers and staff of relevant intersectoral agencies, their records and reports 5. Health agency records and reports, government and private 6. Private medical and other health professionals, traditional care providers 7. Published article on the community and reports of studies, if any. 	<ol style="list-style-type: none"> 1. Review/study and analysis of existing data from records and reports of government and private agencies, health and intersectoral agencies, including census data, public health statistics and research study reports. 2. Interview of appropriate government officials, community leaders, citizens, health care providers and relevant staff of intersectoral agencies 3. Tour of the community – direct inspection of the environment, facilities, natural resources, health care and related resources 4. Survey of the whole community 5. Review of publications with articles/ reports about the community, if any. 	<ol style="list-style-type: none"> 1. Map of the community 2. Interview schedule, questionnaire 3. Survey forms

Table 5.9.8 Continued:

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ul style="list-style-type: none"> a. Religious/ethnic groups <ul style="list-style-type: none"> – Types, number and proportion b. Socioeconomic data <ul style="list-style-type: none"> i. Main occupations/ industries ii. Average family income or GNP iii. Unemployment rate iv. Percentage of population who are below the poverty level v. Education – Percentage of population who completed: <ul style="list-style-type: none"> • Elementary school • High school • College • Graduate education • No schooling vi. Literacy rate 3. Environmental Health Facilities <ul style="list-style-type: none"> a. Water supply – sources, type of distribution, quality of water b. Waste disposal system – types, sanitary condition c. Refuse/Garbage disposal systems – types of collection and disposal d. Housing – types and condition e. Presence of pollution <ul style="list-style-type: none"> i. Air – quality in general ii. Water – condition of rivers iii. Noise iv. Land – uncollected refuse/garbage in public places 4. Public Health Statistics and Related Information/ Literature <ul style="list-style-type: none"> a. Fertility/Natality Rates 			

Table 5.9.8 Continued:

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ul style="list-style-type: none"> a. Mobility – rates and leading causes, endemic diseases, past epidemics b. Mortality – rates and leading causes c. Life expectancy at birth d. Reports of studies on health and health-related matters <p>5. Health Care Resources – Government and private, nature, scope and quality of service provided</p> <ul style="list-style-type: none"> a. Hospitals – location, type, bed capacity, facilities, occupancy rate b. Health centers/dispensaries – number, location, service programs, personnel, utilization by public c. Private medical clinics – number, location d. Dental clinics – number, location e. X-ray and Laboratories f. Traditional health care providers <ul style="list-style-type: none"> i. traditional healers – number and type; location ii. traditional birth attendants – number and location; number trained; percent of births attended <p>6. Other Community Resources</p> <ul style="list-style-type: none"> a. Schools – type, number, location, number of students b. Public transportation – types; condition of roads and bridges c. Communication – types, location 			

Table 5.9.8 Continued:

DATA TO COLLECT	SOURCES OF DATA	METHODS OF DATA COLLECTION	TOOLS FOR DATA COLLECTION
<ul style="list-style-type: none"> d. Leisure/Recreation facilities – types, number and location e. Electricity – coverage f. Public markets, commercial centers/malls, stores g. Police/security system – peace and order situation, crime rate and nature of crimes committed <p>7. Government and Community Leadership</p> <ul style="list-style-type: none"> a. Government officials/ formal community leaders b. Informal community leaders c. Influential citizens and groups who participate in decision-making process as well as in the planning, implementation and evaluation of community health and related programs 			

A **nursing diagnosis** is the end result of the assessment process, which refers to a clear, concise and definitive statement of the client's/patient's health needs and problems that can be modified through nursing intervention. Health and health-related needs and problems which are not within the nurse's ability or resources to resolve are referred to other members of the health team or intersectoral teams.

From the final list of defined health needs and problems of a client/patient, the community health nurse and the client/patient identify and decide on the priorities for nursing intervention. These priority needs/problems become the bases for formulating the objectives for nursing care.

Nursing objectives can be **immediate, intermediate or ultimate/long-term** in relation to the time frame for their expected achievement. Table 5.9.9 presents general objectives of nursing care in CHN practice, and the level(s) of clientele to which each objective may apply.

Table 5.9.9		General Objectives of Nursing Care in CHN Practice			
GENERAL NURSING OBJECTIVES		LEVEL OF CLIENTELE WHERE APPLICABLE			
		INDIVIDUAL	FAMILY	GROUP	COMMUNITY
1.	Promotion and maintenance of good health	✓	✓	✓	✓
2.	Prevention of disease and accidental injuries	✓	✓	✓	✓
3.	Change of lifestyle or unhealthful behavior	✓	✓	✓	✓
4.	Improved condition of the environment, i.e. to a more healthful one	✓	✓	✓	✓
5.	Improved ability to do activities of daily living	✓	✓	✓	✓
6.	Improved physical health, e.g. nutritional status, normal blood pressure, etc.	✓	✓	✓	✓
7.	Improved psychological/emotional state	✓	✓	✓	✓
8.	Early diagnosis and treatment of disease	✓	✓	✓	✓
9.	Relief of symptoms	✓		✓	
10.	Improved compliance with prescribed treatment or rehabilitation measures	✓	✓	✓	
11.	Prevention of spread of a communicable disease	✓	✓	✓	✓
12.	Prevention of complications of an existing disease/illness or condition (e.g. pregnancy)	✓		✓	
13.	Rehabilitation – physical, psychosocial, occupational	✓	✓	✓	✓
14.	Prolonging life	✓		✓	
15.	Comfort, freedom from pain for the terminally ill and a peaceful, dignified death	✓		✓	
16.	Increased competence in dealing with common and simple illnesses and accidental injuries	✓	✓	✓	✓
17.	Increased utilization of available health care and related resources	✓	✓	✓	✓
18.	Increased ability to perform one or more health tasks and achieve self-reliance in health care matters	✓	✓	✓	✓
19.	Reduced incidence and prevalence of illness/diseases			✓	✓
20.	Reduced mortality from a given illness/disease			✓	✓

2.2. Nursing Interventions at Various Levels of Clientele

Nursing interventions are actions or measures taken by the nurse to achieve certain predetermined objectives of care. Such actions are in accord with the current or prevailing scope and standards of nursing practice and the nurse's defined roles and functions. They are aimed at reducing or totally eliminating the risk of occurrence of any adverse unwanted outcome related to health, or for the client/patient to effectively cope with the adverse unwanted outcome if it was not prevented from happening.

Table 5.9.10 shows 12 types of nursing interventions in CHN practice and the levels of clientele to which each type is applicable. These interventions are complementary and may be used in combination to deal with a particular health/nursing problem at various levels of clientele. Various ramifications of each type need to be identified, described, tried, tested, evaluated and documented if nursing science is to grow and develop. The typology is an open system. Every CHN practitioner has the challenge to discover new and more effective intervention measures to help clients/patients achieve the ultimate goal of **effective coping** in the face of health problems, and self-reliance in health care. An inquiring mind, creativity, imagination and experimentation on the part of every community health nurse will pave the way towards expanding the armamentarium of nursing interventions in CHN practice.

Table 5.9.10	Types of Nursing Interventions in CHN Practice and the Levels of Clientele To Which Each Type of Intervention is Applicable			
	LEVEL OF CLIENTELE WHERE APPLICABLE			
TYPES OF NURSING INTERVENTIONS	INDIVIDUAL	FAMILY	GROUP	COMMUNITY
1. Administration of Medical Treatments	✓	✓	✓	
2. Direct Nursing Care/Ministration	✓	✓	✓	
3. Indirect Nursing Care/ Ministration	✓	✓	✓	
4. Observational Measures	✓	✓	✓	✓
5. Anticipatory Guidance	✓	✓	✓	✓
6. Health Teaching/Education	✓	✓	✓	✓
7. Counselling	✓	✓	✓	✓
8. Motivation, Support, Development of Support System/Groups/Network	✓	✓	✓	✓
9. Environmental Manipulation, Modification and/or Improvement	✓	✓	✓	✓
10. Referral	✓	✓	✓	✓
11. Advocacy	✓	✓	✓	✓
12. Community Organization and Development			✓	✓

2.3. Evaluating Nursing Care at Various Levels of Clientele

As the last step in the nursing process, **evaluation** is that phase which is concerned with ascertaining whether the objectives of care were achieved. In its broadest sense, evaluation of care involves the analysis of the **appropriateness**, **adequacy**, **effectiveness** and **efficiency** of care, based on systematic documentation, monitoring and observations in relation to:

1. the accuracy, completeness and regularity of assessment;
2. degree of client/patient participation;

3. the quality, scope and timeliness of care provided, and
4. the outcomes of care and the interpretation of differences between observed and expected changes in client/patient condition.

Evaluation relates to **objectives**, and the manner in which objectives are stated affects the ease or difficulty of evaluation. Well-stated objectives specify the outcome(s) expected of nursing care activities, whether in terms of physical, mental or emotional state and/or behavioural outcomes. Nursing care objectives stated in terms of expected outcomes and in clear, specific and measurable manner make evaluation relatively easy.

Evaluation may focus on **structure, resources or inputs**, on the **process** of providing care, and/or **outcomes** of care. Table 5.9.11 shows the specific items to evaluate under the levels of structure/resources/inputs, process and outcomes, and these are applicable to all levels of clientele in CHN practice.

Table 5.9.11		Specific Items to Evaluate Under the Levels of Structure/Resources, Process and Outcome, Dimensions of Evaluation to Which Evaluative Questions are Addressed and Sample Evaluative Questions	
LEVEL OF EVALUATION	SPECIFIC ITEMS TO EVALUATE	DIMENSIONS OF EVALUATION	SAMPLE EVALUATIVE QUESTIONS
I. Structure/ Resources/ Inputs	A. Resources of the nurse		
	1. Competencies: knowledge, skills, attitudes	adequacy; appropriateness	Does the nurse have the requisite knowledge, skills and attitudes to deal with the multiple problems presented by the client/patient? Does she have adequate support in terms of material resources? Were the resources allocated, including time and effort, appropriate and adequate? Were they efficiently utilized?
	2. Material resources: equipment, supplies, transport facility, etc.	adequacy; appropriateness; efficiency	
	3. Time and effort	adequacy; efficiency	
	B. Resources of the client/patient		
	1. Human manpower resources, e.g. adult/employed members	appropriateness; adequacy	Are the present human and material resources of the client/patient appropriate and adequate to deal with the multiple problems at hand? Is the client's/patient's level of competence in health matters adequate? Were actions taken in the past during episodes of illness appropriate?
	2. Material resources: equipment, materials, funds	adequacy; appropriateness; efficiency	
	3. Competence in health care: knowledge, skills, attitudes	adequacy; appropriateness	
	4. Time and effort	adequacy; efficiency	Did the client/patient expend the necessary time and effort in the resolution of the problems identified?

Table 5.9.11 Continued:

LEVEL OF EVALUATION	SPECIFIC ITEMS TO EVALUATE	DIMENSIONS OF EVALUATION	SAMPLE EVALUATIVE QUESTIONS
	C. Resources of the community 1. Health manpower – modern and traditional	adequacy; effectiveness; efficiency; appropriateness	Does the community have appropriate and adequate health manpower, health care facilities and health-relevant organizations that could provide support to the implementation of the nursing care plan? Are these resources effective and efficient in their operations?
	2. Health care facilities 3. Institutions relevant to health, government and non-government, and programs run	appropriateness; adequacy; effectiveness; efficiency	
	D. The nursing care plan 1. Assessment done which served as basis for plan	adequacy; appropriateness; effectiveness; efficiency	To what extent is the care plan likely to solve or reduce the health problems of the client/patient? Was assessment done appropriate and adequate to serve as sound basis for objectives set? Are the nursing objectives appropriate, adequate and realistic? Are there important objectives which were left out? Were the activities/intervention measures and resources selected appear to be adequate, appropriate, efficient and effective to realize the objectives? Is a health teaching plan included? Is a plan for evaluation included in the nursing care plan? If so, does it appear to be appropriate, adequate, effective and efficient? What was the cost in terms of resources of the activities done? What is the cost-benefit ratio?
	2. Objectives set	appropriateness; adequacy	
	3. Activities/interventions planned to be done	appropriateness; adequacy; effectiveness; efficiency; impact	
	4. Resources to be used	appropriateness; adequacy; efficiency	
	5. Plan for evaluation of care	appropriateness; adequacy; effectiveness; efficiency	
II. Process	The implementation of the nursing care plan, specifically the following: 1. Quantity of services/ activities actually implemented	appropriateness; adequacy; progress	Were all nursing activities carried out as planned? What were the constraints faced in implementation of planned activities? Was the care provided comprehensive, coordinated and continuous? Did it consider and meet both the physical and psychosocial needs of the client/patient? What was the quality of the nurse's performance of the activities/interventions done? Were correct techniques and standard operational procedures and guidelines observed in the performance of nursing activities?
	2. Estimated quality of services/care rendered 3. Quality of nurse's performance including involvement and participation of the family in the implementation of the care plan	effectiveness; efficiency; appropriateness; adequacy	

Table 5.9.11 Continued:

LEVEL OF EVALUATION	SPECIFIC ITEMS TO EVALUATE	DIMENSIONS OF EVALUATION	SAMPLE EVALUATIVE QUESTIONS
			To what extent and in what ways was the client/patient involved in the implementation of the nursing care plan?
III. Outcome/ Output	<ol style="list-style-type: none"> 1. Change in physical/mental health status of individual clients/patients, families; change in fertility, morbidity and mortality patterns in groups and in the whole community. 2. Prevention of unwanted results or negative outcomes 3. Change in communication, interaction and relationship patterns, in assumption of roles and functions and in overall functioning. 4. Change in health behaviour and lifestyle. 5. Change in the quality of the environment. 6. Change in level of competence (knowledge, skills, attitudes) in matters relating to health and health care. 	appropriateness; adequacy; impact; progress	Did the intended results or changes occur? What is the magnitude of change? At what cost were the desired results achieved? Was there any unintended or harmful outcome? Was there any negative outcome prevented? Are the outcomes significant and likely to lead to the achievement of the ultimate objective?
	<ol style="list-style-type: none"> 7. Satisfaction or dissatisfaction with nursing services received. 	adequacy	To what extent was the client/patient satisfied with the care received from the nurse? What are their specific complaints, if any?

Evaluation also involves determination of **criteria** and **standards**. Criteria refer to the signs which indicate that the objective has been realized or achieved. Criteria are free from any value judgment and are not attached to a time frame. When a value judgment is applied to a criterion, it becomes a **standard**. A **standard** refers to the yardstick against which results of assessment will be compared in order to make a judgment. It represents the desired condition, situation, state of affairs or level of performance corresponding with a criterion against which the actual condition, situation, state of affairs or level of performance is compared. Applied to the evaluation of nursing care, standards tell us what the client's/patient's situation, behavior, level of performance or capability should be for us to say that nursing intervention was successful, or that the objective of nursing care was achieved. Standards are established by authority, custom or general consent as a model or rule of measurement. They reflect the development of an art, science or service and are usually the product of detailed scientific investigation and professional judgment. Standards can be low, moderate or high; they can also be realistic or unrealistic. Standards also relate directly to the criteria, i.e. for every criterion, there has to be a standard. An adequate statement of objectives specifies both the

criterion and standard of evaluation.

Figure 5.9.3 on the next page schematically presents the steps in evaluating nursing care. Again, they apply to the evaluation of care of individual clients/patients, families, specific population groups and communities. Methods of data collection and sources of evaluative data can range from direct observation, to records and reports review, verbal reports, interviews or questionnaire administration, oral and/or written tests, simulation exercises, and feedback from the recipients of care. While clients/patients may not be aware or knowledgeable about the technical elements of good care, it is necessary and useful to ascertain the client's/patient's satisfaction with health care in general and nursing care in particular. Such satisfaction affects the development and maintenance of a good working relationship between the nurse and the client/patient. Clients'/patients' feedback is particularly useful for evaluating the humanistic, ethical and psychosocial aspects of care, courtesy, respect, sympathy, compassion, kindness, sensitivity and concern expressed by the nurse in the process of providing care. The latter pertain to the **affective component** of nursing competence which are extremely important in clients'/patients' perception of "good" care.

Evaluation is the last phase of the nursing process but it is not the end. It continues and goes back to reassessment of the client's/patient's condition and situation, and to the nursing care plan.

SUMMARY

This Self-Instructional Module defines, describes and explains the basic concepts, features and characteristics of the four levels of clientele in CHN practice: the individual, the family, specific population groups and the community as a whole. It briefly explains the nursing process --- the basic methodology for providing professional nursing care, and it illustrates the application of each step in the nursing process at each level of clientele, from assessment of health/nursing needs and problems, to evaluation of nursing care.

POST ASSESSMENT

Please turn to Page 205 and take your Post-Test. Write your answers in a separate sheet of paper. Do not write anything in the Question Sheet.

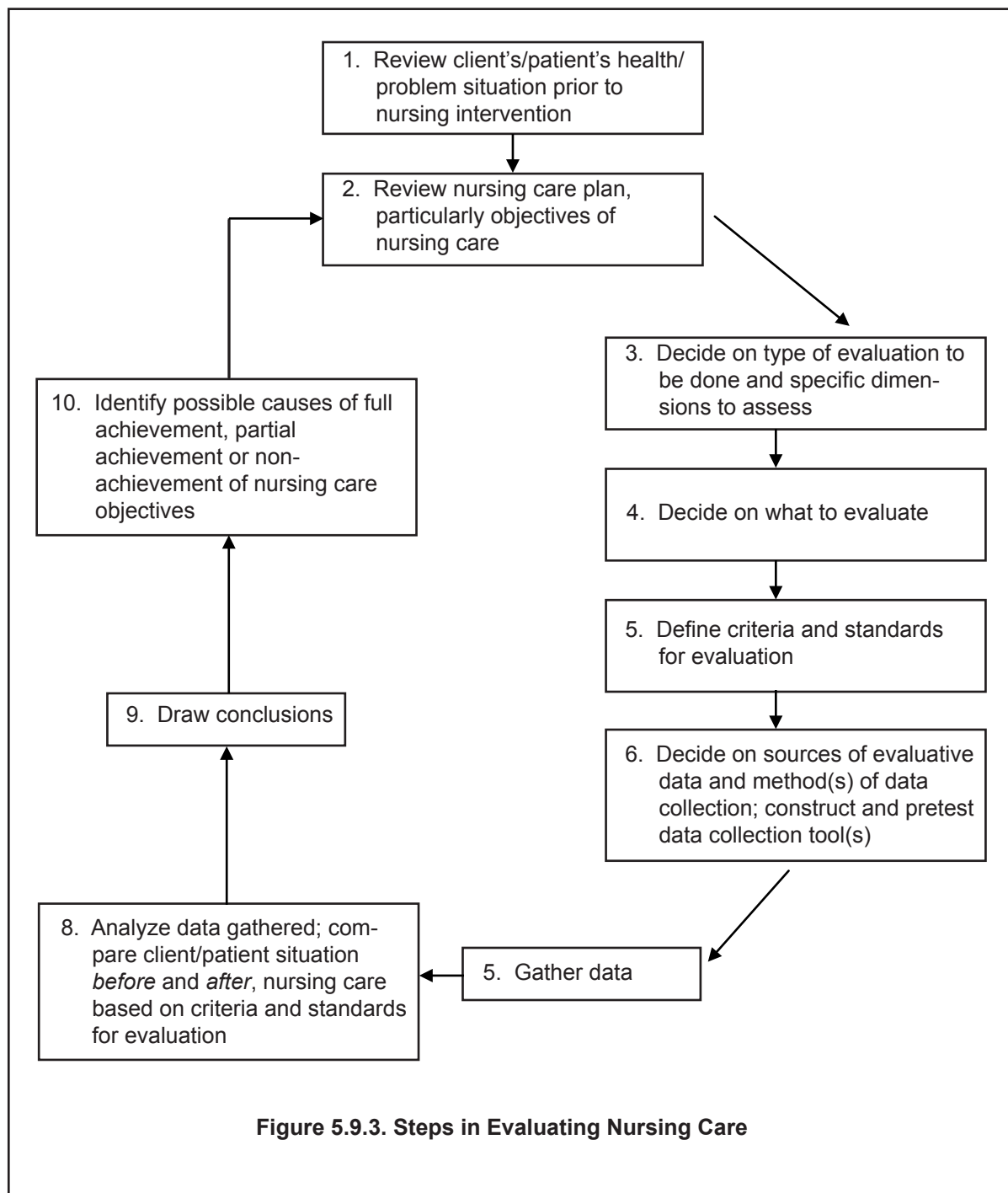


Figure 5.9.3. Steps in Evaluating Nursing Care

Source: Bailon-Reyes, Salvacion G. **Community Health Nursing --- The Basics of Practice**. National Book Store, 2006, p. 178.

POST-TEST

INSTRUCTION: Read carefully each of the following questions, and write your answers in a separate sheet of paper.

1. Identify five (5) areas of difference between Hospital Nursing and Community Health Nursing (CHN). For each area, indicate the difference between the two major fields of nursing practice.
2. Identify the four (4) levels of clientele in CHN practice. Briefly describe each level and differentiate one from the others.
3. For each of the four (4) levels of clientele in CHN practice, identify five (5) initial data to collect to have some idea on possible health/nursing needs/problems.
4. Enumerate five (5) basic functions of a family.
5. Enumerate five (5) health tasks of a family.
6. In no more than two sentences, define the **risk approach to health/nursing care**.
7. For each of the four levels of clientele in CHN practice, identify three (3) kinds of clients/patients to whom you will give priority attention based on the risk approach to health/nursing care.
8. In no more than two (2) sentences, define **Nursing Process**.
9. Enumerate the three (3) major steps in the nursing process.
10. Identify three (3) possible general objectives of the nursing care.
11. Enumerate five (5) kinds of nursing interventions in CHN practice.
12. Identify three (3) specific items to evaluate under **Structure/Resources/Inputs**, three (3) items under **Process**, and three (3) under **Outcomes** of nursing care.

CHECKING AND SCORING YOUR ANSWERS

1. Check your answers against the **Key to Correction** on Pages 173 to 179 of the Module.
2. Score your answers according to the number of points given to each correct answer for every item in the Test.
3. Add up your score for all your correct answers. The Perfect Total Score is 95 points.
4. Indicate your Total Score on the upper right hand corner of your Answer Sheet.
5. Now, compare your Pretest Score with your Post-test Score. An increase in your Post-test Score over your Pretest Score represents your **gain in learning**. For example, your Pretest Score was 20 points and your Post-test Score was 80 points, you have a learning gain of 60 points (equivalent to 63.1% gain in learning). However, if your Pretest Score was higher than your Post-test Score, something went wrong somewhere --- you have to reread/restudy the Module.

If your Post-test Score is lower than 71 points (75%), the Passing Mark, please reread/restudy the Module.

REFERENCE

Bailon-Reyes, Salvacion G. **Community Health Nursing --- The Basics of Practice**. National Book Store, 2006.

Emergency and Disaster Management

SHEILA R. BONITO, RN, MAN, DrPh

INTRODUCTION

The role of nurses in emergency and disaster management cannot be undermined since nurses are always at the forefront of any emergency and disaster response effort. In a country such as the Philippines where natural hazards abound, it is even more important that nurses are trained early on in their undergraduate years about emergency and disaster management. Nurses need to take on their specific roles in the preparedness, prevention, mitigation, response, recovery and rehabilitation efforts in communities affected by emergencies and disasters.

The goal of this module is to guide you as a Master Trainer to facilitate learning to enable learners to perform the specific competency related to emergency and disaster management. Learning objectives are formulated to reflect the performance indicators needed to achieve the above competency in emergency and disaster management. The competency and performance indicators are shown in Table 5.10.1.

Table 5.10.1 NNCCS on Implementing Appropriate Care to Clients During Disaster Situations	
Responsibility 2 Utilizes the Nursing Process in the Interdisciplinary Care of Clients that Empowers the Clients and Promotes Safe Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
2.4.11. Implements appropriate care to individuals, families, vulnerable groups and communities during three phases of disaster situations, such as: (1) pre-incident phase, (2) incident phase, and (3) post incident phase.	<ol style="list-style-type: none"> 1. Participates in the prevention and mitigation of adverse effects of a disaster. 2. Performs preparedness activities as a member of the multi-disciplinary team. 3. Executes appropriate nursing interventions in collaboration with disaster response team. 4. Provides care and support to those injured with chronic disease, maladaptive patterns of behaviour and disabilities during recovery/reconstruction/rehabilitation period.

This module also describes the teaching-learning strategies needed for learners to achieve the competency in emergency and disaster management. These learning strategies ensure that learners are able to achieve the learning objectives needed to perform the competency. These include the use of activities that foster critical thinking and decision-making skills. It also provides hospital and community scenarios to help teachers and learners apply the competency.

Some resources are also listed to help teachers and learners in teaching and learning this competency. These resources include technical content, pedagogical tools, and learning technologies in emergency and disaster management.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to guide learners to:

1. Describe how disasters affect communities;
2. Apply the risk management framework in the prevention and mitigation of adverse effects of disasters;
3. Define the roles and functions of nurses in emergencies and disasters;
4. Perform basic emergency care and services in the pre-hospital and hospital setting;
5. Perform community health nursing interventions related to emergency and disaster management; and
6. Provide basic psychosocial support and mental health services to people affected by emergencies and disasters.

TOPIC OUTLINE

1. Pre-incident phase
 - How disasters affect communities
 - Risk management framework
 - Roles and functions of nurses in emergency and disaster management
2. Incident phase
 - Basic emergency care in emergency and disaster management
3. Post-incident phase
 - Community health nursing in emergency and disaster management
 - Psychosocial support in emergency and disaster management

MODULE OBJECTIVES

1. PRE-INCIDENT PHASE

How disasters affect communities

The Center for Research on the Epidemiology of Disasters (CRED) defines a disaster as “a situation or event, which overwhelms local capacity, necessitating a request to a national or international level for external assistance. Disasters are categorized into: natural and technological. Natural disasters are further classified into 5 sub-categories: (1) geophysical, (2) meteorological, (3) hydrological, (4) climatological, (5) biological.

Table 5.10.2 Natural Disaster Classification by Subgroups, Main Types and Subtypes				
GEOPHYSICAL	METEOROLOGIC	HYDROLOGICAL	CLIMATOLOGICAL	BIOLOGICAL
Earthquake <ul style="list-style-type: none"> • Ground shaking • Tsunami Volcano <ul style="list-style-type: none"> • Volcanic eruption Mass movement (dry) <ul style="list-style-type: none"> • Rockfall • Avalanche • Landslide • Subsidence 	Storm <ul style="list-style-type: none"> • Tropical storm • Extra-tropical cyclone (winter storm) • Local/convective storm 	Flood <ul style="list-style-type: none"> • General river flood • Flash flood • Storm surge/ coastal flood Mass movement (wet) <ul style="list-style-type: none"> • Rockfall • Landslide • Avalanche • Subsidence 	Extreme temperature <ul style="list-style-type: none"> • Heat wave • Cold wave • Extreme winter conditions Drought Wildfire <ul style="list-style-type: none"> • Forest fire • Land fires 	Epidemic <ul style="list-style-type: none"> • Viral infectious disease • Bacterial infectious disease • Parasitic infectious disease • Fungal infectious disease • Prion infectious disease Insect infestation Animal stampede

Source: CRED (2009) EM-DAT: The International Disaster Database. Available at <http://www.emdat.be/classification>

Recommended Resources

The World Bank (2010). *Disaster types and impacts*. In: Safer homes, stronger communities: A handbook for reconstructing after natural disasters. Available at http://www.gfdr.org/sites/gfdr.org/files/Disaster_Types_and-Impacts.pdf

This chapter presents a range of data and a brief discussion on the nature, distribution, and impact of disaster events.

The Philippines has experienced many of these natural disasters because of its high exposure to a number of natural hazards. Its location in the Pacific Ring of Fire exposes it to earthquakes, and volcanic eruptions. It is also visited by an average of 20 typhoons every year, which cause floods and landslides in affected areas. These hazards have had grave social and economic impacts on the country's development over the years.

Recommended Resources

The World Bank (2002). Natural disaster risk management in the Philippines: Enhancing poverty alleviation through disaster reduction. Available at http://siteresources.worldbank.org/INTEAPREGTOPENVIRONMENT/Resources/PH_Disaster_Risk_Mgmt.pdf.

This publication shows hazard exposure and disaster impacts in the Philippines. It also includes disaster management capacity in the Philippines in 2002.

Disaster impacts comprise physical and social impact. The physical impacts of disasters include casualties (deaths and injuries) and property damage. The physical impacts of a disaster are usually the most obvious, easily measured, and first reported by the news media. Social impacts, which include psychosocial, demographic, economic, and political impacts, can develop over a long period of time and can be difficult to assess when they occur.

Recommended Resources

FEMA (n.d.). Hazard, vulnerability and risk analysis. Available at <http://tinyurl.com/m5p9bgg>.

This chapter describes how pre-impact conditions act together with event-specific conditions to produce a disaster's physical and social impacts.

Learning strategies

- Show slides/video of recent disasters in the country, e.g. typhoon and flooding, volcanic eruption, earthquake, bombing, etc.

Capture the learners' attention and interest by showing photo slides and/ or video footage of recent emergencies and disasters in the country.

Draw out their reactions to the slides or video by asking the following questions:

- o Do you remember when this happened?
 - o What were the effects of this disaster?
 - o What were the health impacts of this disaster?
 - o What is this type of disaster? What are the other types of disaster?
 - o What are the other effects and impacts of other type of disasters?
- Show actual data on type of disasters, their frequencies and impact to communities using CRED database. The Centre for Research on the Epidemiology of Disasters (CRED) maintains the Emergency Events Database (EM-DAT), a worldwide database on disasters from 1900 to the present.

Some questions that may be asked:

- o What types of disasters occurred in the Philippines in the last five years?
 - o Which among these disasters caused the highest number of deaths and highest costs in terms of damage to property and infrastructures?
 - o Which disasters could be considered worst in terms of social and health impact?
 - o What factors worsen disaster impact to communities?
 - o What factors foster community resilience to disasters?

Resources

Federal Emergency Management Agency (FEMA). Hazard, vulnerability and risk analysis. Available at <http://tinyurl.com/m5p9bgg>. Washington, DC.

The Centre for Research on the Epidemiology of Disasters (CRED). Available at: <http://www.cred.be>

The World Bank (2002). Natural disaster risk management in the Philippines: Enhancing poverty alleviation through disaster reduction. Available at http://siteresources.worldbank.org/INTEAPREGTOPENVIRONMENT/Resources/PH_Disaster_Risk_Mgmt.pdf

The World Bank (2010). Disaster types and impacts. In: Safer homes, stronger communities: A handbook for reconstructing after natural disasters. Washington, DC, pp. 339-342. Available at http://www.gfdrr.org/sites/gfdrr.org/files/Disaster_Types_and-Impacts.pdf

Risk management and disaster prevention and mitigation

Disaster risk reduction is the concept and practice of reducing disaster risks through systematic efforts to analyze and reduce the causal factors of disasters. Reducing exposure to hazards, lessening vulnerability

of people and property, wise management of land and the environment, and improving preparedness and early warning for adverse events are all examples of disaster risk reduction.

Recommended Resources

United Nations International Strategy for Disaster Reduction (UNISDR) “What is disaster risk reduction?” Available at <http://www.unisdr.org/who-we-are/what-is-drr>.

This website is the United Nations Office for Disaster Risk Reduction which contains information related to its work, such as ensuring disaster risk reduction (DRR) is applied to climate change adaptation, increasing investments for DRR, building disaster-resilient cities, schools and hospitals, and strengthening the international system for DRR.

The Hyogo Framework for Action 2005-2015 crafted during the World Conference on Disaster Reduction held in Kobe, Japan gives the priority action areas to build the resilience of nations and communities to disasters. These priority action areas include:

- Ensure that disaster risk reduction is a national and a local priority with a strong institutional basis for implementation.
- Identify, assess and monitor disaster risks and enhance early warning.
- Use knowledge, innovation and education to build a culture of safety and resilience at all levels.
- Reduce the underlying risk factors.
- Strengthen disaster preparedness for effective response at all levels.

Recommended Resources

The Hyogo framework for action 2005-2015. Available at <http://www.unisdr.org/2005/wcdr/intergover/official-doc/L-docs/Hyogo-framework-for-action-english.pdf>.

This document also defines the concepts in risk management framework, which include hazards, vulnerability, and risk.

The purpose of Hazard, Risk and Vulnerability analysis (HRVA) is to help a community make risk-based choices to address vulnerabilities, mitigate hazards and prepare for response to and recovery from hazard events. Communities make risk reduction choices based on the acceptability of consequences and the frequency of hazards.

Recommended Resources

Emergency Management BC (2004) Hazard, risk, vulnerability analysis toolkit. Available at <http://embc.gov.bc.ca/em/hrva/toolkit.html>.

This tool kit guides communities how to conduct hazard, risk, vulnerability analysis based on informed choices of alternate unwanted outcomes.

Learning strategies

- Watch this youtube video about Disaster Risk Reduction. Available at http://www.youtube.com/watch?v=iugLHrcs_fm#at=75. Ask learners to list the strategies to reduce disaster risks.

- Group work on basic terminologies related to risk management framework. Form groups of 4 - 5 learners. Let each group post their answers in front of class. Compare the groups' answers to the correct definitions found in the Hyogo Framework document.
 - o Define hazards, vulnerability, risks
 - o Provide examples of hazards, vulnerabilities, risks
- Ask learners to form a group and conduct a hazard, risk and vulnerability assessment of a specific community of their choice using the tool kit from Emergency Management British Columbia (BC). Make them write the analysis report for submission and ask them to present this to class.

Resources

Emergency Management BC (2004). Hazard, risk, vulnerability analysis tool kit. British Columbia. Available at <http://embc.gov.bc.ca/em/hrva/toolkit.html>

United Nations International Strategy for Disaster Reduction (UNISDR) (2013). "What is disaster risk reduction?" Available at <http://www.unisdr.org/who-we-are/what-is-drr>.

United Nations International Strategy for Disaster Reduction (UNISDR) (2005). Hyogo framework for action 2005-2015: Building the resilience of nations and communities to disasters. Available at <http://www.unisdr.org/2005/wcdr/intergover/official-doc/L-docs/Hyogo-framework-for-action-english.pdf>

Roles and functions of nurses in emergency and disaster management

Nurses play different roles and functions in emergency and disaster management. Nurses, whether in hospitals or communities, are at the forefront during emergency response saving lives and maintaining health. They also play important roles during prevention, mitigation, preparedness, recovery and rehabilitation.

Recommended Resources

ICN framework of disaster nursing competencies. Available at <http://myweb.polyu.edu.hk/~hswhoccc/resource/D/2009DisasterNursingCompetencies.pdf>.

This publication contains disaster nursing competencies for the generalist nurse help clarifies the role of the nurse in disasters and assist in the development of disaster training and education.

Learning strategies

- Ask learners to gather news, feature articles, videos, showcasing the many roles of nurses in emergencies and disasters. Form groups so that they can present these in any of the following suggested formats:
 - o Blog - A blog (also called a weblog or web log) is a website consisting of entries similar in format to a daily journal. They appear in reverse chronological order with the most recent entry appearing first. They typically include features such as comments and links to increase user interactivity. Blogs are created using specific publishing software such as Blogger, Wordpress, to name a few.
 - o Wiki - A wiki is a web site that lets any reader create or edit the actual site contents without any special technical knowledge or tools. It is a living collaboration and continuously "under revision" whose purpose is the sharing of the creative process and product by many. An example of wiki is Wikipedia.

- o Digital story - Digital story is about telling a story or presenting an idea using short form of digital media such as video, animation, stills, audio or other electronic formats.

Resources

Blogger (2013). What's a blog? Available at https://www.blogger.com/tour_start.g

What is digital story telling. Available at <http://www.youtube.com/watch?v=dKZiXR5qUIQ>

Wikis in plain English. Available at <http://www.youtube.com/watch?v=-dnL00TdmLY>

World Health Organization (WHO) and International Council of Nurses (ICN) (2009). ICN framework of disaster nursing competencies. Geneva, Switzerland. Available at <http://myweb.polyu.edu.hk/~hswhoccc/resource/D/2009DisasterNursingCompetencies.pdf>

2. INCIDENT PHASE

Basic emergency care in emergency and disaster management

Saving lives in emergency and disaster situations is a paramount responsibility of all health workers including nurses. One important skill needed in saving lives during mass casualty incidents is doing field triage. Newport Beach Fire and Marine Department developed the Simple Triage and Rapid Treatment (START) method used by first responders to quickly classify victims during mass casualty incident (MCI) based on the severity of their injury.

First responders using START technique evaluate victims and assign them to one of the following four categories:

- Walking wounded/minor (Green)
- Immediate (Red)
- Delayed (Yellow)
- Deceased/expectant (Black)

Recommended Resources

Maryland Institute for Emergency Medical Services Systems (Available at <http://www.miemss.org/home/TriageTagTraining/tabid/152/Default.aspx>) website shows documents and materials needed for training on triage in emergencies and mass casualty incidents.

This site contains the slides on Newport Beach Fire and Marine Department's START triage technique that can be used in class. Available at <http://www.miemss.org/home/LinkClick.aspx?fileticket=US0tqM-XuWE%3d&tabid=152&mid=539>

START has also been modified to be more suited for children. Since pediatric patients breathe faster than adults, the modified triage technique called JumpSTART assigns the immediate classification on the basis of respiratory rate only if the child's respiration is under 15 or over 45 per minute.

Recommended Resources

Team Life Support, Inc (2011). The JumpSTART Pediatric MCI Triage Tool. Available at http://www.jumpstarttriage.com/Home_Page.php.

This website contains the JumpSTART pediatric MCI triage tool and other pediatric disaster and emergency medicine resources.

Other basic emergency skills and services where nurses should be skilled at include wound dressing, bandaging, lifting and transferring patients. (These skills are usually taken during the first year in undergraduate nursing under foundation courses.)

Learning strategies

- Present the slides on START and JumpSTART techniques.
- Tabletop exercise: Putting it into practice

Case Scenario:

An earthquake with a magnitude of 6.0 struck in the middle of the day in a city center. You were deployed immediately to the site of a school building where around 100 people were inside when the earthquake happened. When you arrived at the scene, you first made sure that there are no immediate hazards to you and the victims. You then proceed to do the triaging.

Materials:

- Triage tapes (green, black, red, yellow)
- Patient profiles (some examples below)

Table 5.10.3	Patient Profiles
Patient 1	<ul style="list-style-type: none"> • A young school aged boy is found lying on the floor • Breathing 10/min • Good distal pulse • Groans to painful stimuli
Patient 2	<ul style="list-style-type: none"> • A teacher kneels at the side of the desk, shaking his head. He says he's too dizzy to walk. • RR 20 • HR 2 sec • Obeys commands
Patient 3	<ul style="list-style-type: none"> • A school aged girl crawls out of the fallen bookshelves. She's able to stand and walk toward you crying. • Jacket and shirt torn • No obvious bleeding
Patient 4	<ul style="list-style-type: none"> • A preschooler lies with his lower body trapped under a collapsed ceiling • Apneic • Remains apneic with modified jaw thrust • No pulse

Processing:

- Ensure that learners follow the principles of field triage (START technique)
- Review each patient profile to see whether the assessment was correct
- Explain when learners do not get it correctly

Resources

Maryland Institute for Emergency Medical Services Systems (2012). Triage Tag Training. Maryland. Available at <http://www.miemss.org/home/TriageTagTraining/tabid/152/Default.aspx>.

Team Life Support, Inc (2011). The JumpSTART Pediatric MCI Triage Tool. Available at http://www.jumpstarttriage.com/Home_Page.php.

3. POST-INCIDENT PHASE

Community health nursing in emergency and disaster management

Nurses' role in the community during emergency and disaster is very crucial. Knowledge about the community's demographics, environment, baseline health status, and existing resources provides public health nurses with the needed information on the community needs, risks and resources that would help in supporting it during emergency or disaster.

Recommended Resources

Landesman, L.Y. (2006). Public health management of disasters: A pocket guide. American Public Health Association, Washington, DC. Available at http://www.apha.org/NR/rdonlyres/ECDFA2EC-49A0-4D7A-B257-1488E671DE5B/0/APHA_DisasterBook_2.pdf.

This pocket guide is intended to be a quick field resource to public health interventions in the days immediately preceding and following emergencies. It discusses the roles and responsibilities of public health authorities, disaster plans and information systems, and federal resources in the United States.

Public health interventions in emergency and disaster include rapid health assessment, epidemiology and surveillance, mass casualty management, temporary shelters, prevention and control of communicable diseases, nutrition, water supply, sanitation and hygiene and mental health and psychosocial support, management of the dead and missing, logistic supplies management, and risk communication, and recovery and reconstruction. Priority public health interventions would depend on the types of hazards, assessment of community risks and resources.

Recommended Resources

Department of Health (DOH) and World Health Organization Western Pacific Regional (WHO-WPR) (2010). Pocket emergency tool, 3rd edition. Available at http://www2.wpro.who.int/internet/resources.ashx/EHA/docs/PET_3rdEd_web.pdf.

This pocket guide contains policies and procedures, program guidelines and technical notes, tools and checklist used by the Health Emergence Management Staff of the Department of Health-Philippines.

Learning strategies

Given the case scenarios below, answer the following questions:

- What are the priority public health interventions needed?
- What will be the role of the nurse in this situation?
- Give specific activities that the nurse can do?

Scenario 1

You are the community health nurse in one of the barangays affected by a strong typhoon, which caused landslides and flooding in the area. Families affected by landslides and flooding were relocated to temporary shelters/ evacuation centers. There were a lot of younger children and babies in the displaced families.

Scenario 2

A group of high school students who recently came back from a travel abroad suddenly developed an unknown form of respiratory condition. They were suspected of having been exposed to a new corona virus that is killing several young people in other countries, including the country where they came from recently. You were asked to go to the school to talk with the school administrator to explain the public health issue and seek cooperation to implement public health measures.

Scenario 3

A strong earthquake hit the city. One particular residential building collapsed causing deaths, injury and some people trapped inside. You were asked to help in the on-scene management of the victims.

Scenario 4

A ferry ship carrying 500 passengers collided with a cargo vessel while on its way to port area. Several hundreds were rescued by nearby coastguards and fishermen. Some died, were injured and some were missing. You were sent to the scene to help attend to the injured and to those looking for their missing family members.

Scenario 5

A fire hit a small community home for the disabled and older persons. No one died in the fire but many residents were sad, confused or angry at what happened. You were requested to help assess the patients.

Resources

Department of Health (DOH) and World Health Organization Western Pacific Regional (WHO-WPR) (2010). Pocket emergency tool, 3rd edition. Available at http://www2.wpro.who.int/internet/resources.ashx/EHA/docs/PET_3rdEd_web.pdf

Landesman, L.Y. (2006). Public health management of disasters: A pocket guide. American Public Health Association, Washington, DC. Available at http://www.apha.org/NR/rdonlyres/ECDFA2EC-49A0-4D7A-B257-1488E671DE5B/0/APHA_DisasterBook_2.pdf

Psychosocial support in emergency and disaster management

The Inter-agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings was developed to enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses to protect & improve people's mental health and psychosocial well-being in the midst of an emergency. It is based on core principles of: (1) human rights and equity, (2) participation, (3) do no harm, (4) building on available resources and capacities, (5) integrated support systems, and (6) multi-layered supports. Mental health and psychosocial support should be a layered system of complementary supports that meets the needs of different groups, which include: basic services

and security, community and family supports, focused, non-specialized supports, and specialized services.

Recommended Resources

Inter-Agency Standing Committee (2007). IASC Guidelines on Mental Health and Psychosocial support in Emergency settings. Available at http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

This document contains a matrix that provides an overview of recommended key interventions and supports for protecting and improving mental health and psychosocial well-being.

Psychological first aid will help nurses (teachers, or other lay persons) know the most supportive things to say and do for people who are very distressed. It will also give information on how to approach a new situation safely for oneself and others, and not to cause harm by one's actions. Psychological first aid has been recommended by many international and national expert groups, including the Inter-Agency Standing Committee (IASC) and the Sphere Project, as an alternative to psychological debriefing. In 2009, the World Health Organization's (WHO) mhGAP Guidelines Development Group evaluated the evidence for psychological first aid and psychological debriefing and concluded that psychological first aid, rather than psychological debriefing, should be offered to people in severe distress after being recently exposed to a traumatic event.

Recommended Resources

World Health Organization (2011). Psychological first aid: Guide for field workers. Geneva, Switzerland. Available at http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

This guide covers social and psychological support, which involves humane, supportive and practical help to fellow human beings suffering serious crisis events. It gives a framework for supporting people in ways that respect their dignity, culture and abilities.

Learning strategies

- Role playing on MHPSS and Psychological First Aid

Instruction:

- Form groups of five. Assign one learner to play the part of the patient, and another to play the part of the nurse. Let the other players in the group create their own roles that would fit the scenario. Ask everybody to be familiar with the scenarios and try to internalize the roles that they play.
- While one group is playing their scenario, ask another group to observe and provide feedback about proper conduct of psychological first aid and other issues related to MHPSS. This feedback will then be shared with the larger group.

Case Scenario 1 (Establishing contact)

You are working in a resettlement camp and notice a woman sitting on her own. Her head is down and you think she looks very sad. You decide to speak with the woman and decide to approach her. What will you say?

Case Scenario 2 (Giving practical assistance)

The woman eventually tells you she is very worried about her husband whom she has not seen since

the emergency. She doesn't know what to do and so has been sitting in the one place hoping he will find her. Using a problem solving approach (Identify, clarify, plan, and act), identify how could you assist her?

Case Scenario 3 (Calming a person/Stabilization)

You are asked by a man if you can assist his mother who is crying uncontrollably. He is very worried because she will not eat or drink. What could you do to help calm the woman? What other things might you do to assist the son?

Case Scenario 4 (Connecting with social support agencies)

There are a number of children in the hospital and many of them do not have their primary care givers present. Some of the children are very withdrawn and others are naughty and difficult to manage. What could you do to help the children?

Case Scenario 5 (Information on coping)

You are speaking to one of your female patients who tells you her husband is not coping well and is drinking heavily and withdrawing from the family. What coping mechanisms could you advise your patient to try to assist her husband with this current inability to cope?

Case Scenario 6 (Linkage with other services)

One of your patients states that he feels that it is hopeless to continue. He has lost many members of his family and his home. He states that he often thinks about committing suicide. You are not a mental health nurse, who can you go to for assistance and to whom you can refer this gentleman on to?

Resources

Inter-Agency Standing Committee (2007). IASC Guidelines on Mental Health and Psychosocial support in Emergency settings. Available at http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

World Health Organization (2011). Psychological first aid: Guide for field workers. Geneva, Switzerland. Available at http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

APPLICATION

This module focuses on preparing learners perform their professional roles in emergency and disaster management. Whether they work in the hospital or community setting, nurses need to have a basic understanding of how disasters affect communities, what are the concepts and strategies under the risk management framework, and the specific role of nurses in emergency and disaster management. It is also important that nurses have the basic knowledge and skills in basic emergency care, public health interventions and psychosocial support and mental health services, including field triage and psychological first aid.

In the specific learning strategies presented previously, case scenarios were used to situate and put context in the performance of the competencies. These case scenarios should facilitate the performance of specific skills as reflected in the following learning activities:

- Conduct a Hazard, Risk, Vulnerability Analysis (HRVA) of a community
- Determine strategies for disaster risk reduction appropriate for this community, which may include prevention and mitigation and preparedness activities, in collaboration with other health and non-health sectors.
- Demonstrate field triage given a (make-believe) emergency situation

- Plan for priority public health actions and determine roles of community health nurses given different emergency and disaster situations.
- Demonstrate psychological first aid to emergency and disaster survivors during response, recovery, reconstruction and rehabilitation phase in a make-believe setting.

SUMMARY

The knowledge, skills and attitudes achieved by learners in this module should help them in implementing appropriate care to individuals, families, vulnerable groups and communities during the pre-incident, incident and post-incident phase of disasters. Understanding how disasters affect communities and the risk management framework, and the role of nurses in emergency and disaster management would help learners prepare for their participation in the prevention, mitigation and preparedness activities in emergency and disaster management. Learning the basic emergency care, public health interventions and psychosocial support and mental health services would prepare them to perform appropriate nursing interventions in caring for communities in emergency and disaster situations. Practicing field triage skills and psychological first aid would make them ready to provide care and support to individuals and families during response phase of disaster management.

EVALUATION

1. What factors worsen disaster impact to communities?
2. What factors foster community resilience to disasters?
3. What is the relationship of hazard, risk and vulnerability in the framework of risk management?
4. What are the principles behind disaster risk reduction strategies?
5. Give examples of roles of nurses in emergency and disaster management and support these with evidence.
6. What are the principles behind field triage in emergency situations?
7. What are the priority public health interventions given different types of disasters?
8. What are the principles and strategies in psychological first aid?

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Documentation, Recording and Reporting System

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INTRODUCTION

The common practice among nurses of “if it’s not documented, it is not done” has a legal and professional authority. More so, it is obligatory in the assurance of quality patient care. Documentation of nursing actions, patients’ progress and other relevant changes in health care outcomes must uphold safe, ethical and effective professional nursing practice.

Registered nurses are accountable to provide precise documentation in all health care settings to facilitate the application of prescribed standards of practice mandated by law to legally and ethically record nursing actions. Each professional nurse is expected to comply with required standards of documentation in a way that is comprehensive, precise, timely, truthful, legible, sequential and intelligent of relevant nursing observations.

This module aims to provide vital components of nursing documentation. It discusses basic elements that will guide the nurse in written or electronically prepared records/reports, and it will familiarize them on the documentation policies, standards and protocol indispensable for quality nursing care.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS that applies on documentation.
2. Select learning activities that will enable the learners to implement the NNCCS on documentation.
3. Apply nursing practice tools, guidelines and/or frameworks on documentation.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in documentation.
5. Demonstrate how the achievement of specified competencies of the NNCCS on documentation will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on documentation.

TOPIC OUTLINE

1. Overview of Documentation
2. Characteristics
3. Cardinal Principles

4. Guidelines in Documentation
5. Confidentiality
6. Ethical and Legal Aspects of Documentation
7. Methods and Systems used for Documentation
 - 7.1. Patient Medical Record
 - 7.2. E-health Record
8. Methods of Documentation
9. Reporting System
 - 9.1. Kardex
 - 9.2. FDAR

MODULE CONTENT

1. OVERVIEW OF DOCUMENTATION

Definitions:

Documents are permanent legal records that provide a comprehensive sequential description of relevant facts, data, and information about the patient's health status. These are compiled either printed or electronically to serve as evidence of care provided by physicians and nurses that are authorized to prescribe medications and treatments to their assigned caseloads.

Documentation of nursing actions done to a patient is critical to determine if the expected standard of care was rendered to a particular patient. Failure to chart in the medical record of specific nursing actions, omissions of important information and poor communication of significant changes in patient's status are unacceptable nursing practice.

The **Medical Record**, is also called as the patient's chart, holds vital information and pertinent data regarding the health status of the patient as they happened where it happened.

The **Nurse** must be mindful at all times that proper documentation is **important** because it:

1. Facilitates interdisciplinary communication within the health care team assigned on different shifts;
2. Coordinates care through the information provided in each record;
3. Provides information for quality assurance and peer review programs;
4. Serves as bases for reimbursement from third-party payers (i.e., PhilHealth);
5. Reflects quality and timeliness of nursing care as revealed in the patient's record;
6. Is utilized as legal document during permissible courtroom events to show quality and quantity.

Table 6.1

NNCCS on Ensuring Completeness, Integrity, Safety, Accessibility and Security of Information

Responsibility 3

Maintains complete, accurate and up-to-date recording and reporting system

COMPETENCIES

PERFORMANCE INDICATORS

3.1. Ensures completeness, integrity, safety, accessibility and security of information

1. Conforms to documentation standards.
2. Documents data on client care clearly, concisely, accurately, and in a timely manner.

COMPETENCIES	PERFORMANCE INDICATORS
	3. Utilizes systems, processes, methods and tools to maintain integrity, safety, accessibility and security of information.

2. CHARACTERISTICS OF GOOD DOCUMENTATION

Nursing documentation requires precise, accurate, and honest description of what and when events occurred, as well as who provided the care. Good documentation has six (6) important characteristics. It should be:

- Factual - concerns with the actual case scenario rather than interpretations or reactions on the incident;
- Accurate - presents exact and correct details pertaining to the incident;
- Complete - contains all the necessary important information that are appropriate;
- Current (Timely) - information that are timely and are presently happening;
- Organized - arrange according to particular order that contributes to efficient and effective management;
- Compliant with standards - dutifully follows specified protocols (Potter & Perry, 2010 p212).

These core principles of nursing documentation apply to every type of documentation in every practice setting.

3. CARDINAL PRINCIPLES

The Medical society of the District of Columbia, USA presented ten **(10) Principles of Documentation for Medical Records**.

1. The medical record should be complete and legible;
2. The documentation of each patient encounter should include:
 - the date;
 - the reason for the encounter;
 - appropriate history and physical exam in relationship to the patient's chief complaint;
 - review of lab, x-ray data and other ancillary services, where appropriate;
 - assessment; and
 - a plan for care (including discharge plan, if appropriate)
3. Past and present diagnoses should be accessible to the treating and/or consulting physician.
4. The reasons for and results of x-rays, lab tests and other ancillary services should be documented or included in the medical record.
5. Relevant health risk factors should be identified
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient non-compliance, should be documented.
7. The written plan for care should include, when appropriate:
 - treatments and medications, specifying frequency and dosage;
 - any referrals and consultations;
 - patient/family education; and
 - specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or the treatment, including through processes and the complexity of medical decision-making as it relates to the patient's chief complaint for the encounter.

9. All entries to the medical record should be dated and authenticated.
10. The specific claim form should reflect the documentation in the medical record.

Activity 1: Chart Audit

Competency:

- 3.1. Ensures completeness, integrity, safety, accessibility and security of information

Directions:

1. Facilitator will get actual patients' records from the Record Section of the hospital;
2. Group learners into three (3) or five (5) members each;
3. Give each group one (1) actual patient record;
4. Ask learners to list down ALL observations on the documentations done by the different members of the health team in the assigned patient's chart. Use the Characteristics of Good Documentation and the Cardinal Principles of documentation;
5. Give learners enough time to review records and be ready for group presentation.

4. GUIDELINES IN DOCUMENTATION

1. Objective/Factual Documentation

Direct observations and objective descriptions of interventions rendered to clients are recorded. Data are entered accurately, completely, and objectively including unintentional errors or any inaccuracy must be recorded properly.

2. Timeliness

Refers to completion of health care notes immediately within time specific care is rendered which reflects credibility and accuracy of health records.

3. Use of Space

Empty lines or spaces are avoided to prevent late-entry of data. Institutional policy on how to manage blank spaces such as writing "Not applicable" or "N/A" should be observed rather than leaving a space blank.

4. Use of Abbreviations

Abbreviations or acronyms that are internationally/institutionally accepted are the only ones used in the unit and that error-prone abbreviations must be eliminated.

5. Follow-up

All follow-up activities related to client care such as assessments, observations or interventions or other follow-up action taken, and the client's response to interventions should be documented on the client's health-care record.

6. Correcting Errors

In isolated cases when errors in documentation are committed it is advised that the SLIDE rule (Baker, 2000) be utilized. The steps of the SLIDE rule includes: cross through the word(s) with a

single line, and insert your initials, along with the date and time the correction is made; then enter the correct information/explanation. Some agencies require that the correction is highlighted by using an arrow or asterisk. Check the agency/facility policy for the accepted means of correcting errors, as some require that words such as “health-care recording or documentation error”, “error”, “mistaken entry” and “void” are included with your initials.

7. Recording Medication Administration

Administration of medications are immediately documented after administration in order to prevent medication errors and promote patient safety. Nurses are expected to document medications they personally administer. In the event another member of the health care are to administer drugs prepared by the nurse, there must be existing institutional policy that must be observed.

8. Recording Assistance with Care

There are numerous circumstances that one nurse is assisted by another nurse in performing a specific nursing intervention, in this event the nurse providing care must document the presence of the other nurse who assisted her in the report. It is not necessary to give the name of the nurse but in critical incidents like falls it is necessary to provide the names of those present.

9. Designated Recorder in Emergency Situations

During emergency situations there must be a designated recorder that identifies the people involved and the care they provided. This is to promote efficiency in delivering required care during emergency situation.

10. Clarification of Orders

Medical orders that are poorly written require nurses to call the writer for clarification. High risk for error and potential for an unsafe practice are evident. A written record of every telephone call should be maintained, whether it is with another care provider for clarification of orders, or with a client following discharge from your facility or unit.

11. Recording a Telephone Conversation with a Client

Telephone conversation with a client does not give the nurse the benefit of verifying objective findings. The hospital record must reflect the date, year and time of the call, the nature of the call, the response by the nurse and all significant health care advice provided to the client.

12. Interactions with other Health-care Professionals

It is the responsibility of the nurse when formulating nursing care plans to include outcomes of agreed upon plan of action and the names of the people involved. All health-care professionals are responsible for documenting the care they provided or the actions taken. The system used should record all interactions with members of the health-care team, including clarification of orders, failed attempts to reach other team members, and the follow up action taken.

13. Client Education

Educational interventions and related health teachings that provide comprehensive information to clients must be documented. It promotes clear communications on a daily basis, of the scope and

depth of health information provided to the client. It also reflects the nursing care provided by the nurse and what other members of the health team can contribute to improve the status of the client.

14. Documenting an Incident in the Health-care Record

It is imperative that all incidents that occurred with its corresponding pertinent data are documented in the client's health record. Prescribed protocol on documenting these types of incidents are to be followed in order to provide clear resolutions.

The following suggestions provide guidance on how to complete documentation regarding an incident:

- Be concise, accurate and objective.
- Record what was seen, and describe the care provided, who else was involved and the client's (person's) condition.
- Do not try to guess or explain what happened (e.g., the RN should record that side rails were not in place, but should not write that this was the reason the client fell out of bed).
- Record the actions taken by other health-care providers at the time.
- Do not blame individuals in the documentation.
- Always record the full facts.

F-DAR

F-DAR is a form of focus charting which includes Data, Action and Response. It describes the focus of action in a structure format that shows patient assessment, nursing actions taken by the health care professional and the response of the client to specific interventions.

Data must show the subjective and objective assessment of the client's status; it must support the described observations of a significant finding; **Actions** are immediate or later actions that are carefully planned according to the evaluation of presenting data; **Response** is the clear description on the client's reactions or development related to the interventions done. It also shows degree of well being outcomes after specific nursing interventions.

It is important that **F-DAR** are written in a way that is: Objective, Precise, Specific and Thorough.

Table 6.2	NNCCS on Adhering to Protocol and Principles of Confidentiality in Safekeeping and Releasing Information	
COMPETENCIES	PERFORMANCE INDICATORS	
3.2. Adheres to protocol and principles of confidentiality in safekeeping and releasing of records and other information.	1. Maintains confidentiality in the safekeeping of records and other information. 2. Releases records and information based on protocol and principle of confidentiality.	

5. CONFIDENTIALITY

Health care personnel are obligated to maintain confidentiality in dealing with all information pertaining to patient's hospitalization and care provided to each one of them. Discretion in the access, retrieval, transmittal and storage of relevant documents and safe-keeping of all copies of valuable health records must be maintained at all times at all costs. Availability of various forms of technology must not change nor disregard this fundamental patient's right to privacy of health information.

6. ETHICAL AND LEGAL ASPECTS OF DOCUMENTATION

6.1. Ethical

(Please refer to Article III Numbers 3 & 4 of the Code of Ethics of the Filipino Registered)

6.2. Legal Implications of Documentation

1. The patient's health-care record is an important legal document.
2. It must contain the following:
 - accountability and the provision of care/treatment
 - database used to resolve questions/concerns about care
 - chronological record of events involving patient care and hospital stay
 - nursing care rendered
3. It is intended to:
 - refresh the nurse of situations that are required to give evidence in court
 - reconstruct events
 - establish times and dates
 - resolve conflict in testimony, and
 - show that standard of care and reasonable and prudent care was provided.
4. Correcting errors in charting/documentation:

Activity 2: Case Analysis

Competency:

3.2 Adheres to protocol and principles of confidentiality in safekeeping and releasing of records and other information.

Case:

Ms. CG, a 28-year-old sexual worker, went to a Dr. X due to a lump she felt at the upper outer quadrant of her right breast. After careful examination Dr. X told CG that she needs to undergo a biopsy. Informed consent for the procedure was given by CG after mentioning to Dr. X that she is HIV positive and would like to keep her status **strictly private**. Dr. X noted Ms. CG's status by placing a red plus sign in her chart which is part of the hospital protocol.

After an uneventful procedure the biopsy revealed benign breast carcinoma. Ms. CG was advised to undergo surgery but eventually discharged due to lack of financial resources. However, 4 weeks after, Ms. CG went back to Dr. X to have the procedure but she noticed that all the medical and hospital staff were uneasy when she's around and preferred not to entertain her request. Later that day, CG complained to the hospital legal officer because her HIV positive status had become common knowledge in the hospital and among her friends in the community. The patient was charging that "somebody at the hospital leaked" this information. The hospital and Dr. X were sued by Ms. CG.

Questions:

1. Does Ms. CG have a legal right to sue the hospital and Dr. X? Why?
2. What documentation guideline was breached by Dr. X and the hospital staff?
3. As the nurse assigned to Ms. CG, how will you maintain confidentiality of her status?

7. METHODS/SYSTEMS OF DOCUMENTATION

Electronic documentation systems have emerged in recent years in response to changes in health-care delivery, and advanced technology has affected the expectations for documentation. Regardless of the

documentation system used, meticulous and accurate documentation is necessary to meet the obligations of registered nursing practice while minimizing legal involvement due to inaccurate or incomplete documentation.

Table 6.3 NNCCS on Implementing a System of Informatics in Health Care Delivery	
COMPETENCIES	PERFORMANCE INDICATORS
3.3. Implements system of informatics to support the delivery of health care.	1. Demonstrates competence in the use of informatics. 2. Utilizes appropriate, up to date and available system of informatics.

7.1. Client Care Provided Through Electronic Means

Today many agencies have moved towards electronic means of providing many aspects of care. From entering requests for tests and consultations to reporting of diagnostic testing, to the documentation of care provided, electronic documentation is part of the everyday care of clients.

“Online nursing documentation is defined as a technology that automates the capture of clinical care data. This can include assessment data, clinical findings, nursing plans of care, nursing interventions (along with results), patient progress towards goals, critical pathways, medication administration, risk assessments, discharge planning, patient education and more” (Kirkley & Renwick, 2003, p647).

Electronic documentation of care can also include, but is not limited to, faxes, e-mail and/or telenursing.

There are many benefits to electronic documentation such as:

- Time efficient for detailed assessments
- Standardization of assessments and care plans with the ability to customize as required
- Large amounts of data can be stored in a small space
- Information can be automatically transferred or “populated” to other areas of the chart
- Increased security such as password protected access to client charts.

Activity 3: Facility Tour

Competency:

3.2 Implements system of informatics to support the delivery of health care.

Directions:

1. Facilitator identifies a health institution using e-health recording;
2. Schedules a facility tour with group of students;
3. Sharing of experiences among students through creative presentation on the common e-health records they observed during the tour. If they can have simple hands-on opportunity it would be GREAT!

8. METHODS OF DOCUMENTATION

Efficient documentation methods provide solutions to what is appropriate in a particular care facility or organization. The most common forms of documentation are:

- a. Narrative

- b. Problem-Orientated Medical Record (POMR)
- c. Subjective Data, Objective Data, Assessment, Plan/Intervention, Evaluation, Revision (SOAP/IER)
- d. Plan, Intervention, Evaluation (PIE)
- e. Focus Charting (sometimes referred to as DAR)
 - Focus: Risk for infection related to incision sites
 - D:** Incision site in front of left ear extending down and around the ear and into neck--approximately six (6) inches in length--without dressing. Jackson-Pratt drain in left neck below ear secured in place with suture.
 - A:** Assessed site and emptied drain. Taught patient signs and symptoms of infection.
 - R:** No swelling or bleeding; bluish discoloration below left ear noted. Jackson Pratt drained 20mL bloody drainage. Patient states understanding of teaching.
- f. Charting by Exception (CBE)
- g. Graphic Sheets and Flow Sheets
- h. Electronic Health Records and Nursing Documentation

Electronic Medical Record or EMR/Electronic Patient Record or EPR and Electronic Health Record or EHR

It was during the late 1990's when electronic health records was introduced in the medical field but several medical projects using electronic recording in health care dated back in the 1950's. In the Philippines it was the Department of Health and the Philippine Medical Informatics Society (PMIS) who initiated numerous projects related to medical health recording in the country.

The terms EMR, EPR and EHR are used interchangeably to refer to electronic medical and nursing data source about the individual patient that are systematically collected in digital format that can be shared among and within the medical team through a network of information systems during and after hospitalization. This system of electronic recording captures accurate data, ensures huge volumes of information without any need of actual storage space for papers and logbooks.

The most common methods of electronic documentation for nurses are presented in Table 6.4.

Table 6.4 Descriptions of Terms Used to Discuss Electronic Records in Health Care	
ENTITY	DESCRIPTION
Healthcare Smartcard	The healthcare smartcard is a card, similar to a credit card, with a magnetic strip that either contains vital emergency healthcare information or creates a link to information in another location. Using the cardholder's pin number and entering the card into a reader enables emergency providers to retrieve designated, health-related information about a given patient. Individuals should always carry their PIN number with them to permit access in an emergency.
Electronic Health Record (EHR)	The EHR is the patient care record created when agencies under different ownership share their data. The goal is for this sharing to be nationwide, creating a situation in which a person's healthcare record is accessible by designated healthcare providers anywhere in the nation. The patient will decide which portions of a record will be available to whom.

ENTITY	DESCRIPTION
Electronic Medical Record (EMR)	An EMR is an electronic patient care record created by an agency or agencies having common ownership. Although these EMRs today are often called EHRs, they are not true EHRs because the data is not shared between providers in agencies under different ownership.
Electronic Database	An electronic database is an electronic collection of data that allows easy searching and easy retrieval of similar pieces of data from many records.
Data in the Aggregate	Data in the aggregate is a collection of a specific type of data, such as nursing diagnoses or medical diagnoses, from many different records.
De-identified Data	De-identified data is data from which all information that could identify the individual from whom the data was gathered is removed.

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i. The Hands-on Automated Nursing Data System (HANDS) Plan-of-Care Method

In order to answer the common concern of nurses on the currently existing doctor-oriented electronic documentation system, the HANDS method was introduced. The HANDS stands for Hands-on Automated Nursing Data System which was developed in the 1990s by the University of Illinois Chicago College of Nursing is an intervention continuously being improved to bring a strong patient focus to the medical record by replacing current forms of care plans with a single, standardized plan and related plan of care processes.

The method addresses the needs, uncovered in this chapter, for summary patient care information that is standardized, meaningful, accurate, and readily available to all clinicians involved in a patient's care across time and space. The HANDS method embodies the concepts and characteristics of high reliability organizations and as such is fixated on ensuring the continuity, quality, and safety of patient care.

Table 6.5 Technology Commonly Used by Nurses		
Direct Nursing Care Delivery Technology Barcode medication administration Intravenous (IV) tubing IV pumps Feeding pumps Nasogastric tubes Endotracheal tube Tracheostomy tubes Syringes Needles Urinary catheters and drainage bags Ostomy appliances Wound drainage tubes Chest tubes Suction equipment Oxygen and air regulators, tubing, and face masks Oxygen tanks and regulators Nebulizers Dressings (from gauze to specialized materials) Traction systems Code carts	Indirect Nursing Care Delivery Technology Robotics Radio frequency identification Electronic inventory systems Computerized staffing systems	Communication With People Distanced by Place and Time Electronic medical records Electronic ordering systems Communication devices (cell phones, PDAs, "Voicera," paging systems) Call systems, including emergency call bell
	Patient Protective Devices Floor mats Beds Elopement/wandering alarms Fall alarms Hip protectors Specialized mattresses (e.g., low air loss) Specialized lighting Hand rails in patient rooms, hallways, and bathrooms Specialized seating cushions Limb compression devices	Patient Assessment, Monitoring, and Surveillance Telemetry Bedside monitoring Ventilators Video surveillance Stethoscope Sphygmomanometer Thermometer Otoscope Ophthalmoscope Pulse oxymetry
Patient Assistive Devices Canes Walkers Robotics Stand assist lifts Trapeze bars Patient transfer devices ECD Bed pans Wheelchair Prosthetic limbs Orthotics (braces, shoes)	Nurse Protective Devices Face masks Gloves Gowns Hand sanitizer dispensers Mechanical lifts Patient transfer devices	Remote Patient Monitoring Telemedicine and telehealth
	Continuous Learning Distance learning Video conferencing Online training	Pattern Identification (To learn from errors and systems influences on adverse events) Electronic medical records Workload and staffing data systems

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9. REPORTING SYSTEM

- 9.1. Kardex
- 9.2. Change of Shift Report (Hand-over)

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Collaboration and Teamwork

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INTRODUCTION

The 2012 National Nursing Core Competency Standards (NNCCS) promulgated by the Professional Regulatory Board of Nursing Resolution No.24 Series of 2012 emphasized the three (3) Roles of the Nurse: Beginning Nurse's Role on Client Care, Beginning Nurse's Role on Management and Leadership and Beginning Nurse's Role on Research. In each of these roles are responsibilities expected of every professional nurse and the needed competencies in order to perform their tasks.

Specifically, one of the beginning nurse's role is the development of the competencies on establishing collaborative relationship with colleagues and other members of the health team to enhance nursing and other health care services provided to individual, family, population group and community.

One of the Learning Outcomes of the Bachelor of Science in Nursing program is to work effectively in teams in collaboration with other disciplines and multi-cultural teams in order to provide effective nursing care services to clients, both in hospital and community settings.

In the same manner the achievement of Level 6 for the Bachelor's degree in the Philippine Qualification Framework (PQF), requires alignment of the educational outcomes to work requirements through development of a degree of independence that allows the graduates to work in collaboration with the teams of related field.

This module is intended to provide the master trainers with a ready to use training guide in the development of the competencies of the beginning professional nurses on establishing teamwork and collaboration in working with colleagues and other members of the health team.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on establishing collaborative relationship with colleagues and other members of the team to enhance nursing and other health care services.
2. Select learning activities that will enable the learners to implement the NNCCS on establishing collaborative relationship with colleagues and other members of the team to enhance nursing and other health care services.
3. Apply nursing practice tools, guidelines and/or frameworks on how to implement approaches to

enhance the capability of the care providers to participate in decision making by the inter-professional team.

4. Utilize teaching-learning strategies that will develop the learner's critical thinking and decision-making skills in establishing collaborative relationship with colleagues and other members of the team that will enhance nursing and other health care services.
5. Demonstrate how the achievement of specified competencies of the NNCCS on collaboration and teamwork will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on collaboration and teamwork.

CRITICAL THINKING IN INQUIRY-BASED APPROACH TO NNCCS

The development of critical thinking skills demands varied teaching-learning strategies. There are suggested activities and references at the end of this module which can be of help to the trainers.

The Trainer is advised to review Module 4 on Ethical Decision-making Model and the module on Competencies on Developing Working Relationship with the Client. These will serve as entry competencies for this module.

After focusing on the client, this time, it will be on establishing teamwork and collaboration with colleagues and other members of the health team and related agencies in the community. Provide opportunities to participate in activities using structured learning experiences.

TOPIC OUTLINE

1. Importance of Collaboration and Teamwork in the provision of quality nursing care services
2. Development of Teamwork and Collaboration
3. Nurse's Role in establishing collaborative relationship in the delivery of safe and quality patient care
4. Approaches in developing the competencies of the care providers to participate in decision making by the inter-professional team.

Table 7.1

NNCCS on Collaboration and Teamwork

Responsibility 4

Establishes Collaborative Relationship with Colleagues and other Members of the Health Team to Enhance Nursing and Other Health Care Services

COMPETENCIES

PERFORMANCE INDICATORS

- 4.1. Ensures intra-agency, inter-agency, multidisciplinary and sectoral collaboration in the delivery of health care.

1. Maintains good interpersonal relationship intra-agency and inter-agency.
2. Respects the role of the other members of the health team.
3. Acts as a liaison /advocate of the client during decision making by the inter-professional team.

COMPETENCIES	PERFORMANCE INDICATORS
4.2. Implements strategies/ approaches to enhance /support the capability of the client and care providers to participate in decision making by the inter-professional team.	<ol style="list-style-type: none"> 1. Explores views of clients prior to decision making. 2. Uses strategies/ approaches to enhance / support the capability of the client to participate in decision making. 3. Supports the views of clients/ families and /or care providers.

MODULE CONTENT

1. IMPORTANCE OF TEAM AND COLLABORATION

Nurses perform their work with their conventional nursing work groups in a single unit or with different professionals at different job levels in an organization, whether it is formal or informal at different settings. The ability to collaborate and interact with the health care team may be difficult and challenging, but is essential to become more effective and efficient in the delivery of quality health care to the clients.

Katzenbach and Smith (1993) describe the **team** as a small number of people with complimentary skills who are committed to a common purpose, performance goals and approach for which they held themselves accountable.

Collaboration is defined as a joint communication and decision-making process with the goal of satisfying the health care needs of a target population. The basis of collaboration is the belief that quality patient care is achieved by the contribution of all care providers. A true collaborative practice has no hierarchy. It is assumed that the contribution of each participant is based on knowledge or expertise brought to the practice rather than the traditional employer/employee relationship (Archangelo, et al; p.106).

Values/Behaviors that facilitate collaborative practice, include:

- **Trust** among all parties establishes a quality working relationship that develops over time as the parties become more acquainted.
- **Knowledge** is a necessary component for the development of trust. Knowledge and trust reduces the need for supervision.
- **Shared responsibility** suggests joint decision making for patient care outcomes and practice issues within the organization.
- **Mutual respect** for the expertise of all members of the team is the norm. This respect is communicated to the patients.
- **Communication** that is not hierarchic but rather two-way facilitating sharing of patient information and knowledge. Questioning of the approach to care of either partner cannot be delivered in a manner that is construed as criticism but as a method to enhance knowledge and improve patient care.
- **Cooperation and coordination** promote the use of the skills of all team members, prevent duplication, and enhance productivity of the practice.
- **Optimism** that this is the most effective method of delivery of quality care promotes success.

The health care team is a group of professionals with different competencies, roles and responsibilities who need each other's contribution to achieve effectiveness and quality patient care. The **interdisciplinary health care team** work together as an identified unit or system whose members consistently collaborate to

provide solutions to health care problems of the clients in hospital or in community settings, which may be too complicated to be solved by one discipline. The **multidisciplinary team** involves or combines several academic or professional disciplines, formal or informal groups that meet to accomplish a specific purpose.

Team structure can be seen as, in a hospital setting, for example, an attending physician requests the assistance of other professionals who communicate by writing reports and with informal conversation. On multidisciplinary teams, members practice independently of one another, each member being guided by his/her own professional standards but the leadership is determined by a profession hierarchy, usually the staff physician. In an inter-disciplinary team, members with a variety of expertise contribute, but on the another hand, they view the health care services provided in a different focus.

The interdisciplinary and multidisciplinary team collaboration involves contribution of different departments of their services and sharing of professional expertise of the different disciplines to achieve optimum health of the patient. The role of the nurse is to coordinate, communicate and document services provided by the team, as shown in the illustration below.

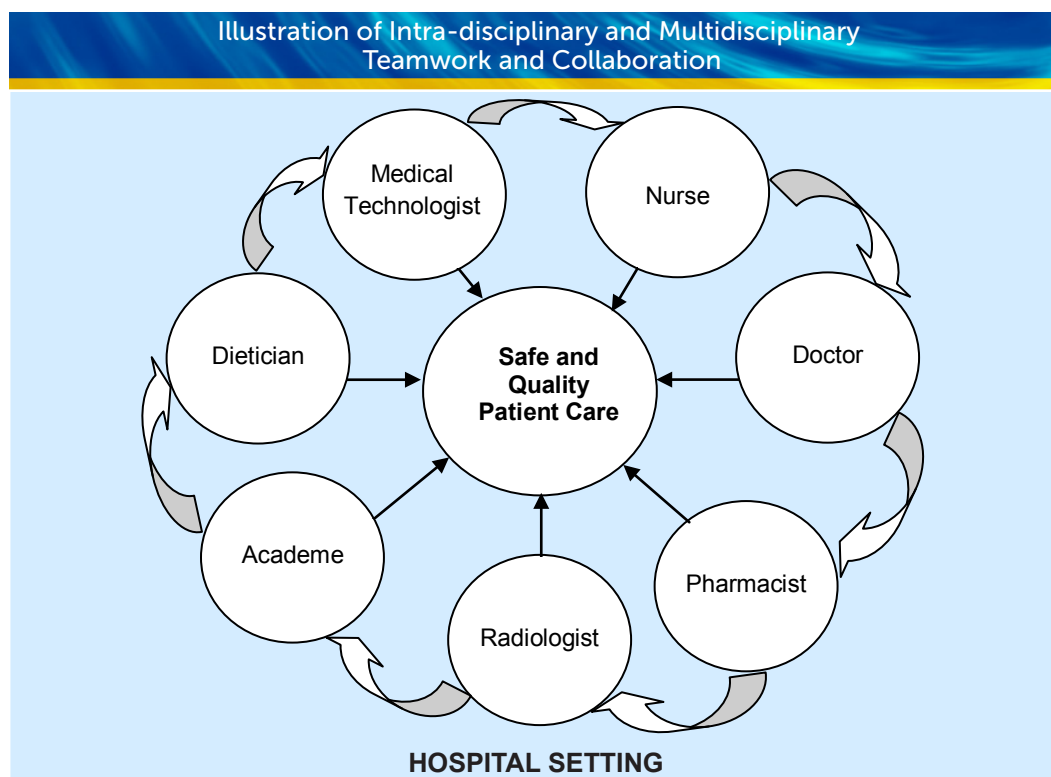


Figure 7.1 Illustration of Intra-disciplinary and Multi-Disciplinary Teamwork and Collaboration

In a community setting, the Intra-agency, Inter-agency, multidisciplinary and sectoral collaboration are important in the effective and efficient delivery of health services to the individuals, families, population groups and the community. The nurse is responsible in maintaining harmonious relationship within the health unit (intra-agency) and coordinating activities of the members of the health team (multidisciplinary) to ensure achievement of group goals. Collaboration with other government and non-government agencies (Inter-agency/ sectoral) contributes to the availability of needed resources, facilities and services provided to the community served.

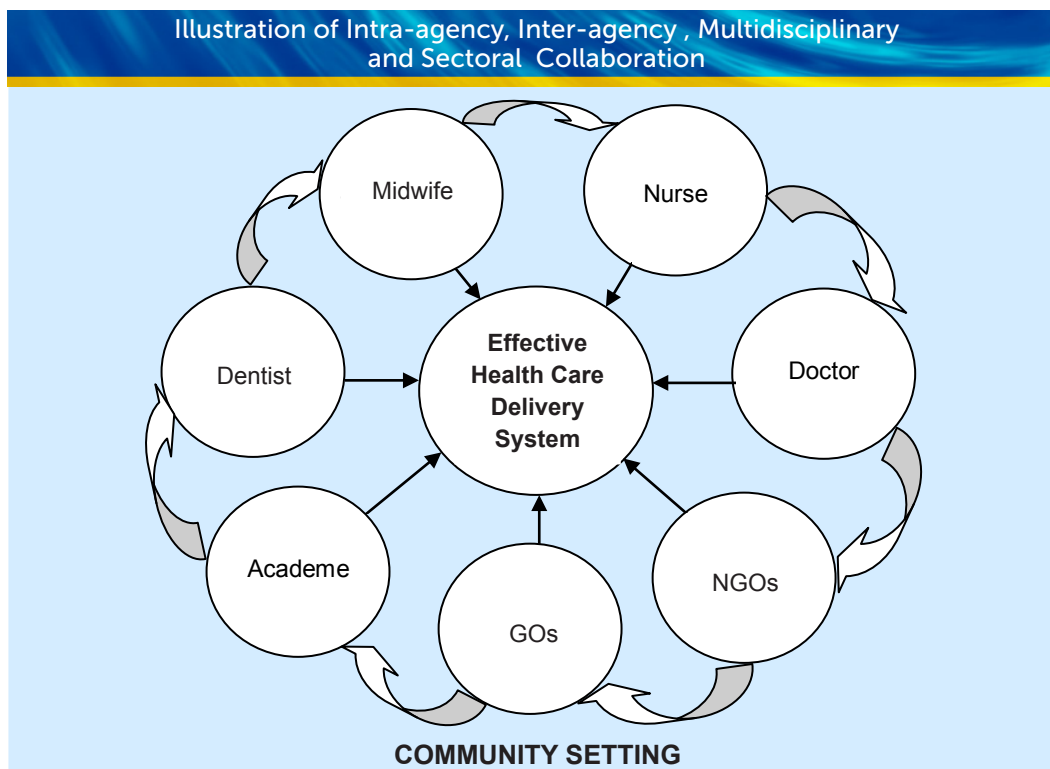


Figure 7.2 Illustration of Intra-agency, Inter-agency, Multidisciplinary and Sectoral Collaboration

2. DEVELOPMENT OF TEAMWORK AND COLLABORATION

The team also undergoes phases of development from immature stage to mature stage. Each stage of team development has its own characteristics with distinct forms of team leadership and team member behavior. A mature team that is fully functioning, where the members trust each other, easily makes decisions accurately.

Stages of Team Development

Tuckman proposed the Forming – Storming – Norming – Performing model of group development. According to him, all these stages are important and inevitable for a team to grow, face challenges and difficulties effectively and deliver positive results. The four stages of Team Development are as follows:

1. Forming

At this stage, the leader may seek control over the team and may exemplify styles such as “tyrant”, “superwoman”, “party host”, or “reluctant candidate”. Team members are also characterized by dependency-seeking behaviors and will most likely rely on the group leader. They may take on the roles of “Scapegoat” and “Helper”.

2. Storming

The leader tries to persuade the team and may use “salesman” and “nice guy” styles often struggling to be a socio-emotional leader. Resistance may be demonstrated by team members.

Despite persistence of Scapegoating among team members, new roles that help reduce tension may emerge. Examples of these new roles are “Hatchetman” vents resistance and the “clown”.

3. Norming

Coalitions of members exercise leadership based on previously demonstrated competence. Members have evolved into colleagues who are able to defer to each other’s relevant experience.

4. Performing

Authority is exercised by a coalition of colleagues. Team members exemplify interdependence. Whenever earlier styles (e.g. tyrant, host, etc.) emerge, they are immediately recognized and dismissed.

Web Resource

The Integration of Team and Group Development Theory adapted from Bennis & Shepard (1956), Tuckman & Jensen (1977), Farrell, Heinemann & Schmitt (1986), and Drinka (1991) can be accessed through the online resource below.

Tools for Facilitating Health Care Teamwork. (n.d.). In *Regional Geriatric Program of Toronto*. Available at <http://rgp.toronto.on.ca/PDFfiles/teamworktools.pdf>.

Tools for Facilitating Health Care Teamwork

Working together does not necessarily produce effective teamwork. Here is a simple outline that will guide in the understanding of the process of developing health care teamwork. Analysis of informal roles provides another useful tool for understanding the team process. There are three (3) broad sets of informal roles:

- A. **Task roles** that are necessary for accomplishing the team’s task. These roles are as follows:
 1. Initiating/energizing
 2. Information/opinion giving
 3. Information/opinion seeking
 4. Reality testing/clarifying
 5. Coordinating
 6. Orienting
 7. Procedural Technician
- B. **Maintenance roles** which help the team function as a team. Maintenance roles are:
 8. Harmonizing
 9. Gatekeeping
 10. Encouraging
 11. Following
 12. Climatizing
- C. **Individual roles** in which a team member attempts to satisfy individual rather than team goals. A team is most productive when all three (3) sets are managed simultaneous. Individual roles are:
 13. Blocking/Aggressing
 14. Out of field
 15. Digressing

3. NURSE'S ROLE IN ESTABLISHING COLLABORATIVE RELATIONSHIP IN THE DELIVERY OF SAFE AND QUALITY PATIENT CARE

1. Maintains good interpersonal relationships intra-agency and inter-agency.
2. Respects the role of other team members.
3. Acts as a liaison/advocate of the client during decision making by the inter-professional team.

Interpersonal Relationship Defined:

The term **Interpersonal Relationships** refers to reciprocal social and emotional interactions between two or more persons in an environment and who share common interests and goals.

Importance of Interpersonal Relationship for Nurses:

1. Helps build positive functional multidisciplinary team.
2. Improves intra and/or inter-team communication, coordination, and cooperation
3. Builds mutual understanding and cooperation
4. Facilitates better understanding of oneself
5. Improves decision making and problem-solving

In order to maintain good interpersonal relationship in working with a team to achieve its goal of providing safe and quality patient/ client care, it is also important for the nurse to appropriately respond to conflict situations. In the process, conflict may occur within the individual (intrapersonal), between two or more individuals (interpersonal), and between one or more groups (intergroup).



Figure 7.3 Categories of Conflict

Conflict is a disagreement among people involved that results from differences in ideas, values, or feelings, differences in economic and professional values, poorly defined role expectations and when there is competition among the professionals themselves. Filley (1975) proposed three strategies in dealing with conflicts.

- a. Win - lose strategy
 - Majority rules. One party wins over the other by means of dominance, usually by power of authority. The other party submits and loses.
- b. Lose - lose strategy
 - Both parties involved are not satisfied with the settlement. Hence, neither of the parties wins.
- c. Win - win strategy
 - Needs of both parties are addressed and satisfied.

In dealing with conflicts, (Tomey 2004:p.153), here are some helpful strategies, choosing what is the best strategy depends on the situation and the person involved:

1. Do not blame anyone for the problem.
2. Focus on the issues, not the personalities.
3. Protect each party's self-respect.
4. Facilitate open and complete discussion of the conflict.
5. Give equal time to each party.
6. Encourage the expression of both positive and negative feelings.
7. Encourage each party to listen actively and try to understand the other person's point of view.
8. Help develop alternative solutions.
9. Summarize key points and plans.
10. Later follow-up on the plans and give positive reinforcement as appropriate.
11. Facilitate further problem-solving as necessary.

Team Culture and Inter-Team Collaboration

One of the responsibilities of the nurse is to respect the role of other team members. Teams have their own characteristic individual culture – sets of norms, beliefs, values, traditions and behaviors. In general, such culture can mean teams can be divided into:

- Power focused teams
- Role focused
- Task focused
- Person focused
- Customer focused

It is important to determine the focus of the team since this may affect the goal of providing quality patient care. Having more than one focus is not necessarily detrimental to the team's provision of health care as long as the improvement of patient care, or the provision of the best possible care, remains the goal. (Anderson, 1996).

4. STRATEGIES/APPROACHES TO ENHANCE/SUPPORT THE CAPABILITY OF THE CLIENT AND CARE PROVIDERS TO PARTICIPATE IN DECISION-MAKING BY THE INTER-PROFESSIONAL

1. **Decision-making** is a behavior exhibited in making a selection and implementing a course of action from alternatives. It may or may not be the result of an immediate problem. **Problem-solving** is the process of identifying possible courses of action or alternatives that will alleviate a problem. Both decision-making and problem-solving use critical thinking. **Critical thinking** was defined as thinking while you are thinking in order to make you thinking better. It is described as purposeful, outcome-directed thinking that aims to make judgments based on scientific evidence rather than tradition or conjecture or guesswork. **Critical thinking** involves metacognition, which means, examining one's own reasoning or thought process while thinking, a process that helps to strengthen and refine thinking skills. (Heidenthal, 2004:pp.224-225)

Below are the five steps for an effective decision-making process:

1. Identify the need for a decision.
2. Determine the goal or the outcome.
3. Identify alternatives or actions, with benefits and consequences of each.
4. Choose an alternative.
5. Evaluate the alternative chosen and check if the goal was achieved.

2. Demonstrate Skills in Resolving Difficulties/Conflicts in a Team Environment

- 2.1. Effective communication skills in a team environment
- 2.2. Decision-Making Process
- 2.3. Conflict Management Strategies

TEACHING-LEARNING ACTIVITY

1. Evocative Discussion by groups to differentiate the following:
 - Groups, Teams, Teamwork, Collaboration
 - Intra-disciplinary, Interdisciplinary and Multidisciplinary Collaboration
 - Critical thinking, Problem-solving, Decision-making
2. Practice sets on working with a team in the delivery of health care services to the patients/clients (individuals, family, population group and community).
3. Use of Checklist
4. Structured-learning experiences (SLEs) on teamwork and collaboration.

Sample SLE on Decision-Making: Round the World Trip

Instructions:

1. The participants count off 1-3 and those who have the same number form a group and each group sits in a circle.
2. Each group is given a Problem Situation Sheet
3. Each group is given 15 minutes to do the task.

Problem:

You and your groupmates are friends who share one ticket in a Contest. You have won the grand prize - a round-the-world trip for one person, all expenses paid. The prize cannot be encashed. Neither can any of you afford to pay the share of the others, so that only one of you can take the tour. Decide what to do with the prize. You have 15 minutes to come up with the decision or else the prize will be forfeited.

Processing:

A representative of each group reports the responses to the big group:

1. What was the initial reaction when you learned that only one of you can avail yourself of the valuable prize?
2. What was the decision of your group?
3. How did you arrive at the decision?
4. Who were the participants who helped in arriving at the decision? What did they do or say?
5. What factors seem to interact in group decision making?

Synthesis and Integration:

1. How can you apply the insights learned from this experience to your own work situations?
2. In collaboration with your team, what are the techniques or approaches that proved to be effective in making group decisions?

EVALUATION/SELF-ASSESSMENT QUESTIONS

1. You are part of the team promoting breastfeeding in your hospital, to what extent did the members of the team understand and accept the project goals and how did they contribute to the attainment

- of these goals?
2. What is your participation in the decision made by the team?
 3. Illustrate how teamwork and collaboration works in meeting the health needs of the community?
 4. Describe a most recent incidence of conflict in which you were involved. What steps did you take to resolve your conflict? Was this resolved successfully?

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Self-Mastery and Professional Growth

TERESITA I. BARCELO, RN, PhD

INTRODUCTION

Practice of nursing is both a privilege and a responsibility. It is a privilege a nurse gets upon passing the licensure examination and taking the oath of professionals. Likewise, it is a responsibility of the nurse to ensure that one's practice is safe, according to standards and based on current evidences of efficacy and efficiency. For one to remain professionally competent, there is a need for continual updating of one's knowledge and skills. Hence, it is incumbent on the professional nurse to continually update oneself.

For one to be successful in one's chosen field of practice in nursing, a good self-assessment is needed. What should a self-assessment look at? It should include a look at your values, interests, personality, and skills. For example you need to look at which values are more important to you to make you satisfied in your work like salary, autonomy, prestige of your chosen place of work, security and others. You also need to look at your motivations or drives for your work, what you enjoy doing and the like.

Career planning is needed so that you can determine what you need to do to be able to achieve your career goals. With a career plan you can assess what qualifications you need to have or possess to move up in your career ladder. You can identify the steps you need to take to be able to achieve your career goals.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on care of the childbearing woman as a client.
2. Select learning activities that will enable the learners to implement the NNCCS on the care of the childbearing woman as a client.
3. Apply nursing practice tools, guidelines and/or frameworks in the care of the childbearing woman as a client.
4. Utilize teaching –learning strategies that will develop in the learner critical thinking and decision making skills in the care of a childbearing client.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the care of the childbearing woman as a client will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on the childbearing woman as a client.

Table 8.1 NNCCS on Self-Mastery and Professional Growth	
Responsibility 5 Promotes Professional and Personal Growth and Development	
COMPETENCIES	PERFORMANCE INDICATORS
5.1. Assumes responsibility for lifelong learning, own personal development and maintenance of competence.	<ol style="list-style-type: none"> 1. Identifies learning needs/issues based on current and projected/future practice requisites. 2. Specifies lifelong learning plan/activities to address learning needs/issues based on current and projected practice requisites. 3. Obtains feedback from peers and other sources to augment one's assessment as basis of a learning plan. 4. Validates new knowledge that support and improve one's nursing practice competency. 5. Updates one's learning plan to maintain competence as a registered nurse.
5.2. Demonstrates continued competence and professional growth.	<ol style="list-style-type: none"> 1. Develops a career plan. 2. Undergoes training voluntarily for personal and professional growth. 3. Participates actively in professional activities 4. Complies with regulatory requirements for competence (e.g. CPE – Continuing Professional Education).
5.3. Engages in advocacy activities to influence health and social care service policies and access to services.	<p>In collaboration with a senior nurse:</p> <ol style="list-style-type: none"> 1. Identifies barriers to the well-being of clients. 2. Helps clients gain access to needed resources. 3. Negotiates relevant services on behalf of clients. 4. Identifies potential allies for confronting barriers to care. 5. Develops alliances with groups working for change. 6. Interprets data to show the urgency of change. 7. Analyzes the sources of political power and social influence within systems. 8. Utilizes conflict-resolution strategies to address resistance.
5.4. Models professional behaviour.	<ol style="list-style-type: none"> 1. Articulates the values and roles of nursing to the public. 2. Demonstrates consistently professional behaviour in words, actions and in relating with clients, colleagues, and the general public.

TOPIC OUTLINE

This module focuses on some essential concepts as exemplars for teaching the responsibility of the practitioner focusing on self-mastery and professional growth. Suggested teaching-learning methods as

well as evaluation methods to assess learners' achievement are included.

This module is not intended to provide the needed content on the major concepts of self mastery and professional development. However to assist you, as the trainer, on the content needed when teaching this module, references and additional content in soft copy are provided in the CD.

Self-Assessment Questions (SAQs) are intended for you, the learner ,as a self-check on one's learning from this module. Answers to the SAQ are also provided at the end of the module.

Annexes in the CD are provided to give the learner the needed content since not one book available in the local bookstores contains in full all these materials needed to expound on Responsibility No. 5 Practitioner: Self-Mastery and Professional Growth. As well, there are many online websites that the learner is directed to visit to enhance one's knowledge about the subject matter.

MODULE CONTENT

STRATEGIES FOR ENSURING PROFESSIONAL GROWTH AND SELF-MASTERY

There are strategies for continuing professional education, advocacy strategies and guidelines for professional behaviour. Below are some common strategies that a nurse can use to ensure one's professional growth and self-mastery.

1. Career Planning

Four-Step Career Planning Process

According to Dawn Rosenberg McKay, a known career planning expert, the career planning process can be summarized as:

- Knowing yourself
- Exploring possibilities
- Making choices
- Making it happen

She advises that you need to take your time to work your way through these four steps and don't make any decisions before thinking through 'knowing yourself' and 'exploring possibilities'.

2. Continuing Professional Education Strategies

- 2.1. **Formal:** graduate studies
- 2.2. **Non-formal:** short course training on specialty content according to one's interest/specialization
- 2.3. **Informal:** reading professional articles/books in print or online; participation in discussion groups among nursing colleagues/co-workers; active participation in meetings affecting the welfare of nurses and health; active membership in professional organizations like PNA (See Annex U LOI 1000) and specialty organizations; attendance in conventions, seminars, workshops and conferences of professional organizations in nursing and related disciplines.
- 2.4. **PRC Resolution 2013-774 Revised Guidelines for Continuing Professional Development Program for all Registered and Licensed Professionals** promulgated last July 26, 2013 (See

Annex V) contains a list of all possible sources of continuing professional development (CPD) units and activities that encourage lifelong learning. It also states that all regulated professionals need to earn 60 CPD units every three years and such units earned will be presented upon renewal of the professional's Professional Regulation Commission (PRC) ID.

3. Advocacy

One of the roles of a professional nurse is to be a patient advocate. To be an effective advocate, one must know the strategies for advocacy as well as the rights and obligations of the clients.

- 3.1. What and Why of Advocacy (See Annex W)
- 3.2. Advocacy Guidelines and Tools (See Annex W)
- 3.3. Strategies for Effective Advocacy
 - 3.3.1. Preparing for Action
 - 3.3.2. Getting in Touch
 - 3.3.3. Communicate
- 3.4. Strategies for Legislative Advocacy

Web Resources

Strategies for Advocacy. (2012). In *Indiana Association of Area Agencies on Aging*. Retrieved from <http://www.iaaaa.org/strategiesforadvocacy.asp>.

Effective Strategies for Legislative Advocacy. (n.d.). In *Durham's Partnership for Children*. Retrieved from <http://dpfc.net/GetInvolved/Documents/Strategies.pdf>.

As a patient/ client advocate, the nurse needs to be aware of the Patient's Rights. The Philippine Congress has attempted to legislate a Patient's Bill of Rights but has not been successful in approving one. Hence, in our setting at this time, we consider the following documents as useful references in addition to our own Code of Ethics for Nurses.

1. American Hospital Association Patient Care Partnership - This document has replaced the Patient's Bill of Rights often cited in our lectures.

Web Resource

The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities. (2003). In American Heart Association. Retrieved from www.aha.org/content/00-10/pcp_english_030730.pdf.

2. Philippine Medical Association (PMA) Patients' Rights and Obligations - Locally, in addition to our own Code of Ethics, this document promulgated by PMA is a good source of information that applies to our own setting. Many of our local hospitals have their own set of patient's rights and obligations. This document made by the PMA is more detailed and applies to almost all aspects of hospital care. (See Annex F)

GUIDELINES FOR PROFESSIONAL BEHAVIOR

Nurses are expected to observe professional decorum in the practice of their profession whether in education, nursing service or in community work. Sometimes, nurses forget how to behave in relation

to the client, co-workers, physician, colleagues and the public in general. This is why the Code of Ethics for Nurses has been promulgated by the Professional Regulatory Board of Nursing (PRBoN). Before the 1980s, the Philippines did not have its own Code of Ethics. Hence, we followed voluntarily the International Council of Nurses (ICN) Code of Ethics. Eventually in 1989 the PRBoN officially adopted the ICN Code of Ethics and in 1994, the PNA Code of Ethics was adopted by the PRBoN for the Filipino nurses. Our PRC Code of Ethics has undergone another revision in 2004 which is now currently being followed by our Filipino professional nurses.

In addition to the PRC Code of Ethics for Nurses, nurses working in the government sector also must abide by the Code of Conduct and Ethical Standards of Public Officials and Employees RA6713.

To prevent our nurses from losing their professional license, there is a need to emphasize the provision of the Philippine Nursing Act (Republic Act (RA) 9173) Section 23 Causes for Revocation or Suspension of License and Section 35 Prohibitions in the practice of nursing.

Nurses can also be victims of sexual harassment in the workplace. Hence, it is important to inform the nurses that there is a law that protects them from sexual harassment, RA6713.

SUGGESTED TEACHING-LEARNING STRATEGIES FOR THE LEARNERS

1. Self-analysis or self-assessment and career planning
2. Case analysis - Use real cases either from PRC/ local courts/ incident reports of local institutions (ensure anonymity). Identify measures to prevent this kind of errors in the future.
3. Interview of nursing leaders - Example: Interview of a nursing director/chief nurse/supervising public health nurse/dean of a college of nursing on institutional policies related to professional behavior, in-service education program, CPE programs.
4. Round Table Discussion (RTD) or debate on timely relevant issues affecting nursing
 - 4.1. Image of nurses and the nursing profession in the country
 - 4.2. Nursing migration and health status in the country
 - 4.3. Global shortage of nurses and quality of nursing education in the country
5. Field trip to PNA National HQ and interview incumbent National President or send a questionnaire via email to the PNA National President on the following topics
 - 5.1. Mission of PNA
 - 5.2. Programs for the general welfare and development of nurses
 - 5.3. Advocacies related to nurses welfare and nursing development if any

Submit a written report of the interview/questionnaire responses and include a personal reflection on your findings.

6. Attend a conference/seminar on nursing and health-related topics and share significant learning with colleagues in the work setting after.
7. Join a study tour to other hospitals/health facility/educational institution to bench mark how in-service program and/or continuing professional development program is/are implemented.

SUGGESTED EVALUATION METHODS FOR ASSESSMENT OF LEARNER COMPETENCIES

1. Analysis of Self assessment and career plans
2. Graded reports based on criteria or rubrics - video presentation, written report, essay
3. Graded discussion of case analysis based on rubrics or criteria
4. Written test using modified/situation-type multiple choice items
5. Re-entry plan after attending a training program with emphasis on how the unit can be improved or quality of nursing care enhanced or a re-entry plan to improve the in-service program or continuing education development program in your own institution after joining a study tour.
6. Conducting an Echo Seminar of the conference/seminar attended for the benefit of the colleagues who did not attend.

SELF ASSESSMENT QUESTION (SAQ)

1. What are the ways by which a professional nurse can obtain units for continuing professional development?
2. What strategies can be done to advocate for the passage of the Legislative Bill on Nursing Reform?
3. What teaching-learning strategies can be used to achieve competencies on self-mastery and professional growth?
4. What evaluation methods can be used to determine if the expected competencies on self-mastery and professional growth are achieved?

APPLICATION IN PRACTICE

Nursing is a dynamic profession affected by developments in the life sciences, legal and ethico-moral issues and pronouncements, socio-cultural determinants of health and many other dimensions affecting human life. Thus, we need to continuously update ourselves to ensure that we are abreast with these developments. Human Resource Development Departments need to provide their personnel with adequate training through seminars, workshops and conferences whether provided in-house or externally.

The Nursing Service Department must provide support for innovative ideas of their nursing personnel to motivate them to contribute to nursing development and improvement of patient care and services. Young nurses are quite ideal and many have ideas that they want to share. While, the senior staff nurses have been honed by experience and practice and their wisdom when combined with the fresh ideas of the young nurses can generate innovative techniques and strategies that can result to improved quality of patient care and patient satisfaction. Meetings of the nurses in the unit can be enhanced by including in the agenda sharing of new developments in nursing, health and the life sciences. Posting of professional articles that will benefit the staff nurses in a specific ward/unit/public health facility is a form of informal type of continuing professional education and should be encouraged by those in nursing management.

Training needs assessment should be done regularly and is an important means of involving the nurses in planning for their own continuing professional development. Nurses sent for advance training outside of the company/health facility should be required to develop a re-entry plan which can be presented and discussed with management for possible implementation or to echo what they have learned from the training program with their fellow nurses in the health facility/company.

Nursing service personnel in both private and government health facilities should be encouraged to actively participate in professional organizations like the PNA and specialty nursing organizations. Active

involvement in the affairs affecting the profession should be engaged in by every professional nurse. Professional organizations in nursing will only be as strong as their members. Hence, every nurse must take it upon one's self to get involved, stand up and be counted in issues affecting the profession.

Many times nurses are hesitant to act as a patient advocate because they don't feel confident of what to do to be able to help the patient. Updates on topics like patients' rights, universal health care, sick leave and maternity leave benefits, hospitalization benefits and other health-related topics are relevant topics for nursing conferences and fora.

ANSWERS TO THE SELF ASSESSMENT QUESTIONS (ASAQs)

1. What are the ways by which a professional nurse can obtain units for continuing professional development?

Answer:

- a. Formal means through graduate studies
- b. Non-formal means through short course training for specialization or leadership and management
- c. Informal means through attending professional lectures, seminars, conferences, reading professional articles with CPD credits
- d. Other means provided in the PRC Resolution 2013-774

2. What strategies can be done to advocate for the passage of the Legislative Bill on Nursing Reform?

Answer:

Advocacy Strategies:

- a. Build relationships. Get in touch with your elected officials. Who do you know is an elected or appointed official? Who do you know who knows someone? People are more likely to give "credit" to those they know and trust.
- b. Gather information. Read the paper, listen to news, ask questions or get information from your local associate
- c. Prepare. Think about the point you are trying to make so you can state it your own way.
- d. Communicate. Let your colleagues and friends know why they should care.

3. What teaching-learning strategies can be used to achieve competencies on self-mastery and professional growth?

Answer: As discussed in this module, some of these strategies are field trips or educational tours to benchmark with other health facility, educational institution or agencies; debates and round table discussions on relevant issues affecting nursing; interviewing nursing leaders; doing advocacy work; case analysis

4. What evaluation methods can be used to determine if the expected competencies on self-mastery and professional growth are achieved?

Answer:

1. Graded reports based on criteria or rubrics - video presentation, written report, essay
2. Graded discussion of case analysis based on rubrics or criteria
3. Written test using modified/situation-type multiple choice items
4. Re-entry plan after attending a training program with emphasis on how the unit can be improved or quality of nursing care enhanced or a re-entry plan to improve the in-service program or continuing education development program in your own institution after joining a study tour.
4. Conducting an Echo Seminar of the conference/seminar attended for the benefit of the colleagues

who did not attend.

REFERENCES

A. Online Resources

<http://www.job-interview-site.com/career-goals-examples-of-career-goals-and-objectives.html>
<http://www.iaaaa.org/strategiesforadvocacy.asp>
http://www.care.org/getinvolved/advocacy/tools/english_01.pdf
http://www.care.org/getinvolved/advocacy/tools/english_02.pdf
<http://www.planning.org/ncpm/advocacy/10strategies.htm>
<http://www.dpfc.net/GetInvolved/Documents/Strategies.pdf>

B. Relevant Laws (See Annexes)

RA9173 Philippine Nursing Act of 2002
 RA 6713 Code of Conduct and Ethical Standards for Public Officials and Employees
 RA 7877 Anti-sexual Harassment at work and education
 LOI 1000 Government agencies to support only PRC accredited professional organizations' conventions, conferences and to give priority to bona fide members of accredited professional organizations when hiring.

C. Relevant Professional Regulatory Board of Nursing Resolutions

BON Res. 220 s. 2004 Code of Ethics
 BON Res. 22 s. 2009 Adopting a national career progression program
 BON Res. 24 s. 2012 Revised National Core Competency Standards
 PRC Res. 2013-774 s. 2013 Mandatory continuing professional development

D. International Council of Nurses (ICN) Code of Ethics

BEGINNING NURSE'S ROLE ON LEADERSHIP AND MANAGEMENT

- Module 9.1: Leadership and Management in Safe and Quality Care (Hospital)
- Module 9.2: Leadership and Management in the Community: Safe and Quality Care
- Module 10: Nursing Leadership and Management in Safety and Accountability
- Module 11.1: Leadership and Management Skills in Delivering Health Programs and Services (Hospital Setting)
- Module 11.2: Leadership and Management in the Community: Effective Delivery of Health Programs and Services to Specific Client Groups
- Module 12.1: Managing a Nursing Service (Hospital)
- Module 12.2: Community-based Health Facility/Health Program Management in the Community
- Module 13: Staff Management
- Module 14: Networking, Linkage Building and Referral

Leadership and Management in Safe and Quality Care (Hospital)

ELSA V. CASTRO, RN, PhD

INTRODUCTION

In the fast changing health care environment, nursing service needs effective leaders who can understand change and take opportunities as they arise. Nurses need to be aware that each one needs and can be a leader even nurses providing direct care. During the past years, the nurse manager function has rapidly changed into a role with a greater authority and responsibility. Thus, in order to provide safe and quality health services, managers and healthcare professionals need to have a thorough knowledge and understanding of how to plan, organize, direct and control resources. Likewise, healthcare providers have to respond to patient demands for effective, integrated, high quality of healthcare services.

“The role of nurse manager is critical in the provision of effective and high quality care in any patient care delivery setting. This individual is actually the Chief Executive Officer (CEO) of that clinical area. She or he is accountable and responsible for patient safety and quality. This includes all of the nurse sensitive indicators recognized by regulatory and accrediting bodies, patient satisfaction, and financial performance. In addition, the nurse manager represents the direct caregiver voice at nursing leadership decision-making tables.” (Everett, 2012 AONE)

This module utilizes different teaching – learning activities that will promote critical thinking which will engage the trainees in an active learning process. Participants can benefit from strategies through their appreciation for the value of diverse learning.

This NNCCS training module intends to educate and develop nurse managers in terms of knowledge and competencies important to their crucial role in the health care delivery system in the country. This training module emphasizes the reflective/critical thinking and ethics-based reasoning and decision making.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the management and leadership skills to provide safe and quality care.
2. Select learning activities that will enable the learners to implement the NNCCS on management and leadership capabilities/skills on providing safe and quality nursing care.

3. Apply nursing practice tools, guidelines and/or frameworks on the nursing leadership and management on providing safe and quality nursing care.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in demonstrating leadership and management skills to providing safe and quality care.
5. Demonstrate how the achievement of specified competencies of the NNCCS on management and leadership capabilities/skills on providing safe and quality nursing care will be assessed with appropriate methods and tools;
6. State policies and actions necessary to facilitate implementation of the NNCCS on the leadership and management in providing safe and quality nursing care.

TOPIC OUTLINE

1. Demonstration of Leadership and Management Skills to provide Safe and Quality Nursing Care
2. Utilization of Health Resources
3. Establishing Healthy Working Environment for Health Workers
4. Creating a Safe Environment of Care

MODULE CONTENT

1. DEMONSTRATION OF LEADERSHIP AND MANAGEMENT SKILLS TO PROVIDE SAFE AND QUALITY NURSING CARE

Nurses are expected to exhibit their leadership and management skills at the workplace. These skills are geared towards rendering safe and quality nursing care. Likewise, the roles of nurses vary in any health care setting to accomplish tasks and performance of care for different clients in consideration with accountability and in accordance with the institution's policies, guidelines and procedure. Part of these responsibilities is having the ability to identify needs related with multiple interventions for client with co-morbidities and complex, rapidly changing health status.

Table 9.1.1 presents the list of performance indicators of the NNCCS on the utilization of strategies in managing multiple nursing interventions and the use of leadership and management skills in the care of patients. This denotes the machinery and fundamentals for increasing nurse managers' critical thinking skills and decision making focusing on the delivery of safe and quality nursing care.

Table 9.1.1	NNCCS on the Utilization of Strategies in Managing Multiple Nursing Interventions	
Responsibility 1	Demonstrates Management and Leadership Skills to Provide Safe and Quality Care	
COMPETENCIES		PERFORMANCE INDICATORS
1.1. Utilizes appropriate and efficient methods/ strategies/tools to manage multiple nursing interventions for clients with co-morbidities, complex and rapidly changing health status with consultation as needed.		<ol style="list-style-type: none"> 1. Identifies needs/concerns/issues related with multiple interventions for clients with co-morbidities and complex, rapidly changing health status. 2. Specifies required tasks, activities and staff to handle/address these needs, concerns, issued based on the priorities and objectives of care.

COMPETENCIES	PERFORMANCE INDICATORS
	<ol style="list-style-type: none"> 3. Delegates the tasks and activities based on staff competencies. 4. Checks/keeps track of results/outcomes of delegated tasks. 5. Analyzes results/outcomes of care with nursing and health care team members. 6. Modifies methods/strategies to address gaps, deficiencies, and/or emerging problems in partnership with the team.

Modalities of Nursing Care

This refers to the manner in which nursing care is organized and provided. It depends on the philosophy of the organization, nurse staffing and client population. (<http://nursingcrib.com/nursing-notes-reviewer/fundamentals-of-nursing/modalities-of-nursing-care/>)

Functional Nursing

It is a system of care that concentrates on duties. It can be seen as an “assembly line” of care. The registered nurse (RN coordinates) cares for an entire unit or team. Other nurses are assigned to pass medications and perform treatments. Personnel with less training are assigned to provide more basic care such as bed bath and bed making. It began during the World War II when the demand for client care outstripped the supply of nurses. (Black and Hawks, 2008)

Primary Nursing

It is a model of care delivery that emerged during the 1980's to meet the increasing complex needs of clients. The goal is for each client's care to be comprehensive and coordinated, from the admission to discharge. Each client is assigned to a primary nurse, who is an RN, and that the nurse provides care for that client when he or she is working. Advantages are: the client has the same nurse, the client's psychosocial needs can be met, communication with the physician improves and the nurse feels autonomous. (Black and Hawks, 2008)

Team Nursing

In team nursing, the RN works with one or more health care personnel to provide care for four or more clients. Advantages are that an RN is usually head of the team and generally knows the clients. In addition, the team leader can provide guidance to new or inexperienced nurses and other staff. (Black and Hawks, 2008)

Case management

It is a care delivery model that incorporates concepts of continuity and efficiency in addressing both long and short-term physical needs, psychological and social needs of clients. The primary goals are promoting self-care, upgrading the quality of life and using resources efficiently. Case managers are nurses who coordinate care of a group of clients, monitor the implementation of interdisciplinary care plans, and maintain communication with third party payers and referral sources. The nurse follows the client through the entire stay in the health care system and back into the community. (Black and Hawks, 2008)

Case Method

It is the oldest patient care delivery method. In this method one professional nurse assumes total responsibility of providing complete care for one or more patients (1-6) while she is on duty. This method is used frequently in intensive care units and in teaching nursing students.

(http://faculty.ksu.edu.sa/Hanan_Alkorashy/Nursing%20management%20489NUR/10._Patient_Care_Delivery_System.pdf)

Total Patient Care

It is the oldest of the care delivery systems. One nurse is assigned to one client and provides all care. The one-to-one pattern is common in critical care, with student nurses, and with private duty nurses. The advantage is that the client needs to work with only one nurse and that one nurse can focus on meeting all the biopsychosocial needs of the client and the family. (Black and Hawks, 2001)

Suggested Teaching-Learning Strategies

- Lecture Discussion
- Role Playing on Different Modalities of Nursing Care

Recommended Resources

- Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.
- Marquis, B. L., & Huston, C. J. (2006). *Leadership roles and management functions in nursing: Theory and application*. Philadelphia: Lippincott Williams & Wilkins.
- Roussel, L. & Swansburg, R.C. (2006). *Management and Leadership for Nurse Administrators*. (4th Edition). Burlington, MA: Jones & Bartlett Publishers.

2. UTILIZATION OF HEALTH RESOURCES

This course is a presentation of health and economics combined together for the utilization of the health sector. Micro health economics focuses more on the behavior of individuals and firms while Macro focuses on the systems structure and complex processes between components that may affect national health system. Every topic and issue under this course is important in rendering safe and quality nursing care in the country.

Table 9.1.2 presents the different competencies which should be mastered by all master trainers and embedded in “end-learner/user”. Theories that will be discussed are expected to provide huge impact on managers’ analysis and may greatly influence health decision making. Through this framework the master trainers and learners will be able to understand how the Philippines Health system is structured. Further, nurse managers across the country will be able to work and provide globally acceptable quality nursing care by working within their means and making every plan possible by utilizing available resources. This also includes topics and performance indicators in ensuring and strengthening the awareness on the importance of effective communication and system management among nurse managers.

Table 9.1.2 NNCCS on Coordinating Care by Organizing and Prioritizing Resources	
COMPETENCIES	PERFORMANCE INDICATORS
1.2. Coordinates care by organizing and prioritizing use of human, material, financial and other resources to achieve expected health outcomes.	<ol style="list-style-type: none"> 1. Identifies appropriate and efficient methods and tools to organize and prioritize use of human, material, financial and other resources. 2. Utilizes cost effective strategies. 3. Participates actively in the creation of a preventive maintenance program to ensure proper function of equipment. 4. Adopts measures to work within the budget allocation without compromising related principles and standards.

Health Economics

Health economics is used to promote health through the study of health care providers, hospitals and clinics, managed care and public health promotion activities. Health economists apply the theories of production, efficiency, disparities, competition, and regulation to better inform the public and private sector on the most efficient, or cost-effective, and equitable course of action. Such research can include the economic evaluation of new technologies, as well as the study of appropriate prices, anti-trust policy, optimal public and private investment, and strategic behavior.

Health economics can also be used to evaluate how certain social problems, such as market failure and inequitable allocation of resources, can impact on the health of a community or population. Health economics can then be used to directly inform government on the best course of action with regards to regulation, national health packages, defining health insurance packages and other national health programs. (<http://www.jhsph.edu/departments/international-health/global-health-masters-degrees/master-of-health-science-in-health-economics/what-is-health-economics.html>)

Suggested Teaching-Learning Strategies

- Lecture on different topics concerning Health Economics focusing on Nursing Service department
- Small group discussion and design a plan or scheme of benefits acceptable to institutional policies.

Recommended Resources

Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.

Getzen, T.E. (2004). *Health Economics: Fundamentals and Flows of Funds*. (2nd ed.). Massachusetts: John Wiley & Sons.

Philippine Statistics Authority – National Statistical Coordination Board: www.nscb.gov.ph

What is Health Economics?. (n.d.). In *John Hopkins Bloomberg School of Public Health*. Retrieved from <http://www.jhsph.edu/departments/international-health/global-health-masters-degrees/master-of-health-science-in-health-economics/what-is-health-economics.html>

WHO Statistical Information System: www.who.int/whosis/en/.

3. ESTABLISHING HEALTHY WORKING ENVIRONMENT FOR HEALTH WORKERS

Harmonious and collegial relationship among members of the health team for effective, efficient and safe client care is a crucial factor in the delivery of care.

It focuses on the utilization of various avenues for open communication, strategies, and approaches for conflict resolution for health team members with the 2-Challenge Rule (CUS and DESC).

Table 9.1.3 states the performance indicators in maintaining a harmonious and collegial relationship among healthcare team. This includes performance indicators on ensuring and strengthening the awareness on the importance of effectual communication and system management among nurse managers as vital factor in providing safe and quality nursing care.

Table 9.1.3	NNCCS on Establishing Healthy Working Environment for Health Workers
COMPETENCIES	PERFORMANCE INDICATORS
1.3. Maintains a harmonious and collegial relationship among members of the health team for effective, efficient and safe client care.	<ol style="list-style-type: none"> 1. Utilizes various avenues for open communication. 2. Listens to suggestions and recommendations. 3. Specifies conflict resolution strategies/ approaches to resolve/transform conflict situations. 4. Helps health team resolve differences or areas of conflict by emphasizing concerns about specific situation or action involving a safety issue and suggesting alternatives and stating consequences related principles and standards. (e.g. use of 2-Challenge Rule: CUS and DESC)

Teamwork and Collaboration

These are some of the most important aspects in health care. As a nurse, you are not the only person caring for an individual patient. Each patient has an interdisciplinary team that provides for them. The team can consist of a physician, nurse, dietitian, social worker, respiratory therapist, occupational therapist, and many other specialties. It is essential that there is good communication between the health care team in order to provide the best care for the patient. Safety is the highest priority when it comes to patient care. Patient safety is also a large part of teamwork and collaboration. Having clear communication between the health care team about the care plan, goals for treatment, or change in care is very important.

What is Collaboration?

Collaboration is a working practice whereby individuals work together to a common purpose to achieve business benefit. Key features of collaboration tools are:

- Synchronous collaboration such as online meetings and instant messaging
- Asynchronous collaboration such as shared workspaces and annotations

Many organizations are also looking at Free-form Collaboration tools to improve collaboration and reduce the number of emails used for collaboration.

Collaboration, at the conceptual level, involves:

Awareness - We become part of a working entity with a shared purpose

Motivation - We drive to gain consensus in problem solving or development
 Self-synchronization - We decide as individuals when things need to happen
 Participation - We participate in collaboration and we expect others to participate
 Mediation - We negotiate and we collaborate together and find a middle point
 Reciprocity - We share and we expect sharing in return through reciprocity
 Reflection - We think and we consider alternatives
 Engagement - We proactively engage rather than wait and see

(See more at: <http://www.aiim.org/What-is-Collaboration#sthash.m5bvnSeR.dpuf>)

What is Teamwork?

It is the process of working collaboratively with a group of people in order to achieve a goal. Teamwork is often a crucial part of a business, as it is often necessary for colleagues to work well together, trying their best in any circumstance. Teamwork means that people will try to cooperate, using their individual skills and providing constructive feedback, despite any personal conflict between individuals.

(Read more: <http://www.businessdictionary.com/definition/teamwork.html#ixzz2uaHBoxPF>)

Suggested Teaching-Learning Strategies

- Lecture on the Different concepts concerning collaboration and teamwork.
- Case Analysis

Case Study: Getting the work done to reach the best outcomes

A senior nurse was trying to accomplish work delegated to her by the head nurse in the surgical unit. There were several admissions during the night shift. Among the admitted patients were vehicular accident and gunshot victims. Three of these patients were scheduled for surgical procedures. A student nurse who could only provide basic nursing care under the supervision of a clinical instructor was assigned to take care of one patient. The unit was managed by one (1) head nurse, two (2) senior nurses, one (1) registered nurse (staff nurse), one (1) nursing aide and one (1) orderly. The surgical unit had a total census of twenty (20) patients. Out of the patients in the area, three (3) patients who were just admitted were scheduled for surgery in the morning, two (2) patients were for discharge. All of the eighteen (18) patients had intravenous fluid and had to be monitored and be given medications according to the physician's order. All patients were admitted in a private room. The head nurse made the necessary plan of care for the unit.

Questions:

1. Identify the key team member characteristics that the team leader needs to consider as potential strengths or limitations.
2. What should the team leader remember about delegating to staff nurse, nursing aides and orderly?
3. What should the team leader consider about assignments for the nursing student and working with the student? What are the priorities?
4. Considering the patients assigned to the team and possible tasks and responsibilities, describe how the team leader might delegate to the team members.
5. How should the team leader supervise the team members' work?

Recommended Resources

- Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.
- Marquis, B. L., & Huston, C. J. (2006). *Leadership roles and management functions in nursing: Theory and application*. Philadelphia: Lippincott Williams & Wilkins.
- Roussel, L. & Swansburg, R.C. (2006). *Management and Leadership for Nurse Administrators*. (4th Edition). Burlington, MA: Jones & Bartlett Publishers.
- South Australia Health: <http://www.sahealth.sa.gov.au>

4. CREATING A SAFE ENVIRONMENT OF CARE

The Agency for Healthcare Research and Quality (AHRQ) is a leading agency charged with improving the quality, safety, efficiency and effectiveness of health care. It defines quality health care “as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”[8]

Table 9.1.4 show different competencies which emanate from the concept of continuous quality improvement and quality assurance in relating to safety programs and goals of one’s institution/department.

Table 9.1.4 NNCCS on Safe Environment of Care Through Quality Assurance, Continuous Quality Improvement and Risk Management	
COMPETENCIES	PERFORMANCE INDICATORS
1.4. Creates a safe environment of care through the use of quality assurance, continuous improvement and risk management strategies.	<ol style="list-style-type: none"> 1. Seeks current information about area of practice from journals and experts in the field. 2. Applies principles of evidence-based practice in decision making to ensure a safe environment of care. 3. Utilizes critical thinking in solving problems/address issues that arise using current information input from patients and colleagues. 4. Carries out strategies and actions to ensure a safe environment of care in partnership with the health team, the client and other support staff.

What Is Continuous Quality Improvement?

- CQI is an approach to quality management that builds upon traditional quality assurance methods. It focuses on “process” rather than the individual, recognizes both internal and external “clients” and promotes the need for objective data to analyze and improve processes.
- CQI is a philosophy which contends that most things can be improved. This philosophy does not subscribe to the theory that “if it ain’t broke, don’t fix it.” At the core of CQI is serial experimentation (the scientific method) applied to everyday work to meet the needs of those we serve and improve the services offered. (<http://www.msubillings.edu/cqi/faq.htm>)

Suggested Teaching-Learning Strategies

- Lecture on the different quality assurance concepts
- Small group discussion on experiences and actions taken rooted in quality assurance theory

Case Scenario: How to address data for continual improvement to ensure a safe environment of care

The Quality Assurance Coordinator met with the nurse managers to review data from nursing units for the last six (6) months. The data revealed medication errors, falls and nosocomial infection. They identified the need to review the data and make the necessary action plans on how to address concerns identified for continual improvement for safe and quality care.

Questions:

1. Based on the data provided, how could you address the problem utilizing the Plan-Do-Check-Act (PDCA) approach to ensure a safe environment of care?
2. What best practices can you share to ensure safety?

Recommended Resources

- Chase R.B., Jacobs F.R. & Aquilano N.J. (2006). *Operations Management for Competitive Advantage*. (11th ed.). New York: McGraw-Hill/Irwin.
- Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.
- Hampton, T. (2006). Health Agencies Update: Medication Errors. *Journal of the American Medical Association*, 296(4), 384doi:10.1001/jama.296.4.384-a.
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- Lanham B. & Maxson-Cooper P. (2003). Is Six Sigma the answer for nursing to reduce medical errors and enhance patient safety? *Nursing Economics*, 21(1), 39-41, 38. Retrieved August 17, 2007, from <http://www.medscape.com/viewarticle/449692>.
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- The Essential Guide to Health Care Quality. (n.d.). In *National Committee for Quality Assurance*. Retrieved from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf.

Leadership and Management in the Community: Safe and Quality Care

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INTRODUCTION

The main goal of this Master Trainer Training Program is to prepare master trainers like you to help facilitate the adoption and implementation of the NNCCS. The NNCCS covers the responsibilities and competencies of beginning nurses related to client care, leadership and management and research.

This module is on one of the six professional responsibilities on management and leadership. These responsibilities are:

1. Demonstrate management and leadership skills to provide safe and quality care;
2. Demonstrate accountability for safe nursing practice;
3. Demonstrate management and leadership skills to deliver health programs and services effectively to specific client groups in the community setting;
4. Manage a community/village-based health facility/ component of a health program or a nursing service;
5. Demonstrate the ability to lead and supervise nursing support staff; and,
6. Utilize appropriate mechanisms for networking, linkage-building and referrals.

This module which focuses on Responsibility No. 1 Leadership and Management (L & M) -- *demonstrates management and leadership skills to provide safe and quality care* -- aims to assist you, the master trainer, to perform your functions related to the NNCCS which are: (1) train implementation facilitators who will implement the NNCCS in their work setting; (2) perform assessments and determine performance gaps; and, (3) prepare, train, and provide consultation to the organization implementing the NNCCS.

This module aims to assist the integration of this professional responsibility to the community setting. Community health nurses include those who are practicing in government health centers (public health nurses), industries (occupational health nurses) and schools (school nurses).

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the beginning community health nurse's responsibility related to leadership and management and its accompanying competencies.
2. Select learning activities that will enable the learners to implement the NNCCS on the beginning community health nurse's responsibility related to leadership and management to enable the

learners to perform the specified competencies.

3. Apply nursing practice tools, guidelines and/or frameworks on leadership and management.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the beginning community health nurse's responsibility related to leadership and management will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on beginning community health nurse's responsibility related to leadership and management.

Table 9.2.1 Beginning Nurse's Role on Management and Leadership	
Responsibility 1 Demonstrates Management and Leadership Skills to Provide Safe and Quality Care	
COMPETENCIES	PERFORMANCE INDICATORS
1.1. Utilizes appropriate and efficient methods/strategies/tools to manage multiple nursing interventions for clients with co-morbidities, complex and rapidly changing health status with consultation as needed.	<ol style="list-style-type: none"> 1. Identifies needs/concerns/issues related with multiple interventions for clients with co-morbidities and complex, rapidly changing health status. 2. Specifies required tasks, activities and staff to handle/address these needs, concerns, issued based on the priorities and objectives of care. 3. Delegates the tasks and activities based on staff competencies. 4. Checks/keeps track of results/outcomes of delegated tasks. 5. Analyzes results/outcomes of care with nursing and health care team members. 6. Modifies methods/strategies to address gaps, deficiencies, and/or emerging problems in partnership with the team.
1.2. Coordinates care by organizing and prioritizing use of human, material, financial and other resources to achieve expected health outcomes.	<ol style="list-style-type: none"> 1. Identifies appropriate and efficient methods and tools to organize and prioritize use of human, material, financial and other resources. 2. Utilizes cost-effective strategies. 3. Participates actively in the creation of a preventive maintenance program to ensure proper function of equipment. 4. Adopts measures to work within the budget allocation without compromising related principles and standards.
1.3. Maintains a harmonious and collegial relationship among members of the health team for effective, efficient and safe client care.	<ol style="list-style-type: none"> 1. Utilizes various avenues for open communication. 2. Listens to suggestions and recommendations. 3. Specifies conflict resolution strategies/approaches to resolve/transform conflict situations.

COMPETENCIES	PERFORMANCE INDICATORS
	4. Helps health team resolve differences or areas of conflict by emphasizing concern about a specific situation or action involving safety issue, and suggesting alternatives and stating consequences.
1.3. Creates a safe environment of care through the use of quality assurance, continuous quality improvement and risk management strategies.	1. Seeks current information about area of practice from journals and experts in the field. 2. Applies principles of evidence-based practice in decision-making to ensure a safe environment of care. 3. Utilizes critical thinking in solving problems/address issues that arise in practice using current information input from patients and colleagues. 4. Carries out strategies and actions to ensure a safe environment of care in partnership with the health team, the client and other support staff.

THE NNCCS: LEADERSHIP AND MANAGEMENT FOR BEGINNING COMMUNITY HEALTH NURSES

There are four major terms that need to be defined related to the first responsibility – management, leadership, safety and quality. This module will not discuss the details of leadership and management because the core concepts for beginning public health nurses should have been adequately covered in earlier courses in the nursing curriculum. You may want to review these concepts though. There are a number of nursing management books that you could refer to, some of which are listed below. However, you must acknowledge the differences in the contexts of nursing management in the Philippines and developed countries where textbooks that are widely used in education and practice, come from.

Because leadership and management will be discussed within a community setting, you must also familiarize yourselves with the Philippine health care delivery system, particularly the public health system. Necessarily you must also refer to community health nursing textbooks in community health nursing, particularly those that deal with the realities in the country – population, problems, policies and programs.

Recommended References

Nursing leadership and management:

- Grossman, S.C. and Valiga, T.M. (2009). *The New Leadership Challenge. Creating the Future of Nursing*. (3rd eDITION). Philadelphia: F. A. Davis Company.
- Huber, D.L. (2010). *Leadership and Nursing Care Management*. (4th Edition). Philadelphia: Saunders/Elsevier.
- Marquis, B.L.M and Huston, C. J (2009). *Leadership Roles and Management Functions in Nursing*. (6th Edition). Philadelphia: Wolters Kluwer/Lippincott, Williams and Wilkins.
- Roussel, L. (ed.) (2006). *Nursing Management and Leadership*. (4th Edition). Boston: Jones and Bartlett.
- Tomey, A.M. (2009). *Guide to Nursing Management and Leadership*. St. Louis, Missouri: Mosby/Elsevier.

Recommended References (Continued)

Community Health Nursing:

- Anderson, E.T. and McFarlane, J. (2008). *Community As Partner*. (5th Edition.) Philadelphia: Wolters Kluwer/Lippincott, Williams and Wilkins.
- Clark, M.J. (2008). *Community Health Nursing. Advocacy for Population Health*. Upper Saddle River, New Jersey: Pearson/Prentice Hall.
- Cuevas, F.P.L. (ed.) (2007). *Public Health Nursing in the Philippines*. Manila: National League of Government Nurses in the Philippines.
- Maglaya, A.S. (ed.) (2009). *Nursing Practice in the Community*. (5th Edition). Marikina City: Argonauta Corporation.
- Nies, M.A. and McEwen, M. (2011). *Community/Public Health Nursing. Promoting the Health of Populations*. St. Louis, Missouri: Elsevier/Saunders.

As a master trainer, you should contextualize the process of management and leadership, included in the NNCCS to the institution, organization or facility where nurses work. You must remember that the public health facilities and programs in the country have long been devolved to the local government units.

TOPIC OUTLINE

As a master trainer you should be able to guide your trainees in navigating the literature on management, leadership, and client-centered outcomes such as safety and quality. You and the implementation facilitators (faculty members and nurses in senior positions) may select any of the many good nursing management books but must ensure that the following topics are included:

1. Management functions – planning, organizing, staffing, leading and controlling; decision-making; management activities performed by beginning nurses
 - 1.1. Process of decision-making within the context of managing client care
 - 1.2. Planning for the care of clients with co-morbidities who require multiple interventions
 - 1.3. Prioritizing the care of these patients and the use of resources for client care
 - 1.4. Tasks and activities to address the needs/problems of these clients (in addition to clinical nursing interventions)
 - 1.5. How to divide the work and give assignments
 - 1.6. How to delegate tasks and activities to other nursing personnel (i.e., midwives) and how to properly supervise them
 - 1.7. Communicating not just with clients and their families or significant others, but also to the other members of the health team, to policy and decision makers (in public health, the local government officials and bureaucrats), and key members or representatives of other sectors or government agencies (e.g., Agriculture, Education, Public Works, etc.)
 - 1.8. Resolving and managing conflicts
 - 1.9. Methods and strategies in promoting and maintaining safety and quality of services/care provided – basic concepts in controlling (such as quality assurance/continuous quality improvement)

Note: Review management activities of community health nurses as reflected in health program manuals published by the Department of Health.
2. Leadership – leadership behaviors; strategies on how to effectively influence others – from the mayor, *Sangguniang Bayan*, particularly the Committee on Health and the local bureaucrats (like the planning officer, administrative officer and budget officer) and co-workers such as the municipal/city officer, midwives and barangay health workers (BHWS).
3. The process of promoting and adopting evidence-based practice (particularly in public health/

- community health nursing) to ensure safety and quality.
4. How to apply or integrate critical thinking in the management and leadership competencies.

MODULE CONTENT

Leadership, which refers to the ability to influence, guide, motivate, inspire and instill vision and purpose can be viewed independently from management. At the level of beginning nurses the emphasis is on their behaviors and actions as they aim to influence their co-workers, clients and significant others, and later even partners from other offices or agencies. Leadership (leading, instead of directing, as some authors emphasized) is also viewed as part of the management process.

Management is a process that includes planning, organizing, staffing, directing and controlling with the purpose of accomplishing specific goals and objectives. The beginning nurse who is assigned to a number of clients is expected to be able to manage their care – coordinate care and prioritize their need for different resources to achieve the predetermined client care outcomes. Given the limited resources in practically all public health facilities, the ability of nurses to prioritize the use of health care resources helps promote ethical practice.

Nurses' ability to maintain harmonious and collegial relationships can help to promote safe and quality client care. A friendly atmosphere encourages staff members to engage in actions that protect the clients -- clarify or verify physician's orders which are not clear or incorrect; to have the initiative to establish whether an intervention, procedure or activity has already been done, or medicine or vaccine has been given, and others. Good interpersonal and working relationships can also lead to effective actions/interventions/programs and efficient utilization of resources.

The last competency – the ability to create a safe environment of care – requires nurses to participate in the health facility's quality assurance program (QAP), continuous quality improvement (CQI) and risk management strategies. To be able to participate in these programs/activities meaningfully, nurses should be familiar with standards (structure, process and outcome) related to the nursing care/services to clients and the different public health programs.

The different levels of management (top, middle and first-level) have different concerns and management activities. In public health, the higher levels of management (e.g., city or municipal health officers) develop policies and prepare programs to ensure that the frontline workers such as public health nurses and midwives have the necessary logistical and organizational support. At the level of the beginning community/public health nurse, the competencies that are related to the management functions are geared directly towards the provision of safe and quality services/care and advocacy for client's rights and welfare. The process of leadership enhances the nurses' performance of their competencies in client care management.

Table 9.2.1 presents the beginning nurses' professional responsibility, competencies and corresponding performance indicators. In helping the learners to integrate the NNCCS in both nursing education and practice, you should always start with the end in mind. The "end" is what the nurses should be able to do (performance indicators). You, then, should work backward and answer the question "how should the 'end-learners' be taught so that eventually, they will be able to perform the required competencies?" In addition, how could learning be made easier so that the learners will be more appreciative of the NNCCS.

You, the master trainer, should emphasize that the competencies of beginning nurses in management and leadership are as important as, and support or synergize, those competencies related to client care. Management and leadership skills, in addition to nursing process skills, ensure the provision of safe and quality care. You must also point out that management and leadership skills address the contextual issues

and problems in service delivery/client care, such as constraints in both human and non-human resources; ineffective communication and constrained interpersonal relationship among members of the health team (and even with the institution's decision makers); non-facilitative systems; obstructive or damaging organizational culture and unsafe environment of care.

The desired outcome of health programs and services is safe and quality care. The Institute of Medicine (IOM) defines quality of care as “the degree to which health services for individuals and population increase(s) the likelihood of desired health outcomes and are consistent with professional knowledge”. This statement implies not only the link between client care and leadership and management, but the responsibility to influence matters that impact on safety and quality. Safety, which is considered as a component of quality care, is “the degree to which the risk of an intervention and risk in the care environment are reduced for a patient..” (Joint Commission Resources. Getting the Board on Board: What Your Board Needs to Know About Quality and Patient Safety, 2007:97). Most of the safety issues or concerns in the community are the same as those identified in a hospital setting such as medication errors, infections, nursing procedures, attending to emergency cases and failure to assess adequately.

In public health the attention of the staff should not only be program accomplishments based on targets but also the safety and quality of care or services provided. Quality is commonly defined in terms of contemporary standards (standards of nursing care and health program standards). It will be helpful for trainers and implementation facilitators to review the different standards that could impact on the quality of care in the community setting.

There are structure, process and outcome standards related to client care (please refer to the standards developed by the Philippine Nurses Association), nursing management/administration (Association of Nursing Service Administrators) and public health nursing (National League of Philippine Government Nurses, Public Health Nursing in the Philippines, 2007).

Critical Thinking Approach in the NNCCS

The NNCCS is premised on the belief that nurses should always think critically to attain desired client-centered outcomes. The need for critical thinking emanates from these realities: clients having different characteristics, problems and backgrounds; and, the health care system and its components (and subcomponents) being highly variable in terms of the way they are managed, the resources available and their organizational culture. Although policies, standards, protocols and procedures minimize variations in the delivery of services, community health nurses will still have to do their own independent thinking (i.e., critical thinking) to ensure the proper fit or responsiveness of nursing actions/interventions/ programs to the identified problems/issues/concerns.

The goal of a nursing unit or nursing component of a health program is the provision of safe and quality care. In addition to their clinical skills, nurses should also develop competence in leadership and management to attain the desired care outcomes. What is safe and quality care? What are the dimensions of safety and quality? What are the factors that promote or hinder the provision of safe and quality care? How can the variations in the quality of care across settings be explained? What are the specific contributions of community health nurses to the realization of these outcomes? For sure you have other questions about the attainment of safety and quality in health care and you could derive logical and relevant answers through critical thinking.

It is not only the answer that is important but also the process of arriving at the answer. This is what critical thinking is all about. According to Wood, critical thinking is the process of purposeful and self-regulatory judgment. This process gives reasoned consideration to evidence, contexts, conceptualizations, methods and criteria (p. 5).

Trainers and facilitators must be more conscious of their role in developing critical thinking among nurses and students. Critical thinkers contribute more to client care and organizational goals than those who are not, or those who just obey orders by authorities unquestioningly. According to the American Philosophical Association, a critical thinker is one who is “habitually inquisitive, well-informed, trustful of reason, open-minded, flexible, fair-minded in evaluation, honest in facing personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused in inquiry, and persistent in seeking results which are as precise as the subject and the circumstances of inquiry permit” (Cook, p.30).

Facione (1992) identified six critical thinking skills that could be used by nurses in improving their performance of competencies: (1) interpretation (categorizing, decoding, and clarifying meaning); (2) analysis (examining ideas, identifying arguments, analyzing arguments and evidence); (3) evaluation (assessing claims, assessing arguments); (4) inference (querying evidence, conjecturing alternatives, drawing conclusions); (5) explanation (stating results, justifying procedures, presenting arguments); and, (6) self-regulation (self-examination, self-correction) (Wood, p.6).

The following are examples of critical thinking questions that learners could ask: Why? How? What is the most fundamental issue? What can I infer from these data? Is this a credible source of information? How could I check the accuracy of this? Are these (data/information) consistent? What might happen if...? (Huber, p. 134)

As a master trainer, you should highlight these skills to the learners (implementation facilitators) who will eventually train beginning nurses and students. Critical thinking is a skill that can improve the performance of all nursing competencies. Refer to the following scenario to illustrate critical thinking to the learners.

Recommended References

References on Critical Thinking:

- Cook, PR (2006) “Critical Thinking in Nursing Education” In AJ Lowenstein and MJ Bradshaw (Eds.). *Fuszard’s Innovative Teaching Strategies in Nursing*. (3rd Edition). Sudbury, Massachusetts: Jones and Bartlett Publishers.
- Wood, K.J. (1998). *Critical Thinking*. Philadelphia: F. A. Davis Company.

TEACHING-LEARNING ACTIVITIES (TLAs)

How should you teach management and leadership as applied to the community setting? Learners usually associate management functions (planning, organizing, staffing, directing or leading and controlling) with headnurses, supervisors and chief nurses. Trainers and facilitators must emphasize that in the community, nurses should be able to demonstrate their management and leadership skills in health facilities (such as health centers and clinics), nursing services/units and in the nursing components of the different public health programs. If there is no clearly identified nursing component of a program (because health programs are basically one very broad undertaking, e.g., immunization program), or no separate structure or unit called Nursing Service (because the health facility is small), you can assist the learners in identifying specific nursing roles or contributions to the health programs.

As a master trainer, what do you think should be a good way to start in teaching leadership and management in the community? Conscious that the teaching-learning activities (TLAs) should always be geared towards the identified competencies, you may construct a table of specifications to serve as a guide. This way, you

can easily be reminded to provide the learners adequate opportunities to learn and practice the required competencies.

In Table 9.2.2, the first column contains the competencies while the second column shows sample TLAs. In preparing your own TLAs you should ensure that these stimulate critical thinking and foster an attitude of inquiry in the trainees. TLAs should also reflect your creativity, caring attitude and commitment to excellence and culture of accountability. It is very important that these TLAs are able to engage the learners in active learning. According to Billings and Halstead (2005, in Jeffries, p. 25), active engagement has been demonstrated to improve the students' critical thinking skills. In addition, there must be a provision for reflection among the learners/trainees and to be effective it should be guided throughout the reflective process (Johns, 1996 in Jeffries, p. 75).

Schon (1983) distinguishes reflection-in-action from reflection-on-action in that the former is the self-monitoring that occurs while an individual is engaged in an experience and the latter is the conscious review of an interaction once it is completed (Jeffries, 74-75). As a master trainer, you must realize that you could vary your TLAs to attract and sustain the attention and interest of the learners. You must make sure, however, that these TLAs are relevant or appropriate to the competencies that should be demonstrated by the learners.

The learners should be constantly made aware of the need to reflect on their actions. They should be asked questions such as, "could you please share with me what you were thinking when you... (specify what the learner said or did)?" or "could you help me understand why you had to... (specify what the learner did)?" Or maybe, you can ask them directly "why did you do that?". Asking these questions may be threatening initially but if the teachers/facilitators show respect and concern, the learners may eventually develop the habit of reflecting on their thoughts and actions.

Recommended Reference

Jeffries, P.R. (ed.) (2007). *Simulation in Nursing Education*. New York: National League for Nursing.

You have always been preparing syllabi and conceptualizing teaching-learning activities. In relation to these NNCCS competencies, the process is basically the same, except that maybe you will have to be more rigorous in your preparation. Your goal as a master trainer is to be able to help disseminate the NNCCS so that in the near future every practicing nurse will adopt and perform these competencies.

Table 9.2.2	Teaching-Learning Activities in Relation to Leadership and Management Responsibility No. 1 and Corresponding Competencies
PROFESSIONAL COMPETENCIES	SAMPLE TEACHING-LEARNING ACTIVITIES
1.1. Utilizes appropriate and efficient methods/ strategies/tools to manage multiple nursing interventions for clients with co-morbidities, complex and rapidly changing health status with consultation as needed.	<p>Lecture-discussion (just a brief review of concepts for the beginning nurses)</p> <p>Case studies could be used to illustrate the different nurses' competencies in management and leadership. The following questions may serve as guide in analyzing cases:</p> <ul style="list-style-type: none"> • What is the problem? • Why is "this" a problem? • What are the possible causes of the problem? • Are the perceived causes supported by evidence?

PROFESSIONAL COMPETENCIES	SAMPLE TEACHING-LEARNING ACTIVITIES
<p>1.2. Coordinates care by organizing and prioritizing use of human, material, financial and other resources to achieve expected health outcomes.</p> <p>1.3. Maintains a harmonious and collegial relationship among members of the health team for effective, efficient and safe client care.</p> <p>1.4. Creates a safe environment of care through the use of quality assurance, continuous quality improvement and risk management strategies.</p>	<ul style="list-style-type: none"> • What actions/interventions/ recommendations would be relevant or appropriate? <p><i>Case Study:</i> Mrs. C., 65 years old, is a diagnosed diabetic and hypertensive. She is complaining of severe right upper quadrant pain. The municipal health officer is absent. The nearest hospital is about 30 minutes away by public transportation. She consults at the health center regularly once or twice a week for blood pressure and blood sugar monitoring. She is a widow and lives alone in a rented house.</p> <p><i>Questions:</i></p> <ol style="list-style-type: none"> 1. What other questions should the PHN collect to be able to manage the problems of Mrs. C.? 2. What should be the immediate actions of the PHN to address the problems of Mrs. C.? 3. How should the PHN coordinate the care of Mrs. C.? <p><i>Case Study:</i> Simplicia is a PHN in a 3rd class municipality with a population of 25,000. The health center has been “doctor-less” for a month. The more senior PHN is on leave for two weeks. Together with the 4 midwives and 10 barangay health workers (2 per day), they seem to manage well.</p> <p><i>Questions:</i></p> <ol style="list-style-type: none"> 1. What are the issues/concerns that Simplicia and her co-workers need to address to provide safe and quality care? 2. What are the considerations in prioritizing the issues/concerns in service delivery? 3. How will Simplicia deal with the health center’s regular clients, particularly those with co-morbidities? 4. How will Simplicia organize and prioritize the activities to deal with the different clients and the resources necessary to carry these out? 5. Given the problem of understaffing, what are the principles that Simplicia should remember and uphold to maintain harmonious and collegial relationship? 6. How can Simplicia and her co-workers maintain a safe environment of care? <p>Participation in health center/clinic activities Provide the learners the opportunity to observe and participate in the provision of health/nursing care/services in the health center/clinics and other activities related to the implementation of the nursing component of health programs. The trainer/facilitator must supervise students, engage in a meaningful interaction with them, and monitor their progress (including their problems or difficulties).</p>

PROFESSIONAL COMPETENCIES	SAMPLE TEACHING-LEARNING ACTIVITIES
	<p>Provide opportunities for students to interact with the nursing personnel – nurses and midwives – and be allowed access to the standards (manuals) and records/documents.</p> <ul style="list-style-type: none"> • Learners should be encouraged to ask the nursing personnel how they implement programs, their specific contributions to the program and problems/issues and concerns related to management. • Learners could also ask the nurses their leadership strategies <p>Observation</p> <p>(1) Ask the learners to focus their observations on the health center staff's interactions (include verbal and non-verbal cues) with each other.</p> <p><i>Questions:</i></p> <ol style="list-style-type: none"> 1. Can you describe the interactions among the personnel? Give specific examples or illustrations. 2. Do you think the health center staff have harmonious and collegial relationships? Support your answer. 3. How did the staff's relationship affect client care or delivery of health services? <p>(2) Give the learners enough time (about 30 minutes) to observe a health facility (RHU/health center, school or occupational health clinic) in terms of safety for clients, staff and other people going there.</p> <p><i>Questions:</i></p> <ol style="list-style-type: none"> 1. Based on your observations, what are the factors that promote or hinder a safe environment of care? 2. What should the health facility staff (particularly the nurses) do to create or ensure a safe environment of care? <p>The answers given by the learners should be discussed and related to the concepts of quality assurance/continuous quality improvement and risk management.</p> <p>Student Journal</p> <p>Students may be asked to write their thoughts/reflections on their experiences in the community (health centers, clinics).</p>

ASSESSMENT OF LEARNING

Assessment of learning or competency appraisal is an indispensable component of any teaching-learning situation. It is done not just for the purpose of giving grades to the learners, but more importantly, to ensure that they could perform the specified competencies. Trainers should promote the idea that nurses should be able to demonstrate the performance indicators (refer to Table 9.2.1) because this is an expression of their accountability as professionals.

Accountability for results implies that: (1) performance standards are clear to your learners, the implementation facilitators, and eventually to the “end-learners”, beginning nurses and students; (2) measurements are valid, that is, they should measure what they are supposed to measure; and, (3) a system should be created to measure the progress of the beginning nurses and the students—from one RLE (related learning experiences) area to another and from one semester (or year level) to the next.

Framework for the appraisal of learning. Donabedian's structure-process-outcome framework used in quality assurance can also be used in the assessment of learning. The appraisal of learning focuses on the outcome, that is, the focus is the ability of the learner to perform the competencies, specifically the performance indicators. The structure (the qualifications of the faculty and the characteristics and resources of the health facilities, among others) contextualizes and helps explain the outcome of learning. The process refers to the “how” and the quality of instruction or the teaching-learning activities prepared and organized by the teacher/facilitator.

Related to the competencies under the professional responsibility -- demonstrate management and leadership skills to provide safe and quality care – competency appraisal should focus on the performance indicators, which as expected are in behavioral terms (identify, specify, listen, delegate, check, keep track, analyze, help, carry out, apply, utilize, participate, adopt and modify). How could these behaviors be measured when the evaluators (implementers, faculty members) are not with the learners all the time? If competency appraisal is well-planned, we can have an acceptable sampling of their performance of the competencies.

It is ideal to have a complete competency performance checklist. Evaluation of the learners' performance is not a one-shot deal; it is done as the opportunity arises and it does not have to be done on the last day of their rotation or assignment to the area. In developing a performance appraisal tool, we should remember that a competency has a number of performance indicators and these are the ones to look for, in the end-learners. For example, related to the first competency, we should ask the question, Could the nurse/student:

- identify needs/concerns/issues related with multiple interventions for clients with co-morbidities and complex, rapidly changing health status?
- specify required tasks, activities and staff to handle/address these needs, concerns, issued based on the priorities and objectives of care?
- delegate the tasks and activities based on staff competencies?
- check/keep track of results/outcomes of delegated tasks?
- analyze results/outcomes of care with nursing and health care team members?
- modify methods/strategies to address gaps, deficiencies, and/or emerging problems in partnership with the team?

Some of the performance indicators are readily and easily observed while the others are not. Those that are not easy to observe could be established through records review and/or interview with the nurses' superiors and/or co-workers. Or, some could just be elicited by asking the nurse, directly (e.g., “how would you rate yourself in terms of...?”) or indirectly (with the use of case studies and vignettes).

In the following example, information on the different performance indicators could be elicited using different methods. To illustrate:

Table 9.2.3		Different Methods to Elicit Information on the Performance Indicators		
PERFORMANCE INDICATORS	YES	NO	SOURCE OF DATA/METHOD OF DATA COLLECTION	REMARKS
<p>Could the nurse/student:</p> <ul style="list-style-type: none"> • identify needs/concerns/issues related with multiple interventions for clients with co-morbidities and complex, rapidly changing health status? • specify required tasks, activities and staff to handle/address these needs, concerns, issued based on the priorities and objectives of care? • delegate the tasks and activities based on staff competencies? • check/keep track of results/outcomes of delegated tasks? • analyze results/outcomes of care with nursing and health care team members? • modify methods/strategies to address gaps, deficiencies, and/or emerging problems in partnership with the team? 				

Instead of a “yes-no” (dichotomous) answer, a rating scale may be used for appropriate items. For example:

- “How often do you delegate the tasks and activities to the midwife?” (almost always, frequently, rarely, almost never)
- “Do you check/keep track of results/outcomes of delegated tasks?” (almost always, frequently, rarely, almost never)
- “Do you identify needs/concerns/issues related with multiple interventions for your clients....?” (almost always, frequently, rarely, almost never)
- “How well do you analyze results/outcomes of care with nursing and health care team members?” (needs improvement, fair, good, excellent)

Examples of a Vignette

1. As usual, it is a busy morning at the health center in a 3rd class municipality because it is the day for prenatal check-ups. The municipal health officer is absent so it is just you, the sole Public Health Nurse (PHN) and three midwives who are on duty. At 8:30 A.M., there are already 20 clients waiting for their turn to be seen and attended to. As the junior PHN, what will you do? How do you plan and organize your day?
2. On Monday morning, after three non-working days there will be a blood-letting activity of the local government unit in cooperation with the Philippine National Red Cross the whole morning. It is also expected that there will be many clients consulting with some urgent cases, usually hypertension and minor injuries. As the only PHN on that day what preparations will you make the week before so that the delivery of health services will not be disrupted? How will you divide the work among the staff? What help do you need and how will you mobilize other people to help?

As a master trainer you should be able to help your trainees to prepare different vignettes to be able to direct their attention on the different performance indicators. Writing the vignettes and the accompanying questions should be well-planned and be based on the performance indicators discussed earlier. As often as necessary, integrate the context of practice in the question. For example: "Given the municipality's limited resources, what could be done to promote efficiency without compromising the institution's and the nursing profession's standards?"

For a competency appraisal to be successful, the following lessons should be observed:

1. The competency appraisal system/processes should be aligned with the competencies (and performance indicators).
2. The purpose of the performance appraisal should be clear to the two parties – the one evaluating and the other who is being evaluated.
3. The assessment of the trainees must use multiple approaches, as much as possible.
4. The trainees should be respected and made to realize that the appraisal aims to help them perform the required competencies.
5. The performance appraisal exercise is more meaningful with the active participation of the one being evaluated.

After the Training of Master Trainers, you are expected to be better equipped in helping other nurses to adopt and implement the NNCCS.

Nursing Leadership and Management in Safety and Accountability

ELSA V. CASTRO, RN, PhD

INTRODUCTION

In the fast changing landscape of health care, nurses are trained to be vigilant in the performance of every nursing intervention or procedure involving patient care.

To better understand this module, let us first define what is accountability in the health care delivery system. According to Geigle, accountability may be thought of as the condition of being held liable or answerable for one's safety performance. Further, he also mentioned that it establishes an obligation to perform assigned responsibilities at a prescribed level or standard. Geigle also stated that accountability is fixed through the application of natural and system consequences. In addition, accountability exists within the safety culture as a condition or state of being.

This NNCCS module is designed to train and further educate our nurses on how to apply their critical thinking, technical and interpersonal skills to improve knowledge acquisition specific to safety and accountability which are required in the provision of quality and safe nursing care.

Reference:

Geigle, S. J. (n.d.). Managing Effective Safety Accountability Systems. In Occupational Safety & Health Training. Retrieved from <http://www.oshatrain.org/notes/3anotes04.html>.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on accountability for safe nursing practice.
2. Select learning activities that will enable the learners to implement the NNCCS on accountability for safe nursing practice.
3. Apply nursing practice tools, guidelines and/or frameworks on accountability for safe nursing practice.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in demonstrating accountability for safe nursing practice
5. Demonstrate how the achievement of specified competencies of the NNCCS on accountability for safe nursing practice will be assessed with appropriate methods and tools;
6. State policies and actions necessary to facilitate implementation of the NNCCS on accountability for safe nursing practice.

TOPIC OUTLINE

1. Policy Making Process
2. Analytic Framework for Accountability and Health Systems
3. Delegation
4. Corrective Actions for Patient Safety

MODULE CONTENT

Table 10.1 below states the competency and performance indicators for policy and standards development designed by nurses in the goal to promote health.

Table 10.1	NNCCS on Policies and Standards for Safe Nursing Practice	
Responsibility 2	Demonstrates Accountability for Safe Nursing Practice	
COMPETENCIES	PERFORMANCE INDICATORS	
2.1. Participates in the development of policies and standards regarding safe nursing practice.	<ol style="list-style-type: none"> 1. Specifies nature and extent of participation in developing policies and standards for safe nursing practice. 2. Involves self actively in policy development. 	

1. THE POLICY MAKING PROCESS

To increase opportunities and better elucidate nursing perspectives about health care and health care professionals, we need to recognize the importance of perusing the possible policy issues including recommended solutions. At present, nurses are brought together with other groups that have a similar interest, as well as to take advantage of the probability of networking and collaboration. All of this has some important factors which are related to leadership and skills of communication, planning, directing, decision making, networking, collaboration and encouraging participation and involvement of all nurses.

One must remember that policy reflects an organization's values that would ensure continuity of quality management and will serve as a guide for actions and decision making. The policies have a huge contribution in sustaining public trust and in upholding organization's reputation.

Guide to Policy Making

- Step 1: Define the issues or problems
- Step 2: Make a research
- Step 3: Discuss and Debate among Board Level
- Step 4: Draft the Policy
- Step 5: Read and Revise
- Step 6: Adopt the Policy
- Step 7: Implementation

2. ANALYTIC FRAMEWORK FOR ACCOUNTABILITY AND HEALTH SYSTEMS

In the publication *Accountability and Health Systems: Overview, Framework, and Strategies*, Brinkerhoff (2003) presented illustrative health system issues associated with the three types of accountability. It then identifies the dominant purposes of accountability associated with these issues: controlling abuse, assuring conformity with standards and norms, and supporting improved performance/learning. This creates a framework for categorizing and taking stock of health system reforms in terms of accountability. Below are the three types of accountability identified by Brinkerhoff.

1. Financial

In this type of accountability, health service issues revolve on budget allocation and accounting of expenses on personnel, operations, pharmaceuticals/supplies, basic benefits packages and contract oversight. This type of accountability focuses on compliance to prescribed input, cost control, resource efficiency measures and elimination of fraud, corruption and wastage of resources.

2. Performance

Some of the health service delivery issues most commonly encountered in this type of accountability are issues on quality of care, involvement of patients in medical decision-making, behavior of service providers and regulation by professional bodies.

The two most dominant purposes of this accountability are assurance and improvement/learning. Assurance emphasizes adherence to the legal, regulatory, and policy framework; professional service delivery procedures, norms, and values; and quality of care standards and audits. Improvement/learning focuses on benchmarking, standard setting, quality management, operations research, monitoring and evaluation.

3. Political/Democratic

Prevailing health service delivery issues in this type of accountability are related to service delivery equity/fairness, transparency, responsiveness to citizens, service user trust and dispute resolution.

Control and assurance purposes are emphasized. Control relates to the citizen's/voter's satisfaction, use of taxpayer funds, addressing market failure and distribution of services (disadvantaged populations). Assurance focuses on oversight; availability and dissemination of relevant information; adherence to quality standards, professional norms, and societal values. (Brinkerhoff, 2003)

Web Resource

Derick Brinkerhoff. (2003). *Accountability and Health Systems: Overview, Framework, and Strategies*. In *World Health Organization*. Available at <http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf>

Suggested Teaching-Learning Strategies

- Lecture on different topics on policy making process and etc.
- Class discussion
- Individual Submission of Policy Designed output from a given simulation (Please see Guide on Policy Making on the previous page)

Recommended Resources

- De Belen, R.T. (2008). *Significant Laws, Rules and Regulations, and Standards in Nursing Practice*. Quezon City: C&E Publishers.
- Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.
- Geigle, S. J. (n.d.). Managing Effective Safety Accountability Systems. In *Occupational Safety & Health Training*. Retrieved from <http://www.oshatrain.org/notes/3anotes04.html>.
- Marquis, B. L., & Huston, C. J. (2006). *Leadership roles and management functions in nursing: Theory and application*. Philadelphia: Lippincott Williams & Wilkins.
- Roussel, L. & Swansburg, R.C. (2006). *Management and Leadership for Nurse Administrators*. (4th Edition). Burlington, MA: Jones & Bartlett Publishers.
- WHO Patient Safety Curriculum Guide. (n.d.). In *World Health Organization*. Retrieved from <http://www.who.int/patientsafety/education/curriculum>.

3. DELEGATION

Table 10.2 NNCCS on Management Skills for Meeting and Achieving Outcomes	
COMPETENCIES	PERFORMANCE INDICATORS
2.2. Organizes own workload demonstrating time management skills for meeting responsibilities and achieving outcomes.	<ol style="list-style-type: none"> 1. Specifies bases for organizing workload to ensure efficiency in meeting responsibilities and achieving outcome. 2. Accomplishes assigned workload within a given time frame.

Principles of delegation

- Delegation must always be in the best interest of the patient and not performed simply in an effort to save time or money.
- The support worker must have been suitably trained to perform the task.
- The support worker should always keep full records of training given, including dates.
- There should be written evidence of competence assessment, preferably against recognized standards such as National Occupational Standards. There should be clear guidelines and protocols in place so that the support worker is not required to make a clinical judgment that he/she is not competent to make.
- The role should be within the support worker's job description.
- The team and any support staff need to be informed that the task has been delegated (e.g. a receptionist in a GP surgery or ward clerk in a hospital setting).
- The person who delegates the task must ensure that an appropriate level of supervision is available and that the support worker has the opportunity for mentorship. The level of supervision and feedback provided must be appropriate to the task being delegated. This will be based on the recorded knowledge and competence of the support worker, the needs of the patient/client, the service setting and the tasks assigned (RCN et al., 2006).
- Ongoing development to ensure that competency is maintained is essential.
- The whole process must be assessed for the degree of risk.

Questions to consider in delegating task:

When delegating a task there are three (3) key questions to be asked:

- Does the registered practitioner view the support worker as competent to carry out the tasks?
 - If they do not believe that the support worker is competent to perform the task then the delegation would be inappropriate and not in the best interest of the patient.
- Does the support worker consider himself/herself to be competent to perform the activity?
 - If not they must inform the delegating nurse or a senior colleague that they are not competent.
- Does the task require an ongoing assessment of the patient to be made?
 - If the task itself is complex and the plan of care may change 'in the moment' then this may not be an appropriate task to be delegated. A risk assessment must be performed to ensure that delegation is appropriate and in the best interest of the patient.

Suggested Teaching-Learning Strategies

- Lecture and Discussions
- Role Playing

Situation for the Role Play:

A nursing aide was helping a diabetic patient to remove his socks before a foot examination and noticed a wound on his right toe which was swollen. Although the nursing aide was considered to have the experience and basic competence in wound dressing, she was also aware of the risks associated with wounds on the feet for diabetic patients and therefore knew that to treat this would be out of her job description. She was also aware that the wound had not been assessed by a registered nurse yet.

The nursing aide reported the wound to be assessed by the registered nurse who would also render the appropriate wound care. The nursing aide knew the protocols of the institution and acted in accordance to what was expected of her to do. She was also able to acknowledge her accountability and responsibility towards the patient as recipient of quality patient care.

Recommended Resources

- Austin Community College: <http://www.austincc.edu>
- De Belen, R.T. (2008). *Significant Laws, Rules and Regulations, and Standards in Nursing Practice*. Quezon City: C&E Publishers.
- Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.
- How to Build a Successful Mentoring Program using the Elements of Effective Practice. (n.d.). In *Mentor: National Mentoring Partnership*. Retrieved from http://www.mentoring.org/downloads/mentoring_417.pdf.
- Marquis, B.L. & Huston, C.J. (2008). *Leadership Roles and Management Functions in Nursing: Theory and Application*. (6th Edition). Philadelphia, PA: Lippincott Williams & Wilkins.
- Roussel, L. & Swansburg, R.C. (2006). *Management and Leadership for Nurse Administrators*. (4th Edition). Burlington, MA: Jones & Bartlett Publishers.
- Royal College of Nursing: <http://www.rcn.org.uk>

4. CORRECTIVE ACTIONS FOR PATIENT SAFETY

Table 10.3	NNCCS on Instituting Appropriate Corrective Measures for Patient Safety
COMPETENCIES	PERFORMANCE INDICATORS
2.2. Institutes appropriate corrective actions to prevent or minimize harm arising from adverse effects.	1. Specifies appropriate corrective actions. 2. Executes judiciously corrective actions. 3. Determines effectiveness of implemented corrective actions.

Why human factors is important

According to WHO, human factors examine the relationship between human beings and the systems with which they interact by focusing on improving efficiency, creativity, productivity and job satisfaction, with the goal of minimizing errors. A failure to apply human factors principles is a key aspect of most adverse events in health care.

The relationship between human factors and patient safety

It is important for all health-care workers to be mindful of situations that increase the likelihood of error for human beings in any situation. A number of individual factors impact on human performance thereby predisposing a person to error. Two factors with the most impact are fatigue and stress. There is strong scientific evidence linking fatigue and performance decrement making it a known risk factor in patient safety. Prolonged work has been shown to produce the same deterioration in performance as a person with a blood alcohol level of 0.05 mmol/l, which would make it illegal to drive a car in many countries. (<http://www.who.int>)

Human error

To err is human, goes the saying. Human error has spelled the doom of numerous accidents during the last half century. Mistakes will inevitably be made in any system that people are involved in, and health care is extremely unforgiving of mistakes.

Factors that affect human performance

Safety Culture

- Positive: In an organisation with a positive culture the senior leadership creates a 'just culture' in preference to 'blaming and shaming'. Staff feels confident to report patient safety incidents and lessons are learned and shared to help prevent future harm.
- Negative: In an organisation with a negative culture the senior management prioritizes targets and efficiency savings over safety. Staff may feel pressure to take risks and commit violations ('take short cuts').

Leadership

- Positive: A senior manager regularly visits wards. She gathers information from her observations and from frontline staff about the levels of safety in her organisation. She uses her information to help design and implement appropriate improvement interventions.
- Negative: A manager implements an improvement initiative in a 'top down' manner, without any

consultation with frontline staff. The staff fails to engage with the project which is eventually abandoned.

Teamwork

- Positive: The team members have a shared understanding of their work goals, use effective channels of communication and proactively manage conflict. They demonstrate their commitment to collective learning by participating in multi-professional meetings to discuss and analyse patient safety incidents.
- Negative: There is a lack of accountability within the team. Patient safety issues are rarely raised or discussed and little or no collective learning happens.

Communication

- Positive: Lay representatives are invited to attend board meetings. They offer a unique patient perspective and make helpful suggestions practical ways in which safety can be improved.
- Negative: Incomplete handovers and discharge summaries predispose to error and patient harm.

Training

- Positive: A community nurse administers effective CPR in a patient's house when he stops breathing. She attended a refresher life support course two months before the incident.
- Negative: Nurses do not receive adequate training to use an intravenous (IV) pump. One of them selects the wrong infusion rate, resulting in fluid overdose in the patient.

Equipment design

- Positive: A nurse is able to stabilize a patient quickly on her first shift using a new equipment as a result of standardized and intuitive alarms and equipment.
- Negative: Due to the similarity of two different syringes, a nurse accidentally administers the drug Vincristine intrathecally instead of intravenously. The patient dies a few days later.

Process/task design

- Positive: A surgical team routinely uses a checklist. In one case they detect that blood products are not available for a scheduled patient. The error is rectified before the procedure.
- Negative: A patient receives a wrong drug due to an overly complex drug prescribing system involving numerous steps.

Distractions

- Positive: Nurses wear vests during their drug rounds to indicate that they should not be distracted.
- Negative: A nurse accidentally dispenses the wrong drug during her round because of a distraction.

Skills

- Positive: A nurse recognizes the rapid deterioration of the patient's condition with subtle changes in vital signs leading to treatment given in a timely manner.
arterial switch operation.
- Negative: A nurse fails several times to start a peripheral IV thus the anesthesiologist had to perform a central line insertion.

Attitude

- Positive: A nurse volunteers to do a favour for an elderly patient.
- Negative: A nurse fails to comply with the hand hygiene protocols in spite of several requests from the nurse manager/ peers.

Stress

- A nurse takes sick leave after feeling bullied at work.

Fatigue

- A nurse finishing an extended double shift fails to notice that the peripheral IV site is inflamed leading to cellulitis of the whole arm.

Workload

- Staff shortages increase a ward's workload to the extent that the nursing staff cannot respond to a patient's request for analgesia. A formal complaint is made against the hospital a few days later.

Physical Environment

- A nurse on night duty struggles to read the display of an infusion pump and accidentally administers an overdose.

Suggested Teaching-Learning Strategies

- Lecture and Discussions
- Case Discussion

Case Study:

This case illustrates a failure in checking protocols in the delivery room.

Jesusa, a 30 year old woman went to see her attending physician who is an obstetrician because of foul smelling vaginal discharge which happened a few days after a normal spontaneous delivery (NSD). She gave birth to a baby boy ten (10) days earlier. Episiotomy was done during the delivery. The attending physician prescribed antibiotics for five (5) days since she suspected a urine infection. She was able to complete the antibiotic therapy since vaginal examination revealed tenderness and swelling on the episiotomy site. She also complained of pain and itchiness on the site. The attending physician also noted other laboratory examinations to be done since the patient still had the foul vaginal discharge even after completing the course of antibiotics.

The obstetrician also reviewed in the delivery room notes and record of sponge count and checked if proper counting was done before closing the wound. Records showed that a scrub nurse did the correct sponge counting which was supported by the circulating nurse. In spite of the medications given, foul vaginal odor still persisted. Therefore, Jesusa sought for a second opinion from another obstetrician. An evaluation was done and she was asked to have another admission for possible dilatation and curettage (D&C). The obstetrician then informed the first physician of the findings that a sponge was left during the delivery. She also suggested that the case should be further investigated.

Recommended Resources

- De Belen, R.T. (2008). *Significant Laws, Rules and Regulations, and Standards in Nursing Practice*. Quezon City: C&E Publishers.
- European Space Agency: <http://www.esa.int>.
- Evidence into Practice: <http://www.evidenceintopractice.scot.nhs.uk>
- Finkelman, A. (2012). *Leadership and Management for Nurse: Core Competencies for Quality Care*. Upper Saddle River, NJ: Prentice Hall.

Recommended Resources (Continued)

- Langley, G. J., Nolan, K. M., & Nolan, T. W. (1992). *The foundation of improvement (Part 1)*. Silver Spring, MD: Associates in Process Improvement, Inc.
- Marquis, B.L. & Huston, C.J. (2008). *Leadership Roles and Management Functions in Nursing: Theory and Application*. (6th Edition). Philadelphia, PA: Lippincott Williams & Wilkins.
- Roussel, L. & Swansburg, R.C. (2006). *Management and Leadership for Nurse Administrators*. (4th Edition). Burlington, MA: Jones & Bartlett Publishers.
- Topic 2: What is human factors and why is it important to patient safety? (n.d.). In *World Health Organization*. Retrieved from http://www.who.int/patientsafety/education/curriculum/who_mc_topic-2.pdf.

SELF-ASSESSMENT QUESTIONS

Which of these items demonstrate safety and accountability in nursing practice?

Table 10.4 Self-Assessment Questions Nursing Leadership and Management for Safety and Accountability		
SELF-ASSESSMENT QUESTIONS		
	YES	NO
1. Demonstrates accountability and acceptance of responsibility for one's own actions and decisions.		
2. Identifies actual and potentially unsafe situations and takes action to protect the patient, self and others from harm.		
3. Reports unsafe practice or professional misconduct of a health care provider according to organizational policy.		
4. Questions and takes action on unclear orders, decisions or actions made by other health care team members that are inconsistent with patient outcomes, best practices and health safety standards.		
5. Applies workplace health and safety principles, including bio-hazard prevention and infection control practices, and appropriate protective devices when providing nursing care to prevent harm to patients, self, other health care workers and the public.		
6. Demonstrates responsibility in completing assigned work and communicates work that is completed and not completed.		
7. Protects patients by recognizing and reporting near misses and errors (the RN's own and others) and initiates action to stop and minimize harm arising from adverse events.		

ANSWERS TO SELF-ASSESSMENT QUESTIONS

All items demonstrate safety and accountability in nursing practice. All items must be answered “Yes”.

Leadership and Management Skills in Delivering Health Programs and Services (Hospital Setting)

MARILOU PERLAS-FURIO, RN, PhD

INTRODUCTION

This module aims to effectively train the Master Trainer on how to teach and implement Management and Leadership Skills of beginning nurses in a hospital setting in order to deliver health programs and services effectively. The statements of responsibilities, competencies and performance indicators were derived from the National Nursing Core Competency Standards (NNCCS, 2012) such as the application of management and leadership principles in providing direction to manage patient care at the point of care in a hospital facility and use of appropriate strategies/approaches to plan nursing services at the bedside.

The module presents concepts that the Master Trainer will use in the lecture and discussion that would enable the beginning nurse to lead and manage effective patient care at the bedside. The didactic part of the module will be reinforced by other teaching strategies to ensure better understanding of concepts presented such as role plays. This will aid in the demonstration of formal and informal demonstration of leading and directing skills at the bedside. Samples of case scenarios are discussed to stimulate critical thinking towards a timely clinical judgment. A self-assessment test and teaching demonstration serve as methods of evaluation to measure the Master Trainer's learning.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the demonstration of management and leadership skills to effectively deliver health care programs in the hospital setting.
2. Select learning activities that will enable the learners to implement the NNCCS on the demonstration of management and leadership skills to effectively deliver health care programs and services in the hospital setting.
3. Apply nursing practice tools, guidelines and/or frameworks on the demonstration of management and leadership skills to effectively deliver health care programs and in the hospital setting.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in demonstrating management and leadership skills for the effective delivery of health services in the hospital setting.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the demonstration of management and leadership skills in the effective delivery of health services in the hospital setting will be assessed with appropriate methods and tools.

6. State policies and actions necessary to facilitate implementation of the NNCCS on the demonstration of management and leadership skills to effectively deliver health care programs and services in the hospital setting.

The specific competencies and performance indicators that are needed to be achieved by the beginning nurse are as follows:

Table 11.1.1	NNCCS on Leadership & Management Skills in the Delivery of Health Programs in the Hospital Setting	
Responsibility 3	Demonstrates Management and Leadership Skills to Deliver Health Programs and Services Effectively to Specific Client Groups in the Hospital Setting	
COMPETENCIES		PERFORMANCE INDICATORS
3.1. Applies management and leadership principles in providing direction to manage a nursing service in hospital setting.		<ol style="list-style-type: none"> 1. Specifies management and leadership principles to manage nursing service. 2. Executes appropriate activities based on management and leadership principles. 3. Determines effectiveness of implemented management activities.
3.2. Uses appropriate strategies/approaches to plan nursing services		<ol style="list-style-type: none"> 1. Specifies appropriate methods and tools in planning nursing services. 2. Carries out appropriate methods and tools in planning nursing services. 3. Evaluates effectiveness of methods and tools utilized in planning nursing services.

TOPIC OUTLINE

1. Competencies of the beginning nurse's role in the hospital setting
 - Safe and quality patient care using the management functions
 - Delegation
 - Communication
 - Collaboration and teamwork

MODULE CONTENT

COMPETENCIES OF THE BEGINNING NURSE'S ROLE IN THE HOSPITAL SETTING

Main points that need to be discussed per competency is provided in relation to attaining realistic and meaningful leadership at the point of care. They are as follows:

1. Safe and quality care using the functions of management

The staff nurse is at the center of all healthcare actions in the hospital and being the closest to the patient, has the critical responsibility of performing the first patient assessment. Many other caregivers rely on his/her findings. Such important actions can be guided by the Joint Commission's recommendation on the 2014 National Patient Safety Goals such as: use medication safely; correct identification of patients; improving

staff communication; prevention of infection; using alarms safely; identification of patient safety risk and prevention of mistakes in surgery.

It is important to cite studies that support the claim that nursing vigilance protects patients against unsafe practices. One example that can be cited is the study of Flynn (2009) which showed that nearly 50% of potential medication errors are caught before making it to the patient. Of those potential errors, 87% are intercepted by nurses. Staff nurses are expected to lead and implement safe and quality care.

The competencies of the beginning nurse on management and leadership should be guided by existing principles that will help her attain pre-determined goals in the delivery of patient care services particularly in the hospital setting. Likewise, theoretical foundation on management functions such as: planning, organizing, directing and controlling, should be the focus of the Master Trainer in facilitating the development of these competencies. Master Trainers should emphasize that practically these functions are overlapping in nature i.e. they are highly inseparable. Each function blends into the other and each affects the performance of others.

Planning and Organizing for the Effective Care of a Group of Patients

The staff nurse must be able to manage his/her time effectively to meet the quality and safety requirement of patient care. In planning, the staff nurse determines the following data so that he/she can effectively handle all assigned patients.

- Number of patients per patient classification that serves as basis for care prioritization in the delivery of services
- Patients for surgeries and other invasive procedures that serve as basis for care priorities for appropriate clinical preparation, accurate handing off for seamless continuity of care
- Know the kind and number of transport equipment, infusion pumps and other medical devices; the knowledge prepares the nurse to anticipate for the need and coordinate in advance with other units to ensure availability of resources ahead of time and ensure better patient care outcome.
- Actual number of vacant rooms that serve as basis to anticipate admission and give opportunity to plan.
- Patients with order to go home that serve as basis to prioritize their care for a timely discharge

Directing

The staff nurse directs the nursing assistants on basic nursing tasks and errands necessary for the timely care of patients.

Controlling

The nurse assesses his/her duty accomplishment every end of the shift and ensures that all required nursing actions were implemented during his/her tour of duty and that patient care outcomes are measured in all patients assigned to him/her. The following are some suggested nursing care performance measures:

- Medication error
- Falls
- Hospital acquired bedsore
- Prompt patient care or there was no delay in patient care
- No complaints

2. Delegation

The nurse works in a complex setting and needs assistance in the performance of basic nursing procedures in order to finish tasks on time. Safe patient care is achieved when proper work delegation to the nursing assistant is done.

3. Communication

A big amount of time of the staff nurse is dedicated to communication in various channels to coordinate patient care activities and ensure effective continuity of care. This is a very important competency as most of the root causes of errors in healthcare are communication related.

4. Collaboration and Teamwork

Baggs and Schmitt (1988) defined healthcare collaboration as cooperatively working together, sharing responsibilities for solving problems and making decisions to formulate and carry out plans for patient care. Ineffective interdisciplinary collaboration can negatively affect the delivery of patient care (Zwarenstein, Goldman & Reeves, 2009). The nurse has a significant role because she/he is the one responsible for providing other stakeholders important patient data as well as the bedside implementors of their desired course of actions.

APPLICATION IN PRACTICE

Being the first healthcare professional at the point of care is very critical in the patient care management towards positive care outcomes. The staff nurse can best be prepared to carry out the responsibilities if he/she exhibits the competencies required for effective nursing at the point of care.

Bedside scenarios are illustrated and by using the inquiry method, ask participants on how to improve scenario based on knowledge acquired from the module towards a successful patient care outcome such as the following.

Case Scenarios

- Setting up requirements for patient admission
- Escalating to the physician critical test results
- Initiating a call for a code
- Carrying out order for immediate transfer of critical patient from the general nursing unit to the intensive care unit
- Demonstrate effective role in ensuring patient safety in times of disaster such as fire
- Managing an irate patient
- Handling of biomedical equipment breakdown while in use
- Preparing patient for discharge
- Handling patient wishing to go home against medical advice
- Coordinating for a medical junta or conference
- Managing patient's complaint related to facilities
- Reporting and correcting a patient care error

SUGGESTED TEACHING-LEARNING STRATEGIES

1. Lecture – discussion on basic concepts of leadership and management as well as its principles as applied in the nursing services of a hospital setting.
2. Lecture – discussion on the concept and importance of nurse's assertiveness in the clinical setting that sometimes tilts the balance between life and death.
3. Demonstration of effective communication techniques in delegating appropriate tasks to nursing assistants.
4. Role play on the various scenarios provided in this module that show the significance of effective nursing leadership at the point of care.
5. Analysis of case scenarios based on actual cases or fictitious, but are structured to simulate actual case scenarios will be used for you to elicit information about projected decisions or actions of the learners. Some case scenarios are provided in the module.

SUGGESTED EVALUATION METHODS FOR LEARNERS

The transfer of knowledge and skills is evaluated thru the following:

1. Paper and pencil test using problem based questions related to case scenarios stated in this module.
2. Class participation
3. Case studies

SELF-ASSESSMENT QUESTIONS (SAQs)

Self-Assessment Questions are intended for the master trainer as a self check on his/her learning from this module.

To assess the master trainer's preparedness and confidence in teaching the module, you must be able to honestly answer the following questions:

- Do I have an adequate knowledge and understanding of the complex setting of a typical nursing unit in a hospital?
- Do I understand the dynamics of events in a typical nursing unit?
- Do I understand the expectations of patient and his/her family, the expectations of each healthcare team member such as physicians, nurse managers, business officers, medtechs, rad techs and other hospital workers?
- Do I understand the performance limitation of a beginning nurse in terms of their entry level competencies?
- Do I have the confidence to teach the Leadership and Management module?

If you answer "yes" to all questions this means that you have the preparedness and confidence to teach the module. If you fail to answer "yes" to any question, go back to the part of the module to learn it.

Evaluation method for the trainer:

- Direct observation of the trainer's delivery of the Leadership and Management module
- Teaching demonstration of the module is evaluated in terms of:
 - Completeness of teaching contents as prescribed

- Effectiveness of teaching style
- Appropriate use of sample scenarios

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- Marquis, B. L. & Huston, C. J. (2006). *Leadership Roles and Management Functions in Nursing: Theory and application*. Philadelphia: Lippincott Williams & Wilkins.
- Sullivan, E. J. and Decker, P.J., (2009). *Effective Leadership and Management in Nursing*. (7th ed.). New Jersey: Prentice Hall.
- World Health Organization. (2011). *Patient Safety Curriculum Guide: Multi-Professional Edition*. Malta.
- Online Resources
- 10 Most Identified Sentinel Event Root Causes. (2013). In *Becker's Hospital Review*. Retrieved May 3, 2014, from <http://www.beckershospitalreview.com/quality/10-most-identified-sentinel-event-root-causes.html>.
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Leadership and Management in the Community: Effective Delivery of Health Programs and Services to Specific Client Groups

WILHELMINA ZARAGOZA -ATOS, RN, PhD

INTRODUCTION

The ultimate goal of this module is to develop a pool of confident Master Trainers like you to help facilitate the easy implementation of the NNCCS, covering the Responsibilities and Competencies of beginning nurses in relation to leadership and management skills to effectively deliver Health Programs and Services. In this module, the focus is to specific client groups of the community health nurse.

This module focuses on integration of Leadership and Management Responsibility No. 3 which states the beginning nurse's role in demonstrating management and leadership skills necessary in the effective delivery of health programs and services to specific client groups in the community setting. Using appropriate approaches to deliver the core functions of beginning professional nurses in the local public health system, this module aims to facilitate your performance as Master Trainer related to NNCCS in: (1) training implementation facilitators who will implement the NNCCS in the community setting, (2) conducting performance appraisal and determining gaps, (3) providing consultation activities to the organization implementing the NNCCS.

This module further presents concepts that you, the Master Trainer, will use in the didactic sessions that would enable the beginning community health nurse to lead and manage delivery of health programs and services in specific settings (government health centers, industrial/ occupational health, school health, home health care, community mental health). The sessions are expected to be enhanced by appropriate teaching strategies and educational aids that will impact with identified target group of learners in community settings. "Real life" case scenarios which mimic as closely as possible the day to day works in specific settings are given to stimulate critical thinking and learning by experience and reflections. Remember that this module is on the 3rd responsibility and earlier modules on leadership and management have given you some knowledge of the topic but the aim of this particular module is to build on existing knowledge. As you are the Master Trainer, this is a higher level of learning which requires you to apply existing knowledge to solve problems.

Note: Remember that the aim of the module is for you, as Master Trainer, to achieve the learning outcomes/module objectives. So self-assessment is indeed imperative so you can track your own progress and confirm that you have achieved the objectives of this module. Summative assessment is for formal examination purposes and will not be covered here.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on demonstration of management and leadership skills to deliver health care programs and services effectively to specific client groups in the community setting.
2. Select learning activities that will enable the learners to implement the NNCCS on demonstration of management and leadership skills to deliver health care programs and services effectively to specific client groups in the community setting.
3. Apply nursing practice tools, guidelines and/or frameworks on leadership and management skills for effective delivery of programs and services in specific group of clients in the community setting.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in the demonstration of management and leadership skills to deliver health care programs and services effectively to specific client groups in the community setting.
5. Demonstrate how the achievement of specified competencies of the NNCCS management and leadership skills to deliver health care programs and services effectively to specific client groups in the community setting will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on demonstration of management and leadership skills to deliver health care programs and services effectively to specific client groups in the community setting.

Table 11.2.1 Beginning Nurse's Role on Leadership and Management	
Responsibility 3 Demonstrates Management and Leadership Skills to Deliver Health Programs and Services Effectively to Specific Client Groups in the Hospital Setting	
COMPETENCIES	PERFORMANCE INDICATORS
3.1. Applies management and leadership principles in providing direction to manage a community/ village based: 3.1.1. health facility 3.1.2. component of a program or 3.1.3. nursing service.	1. Specifies management and leadership principles to manage community/ village based health facility, a component of a health and/or nursing service. 2. Executes appropriate activities based on management and leadership principles. 3. Determines effectiveness of implemented management activities.
3.2. Uses appropriate strategies/approaches to plan nursing services.	1. Specifies appropriate methods and tools in planning community health and nursing service. 2. Carries out appropriate methods and tools in planning community health programs and nursing services. 3. Evaluates effectiveness of methods and tools utilized in planning community health and nursing services.

TOPIC OUTLINE

1. Specific leadership and management concepts and principles to manage community/ village based
 - A. Population - focused Health Planning
 - Nurses role in program planning
 - Population targets and intervention levels
 - B. Planning for Community Change
 - Community Organization Models
 - Structures for Health Planning
 - C. 14 Steps of Program Planning
 - From assessment to program evaluation
 - D. Implementation
 - Types of Intervention
 - Strategies for Implementing Program
2. Appropriate activities based on management and leadership principles
 - Guideline on who should be involved in planning group
 - Steps in establishing a work plan
 - Sample Gantt Chart
3. Methods to determine effectiveness of implemented management activities
 - In-basket Exercise (actual assessment of census) to apply the steps in program
 - Planning and interview of PHN involved in new health program (what aspect were unsuccessful and might have been done differently)
4. Appropriate methods and tools in planning community health and nursing service
 - Community Organization Models
 - Community Empowerment Model
 - Social Action Model
 - Planned Approach to Community Health (PATCH)
 - Data sources: primary (observation, survey, informant interview, community forum, focus group) and secondary data, Registry of vital events, health records and reports FHSIS (DOH-IMS, 2011 in Famorca, 2013, p. 139)
5. Integration of appropriate methods and tools
 - Clinical exposure for integration
6. Evaluation of the effectiveness of methods and tools utilized in planning community health programs
 - Case presentation

MODULE CONTENT

As a Master Trainer, you should be able to facilitate and navigate your learners/ trainees in seeking for literatures, readings, articles, and clinical guidelines on nursing management in the local public health system, organization and administration of school health, home health care, rural health, occupational health and community mental health, leadership in community health nursing, family case management, health planning and interventions and capacity building strategies.

As Master Trainer, you need to remember that management processes are the same but in public health, the context makes management in public health in a way different. (Maglaya, 2009). Particularly in the Philippine setting given the varied macro and micro contexts of the local health organizations, government program policies, budget, local culture and health budgets, management in public health is a unique undertaking. You and the implementation facilitators must ensure that the following topics are included in the discussion of delivery of health programs and services. As beginning public health nurses, they participate in the management of health centers and health programs to improve people's access to and quality of health

services that lead to better health outcomes for the barangay/ community. You have to remember that in small organizations such as local (municipal) organizations, higher management functions reside in the top local officials (devolved organizational structure) and the day-to-day/ operational concerns are with the supervisors (the public health nurses). Top management is responsible for setting the organization's goals, objectives and policies. Supervision (first level management) is concerned with managing an organization's goods and services (Rue and Bryars, 1996, 3-4 cited in Maglaya, 2009, 419) and responsible for directing the work of subordinates.

1. MANAGEMENT FUNCTIONS

Management functions include planning, organizing, staffing, leading or directing and controlling. In the first level management, planning involves determining how to achieve the mandate or work of the unit, which is the delivery of health services and implementation of health programs. A component of the organization's plan is a nursing unit plan. In strategic planning, PHNs participate in reviews (Strengths, Weaknesses, Opportunities and Threats (SWOT)) to articulate their aspirations and unique contributions. The operational plan deals with routine activities of the health center that address the requirements for delivering health services on a daily basis (training of health center staff, income generation, purchase of equipment, introducing new system of recording, staff development, performance evaluation, review of job description, mentoring, coaching, rewards system etc). In the preparation of budget, the Public Health Nurse (PHN) should consider cost-effectiveness of interventions and activities. Likewise, the nurse supervisor should ensure manuals of policies are available to all so that they are informed of rights, duties, and responsibilities as health workers. Organizing is division of work, coordination, unity of command, authority and responsibility span of control.

Questions to Ponder on

Questions to ponder on in relation to organizing are:

1. How will the work (health services) be divided? Is the Division according to client groups (children, women, elderly) or programs (Maternal and Child Health (MCH), Communicable Disease (CD)/Non-Communicable Disease (Non-CD))? Many nurses are designated as coordinators of health programs (Expanded Program on Immunization (EPI), Direct Observed Therapy (DOT), Integrated Management of Childhood Illnesses (IMCI), Information, Education and Communication (IEC)). Sometimes the PHN assigned in health centers maybe accountable to two (2) chief nurses and the head of the health center. In public health setting, the span of control for a PHN who is the direct supervisor of midwives, is determined by level of training or competence of subordinates, degree of geographical dispersion, their accessibility to the supervisor and level of difficulty of their work.
2. How should nurses be reflected in the overall organizational structure? How many levels of management should there be?
3. What needs to be done to increase staffing for a contingency plan in times of need such as disasters? Are there time and motion studies?

2. LEADERSHIP

In an organizational context, it is "making people want to do something" (Kron in Maglaya, p. 425). The challenge for the nurse is how to influence their subordinates (co-workers) to: provide quality service, meet program service targets, observe cost containment measures, and observe organizational values. The flow of communication, delegation, evaluation/performance appraisal and quality assurance guarantee the quality or level of care to the clients. Try to review again Responsibility 1 of Leadership and Management

(L&M) module as you will need it in the performance of specific skills which you will carry through in specific client groups. You need to review also Responsibility 2 of Leadership and Management module so you may be able to differentiate/delineate what is unique if the setting is different.

TEACHING AND LEARNING STRATEGIES

You may want to review the first module on Responsibility No. 1 (Leadership and Management) and refer to the recommended references. Additional references to equip you with how you will achieve the module objectives will be provided as you move through the module.

1. **Lecture** - discussion on the basic principles and concepts of leadership and management in providing direction to manage a community/ village- based health facility, component if health program and / or nursing service.
2. **In-tray or in-basket exercise** is a simulation of work samples on decision-making. It determines a learner's ability to manage multiple tasks, priorities, delegation of work and quick analysis of information. The steps in an in-basket exercise are:
 - a. Read and understand the items on a given scenario. This scenario contains a description of your role and responsibilities and several items or tasks.
 - b. Prioritize and decide your possible actions.
 - c. Answer questions on how you will respond.
 - d. Justify your answers to the evaluator or in a group discussion.
3. **Cases or scenarios** are situations which mimic as closely as possible day-to-day work with specific groups of clients. In a role play, the learner is given a scenario and assigned a role (e.g. Team Leader). The learner responds and interacts with other players (subordinate, co-worker or clients). The performance of the learner is observed or video-taped for processing. Processing and evaluation include asking the players how they felt, why he/she responded in a certain way and what might have been alternative responses. The purpose of role play is to bring out awareness of one's knowledge and attitudes.

Teaching Tip

To be able to facilitate the integration of 2012 NNCCS, specifically that which is related to responsibility 3, "demonstrate management and leadership skills to deliver programs and health services effectively to specific client groups in the community setting", you as a master trainer must be very clear with the information that you want your learner to acquire. Clearly, this information must be accurate and up-to-date. The content should also be clearly referenced so that your learner is able to check the information. There is no problem with reproducing other people's material as long as your reference is cited. Remember to emphasize that the learner must utilize approaches that are most appropriate to the community and the purpose of the unique health event or activity in the community.

ASSESSMENT OF LEARNING

Assessment or evaluation is a process of finding out the effectiveness of learning and programs. In most cases, the assessment for the module should be "formative". This is purely for the master trainer's benefit so that you can track your own progress, the assessment is limited to the learning objectives. The purpose is to allow you to confirm that you have achieved the module's objectives. You as master trainer should perform well in your assessment. Results will also confirm that this module has been effective.

Evaluation in nursing care with communities involves evaluation of programs of care for populations. Program evaluation includes evaluation of outcomes (program goals and outcomes objectives) as well as evaluation of structures and processes to achieve the outcomes (Ervin, 2002). The outcomes are the end results, structures are the social and physical resources, and processes are the “sequence of events and activities” (ANA, 1986 in Maurer and Smith, 2013) used by the nurse during the delivery of care. For example: evaluation of a health program designed to identify adults with high glycosylated hemoglobin or other blood chemistry levels would include the following:

- Structure standard: blood screening will be available to all adults regardless of whether they can pay or not for testing (FBS, glycosylated hemoglobin, lipids, SGPT, creatinine)
- Process standard: blood chemistry screening will be performed on all adults who come to health screening event
- Outcome standard:
 - (A) 100% of the adults screened will be given test results through the Health Clinic
 - (B) 75% of adults with blood chemistry levels above the recommended norm will follow-up with physician's visit for evaluation and nurse health education package

Sample questions answered in evaluation with the Donabedian Model as guide:

Table 11.2.2 Sample Questions Answered in Evaluation		
VARIABLES	QUESTIONS	EXAMPLES OF MEASUREMENT
1. Outcome achieved	Did change occur in the blood chemistry level?	Numbers and rates of adults screened; Number and percentage of followed up visit
2. Appropriateness	Are goals and plans acceptable both by the nurse and client?	Adult preferences of blood screening
3. Adequacy	To what degree does the intervention (blood screening) meet total needs of the community?	Rate of effectiveness x number of adults screened to blood chemistry and follow up visit
4. Efficiency	What resources were used by the center?	Relationship of identified factors and outcomes achieved
5. Process	Do benefits of health program designed justify use of resources? What did nurses do? When was this done? Where was this done?	Number of screening sessions and client encounters per week/month

MASTER TRAINER'S SELF - ASSESSMENT QUESTIONS

To assess your preparedness and confidence in teaching this module, you need to go back to the module objectives. You, as master trainer, need to be able to answer with honesty, if you have a clear idea of the learning objective and determine if you have achieved the objectives.

Table 11.2.3

Self-Assessment Questions on Health Service Delivery in the Community Setting

MODULE OBJECTIVES	SCALES			
	AGREE	STRONGLY AGREE	DISAGREE	STRONGLY DISAGREE
1. I can describe the NNCCS on Demonstration of Management and Leadership skills to deliver health care programs and services effectively to beginning nurses in specific client groups in the community setting.				
2. I can specify what and how an appropriate instructional strategy/ activity can be carried out to enable the learners to perform the specified competencies in community setting.				
3. I can identify appropriate community health nursing practice tools, guidelines, frameworks on leadership and management skills for effective delivery of programs and services in specific group of clients.				
4. I can describe teaching-learning strategies/activities to guide learners through critical thinking in inquiry-based nursing practice.				
5. I can illustrate evaluation methods and tools to determine the achievement of Competencies using the specified performance indicators in the community setting.				
6. I can specify decisions, policies and actions which are necessary to facilitate implementation of NNCCS in appropriate work- setting.				

LEARNING BY EXPERIENCE AND REFLECTIONS: SAMPLE SCENARIOS (WIND SHIELD SURVEY)

Scenario # 1

You and your learning group are strolling around Guirayan St. at Barangay Imelda. It is a sunny day yet the cold breeze of January 2013 does make you feel uneasy as your eyes are drawn to the surroundings. The rows of semi-concrete houses are in various physical states. Some are in deterioration and you can still

see traces of “Habagat” and the recent heavy rainfall. No grass is growing in the front and backyard and the street is littered with trash. People are passing by, some are sitting on the sidewalks talking and watching the traffic pass by. There are young female adolescents sitting holding infants. Children of different ages are playing in the streets. The neighborhood is full of activity and noise from the jeepneys passing by.

As you continue walking, you enter an area with houses and small yards with green grass, and streets lined with blooming flowering plants. Few adults and children are in the local park. The scene is an exact contrast to the other end of the street.

Question to ponder: Two scenes were presented to your eyes - geographically close but different.

1. Who live in these two neighborhoods?
2. What would it be like to live in there?
3. If you were to assess the demographic characteristics of the community as a community health nurse, predict what health problems are likely to exist?
4. Based on your assessment in #3, apply the steps for program planning. Be sure to identify who needs to be involved in the planning process to ensure its success. Develop at least one program goal and related outcome and process objectives.
5. Consider which model of community organization you are more inclined to use.

Scenario # 2 (Program Planning)

You have a friend who owns a large automobile factory with corresponding workers. Your friend told you that almost 50% of their workers are exhibiting mild respiratory symptoms at present. Your friend is aware that you are a Public Occupational Health Nurse. Your friend told you that the company is considering a program designed to control respiratory disease among the workers. Workers have been exposed to different respiratory hazards, 20% of the workers are within the reproductive age group, 10% are women. The main problem is exposure to formaldehyde. The company is interested to develop a pilot program that will need the collection of health and industrial hygiene data. The workers and the company owner support the project.

Questions to ponder:

1. What are the implications of discovering the adverse effect among the current workers? What ethical insights can be drawn from this information?
2. Create a pilot health program proposal for this special client in community setting.

Sample In- tray/In-Basket Exercise Scenario

In this scenario, provide the questions you need to ask so that you can assess the learner's behavioral response and competency/objective.

- You have just started a new job in a health facility. You did a wind-shield survey of the locality on a Saturday to familiarize yourself with the things before you officially start work on Monday. When you arrived that Monday, your supervisor called you and she wants you to stand-in for her for the next 7 days.
- Having been in your job for a short while, your boss asks you to manage the center's strategic project over the next two weeks as she has been called to the head office.

You have just completed the learning by experience and reflections through sample scenarios. These exercises will assist you understand and appreciate more the leadership and management skills needed for effective delivery of health programs and services to specific client groups.

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Managing a Nursing Service (Hospital)

MILA DELIA M. LLANES, RN, PhD

INTRODUCTION

The outcomes of health care and nursing services are largely dependent on how nursing services are managed and coordinated by those who are responsible and accountable for the service delivery. Nurse managers and leaders are at the pivotal point in the health care system. Hence, it is imperative that they demonstrate the essential competencies in managing nursing services.

This module aims to prepare the master trainer to facilitate the development of the competencies of the learner in managing the nursing service of a nursing unit in a hospital setting.

This module focuses on the core competencies of a beginning nurse leader-manager in managing a nursing service (Responsibility 4).

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on managing a nursing service in a nursing unit hospital or facility-based setting.
2. Apply the concepts, theories and principles of coordination, collaboration, and supervision in the vignettes or case studies prepared to facilitate learning of the competencies.
3. Select learning activities that will enable the learners to implement the NNCCS on managing a nursing service in a nursing unit hospital or facility-based setting.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in managing a nursing service in a nursing unit hospital or facility-based setting.
5. Demonstrate how the achievement of specified competencies of the NNCCS on managing a nursing service in a nursing unit hospital or facility-based setting will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on managing a nursing service.

Table 12.1.1		NNCCS on Managing a Nursing Service (Hospital)	
Responsibility 4		Manages a Community/Village-Based Health Facility/ Component of a Health Program or Nursing Service	
COMPETENCIES		PERFORMANCE INDICATORS	
4.1. Coordinates the task/functions of other nursing personnel.		<ol style="list-style-type: none"> 1. Chooses appropriate strategies/methods/tools to ensure coordination of tasks/functions of other nursing personnel (midwife, barangay health worker, utility worker) 2. Implements chosen strategies/methods/tools 3. Evaluates effectiveness of implemented strategies/methods/tools 	
4.2. Collaborates with other members of the health team in the implementation of services.		<ol style="list-style-type: none"> 1. Specifies appropriate strategies with other members of the health team in the implementation of programs and services. 2. Carries out appropriate strategies to collaborate with other members of the health team in the implementation of programs and services. 	
4.3. Ensures adequate resources (e.g. human, material) to effectively implement services based on requirements, ratio and standards.		<ol style="list-style-type: none"> 1. Selects appropriate methods/tools to ensure adequacy of resources 2. Uses appropriate methods/tools to ensure adequacy of resources for effective program/ service implementation based on requirements, ratio and standards 3. Determines effectiveness of methods in maintaining adequacy of resources 	
4.4. Mobilizes resources for effective service delivery.		<ol style="list-style-type: none"> 1. Specifies strategies necessary to mobilize resources for effective program implementation/s service delivery 2. Implements necessary strategies necessary to mobilize resources for effective program implementation/service delivery 	
4.5. Supervises the implementation of the nursing services.		<ol style="list-style-type: none"> 1. Determines appropriate strategies to supervise implementation of the nursing component of the health services 2. Uses appropriate strategies to supervise the implementation the nursing component of the health services 	
4.6. Ensures that all nursing personnel adhere to the standards of safety, bioethical principles and evidenced-based nursing practice.		<ol style="list-style-type: none"> 1. Selects appropriate strategies/methods/tools to ensure that all nursing personnel adhere to standards of safety, bioethical principles and evidenced-based nursing practice 2. Implements appropriate strategies/methods/tools to ensure that all nursing personnel adhere to standards of safety, bioethical principles and evidenced-based nursing practice 	

COMPETENCIES	PERFORMANCE INDICATORS
4.7. Evaluates specific components of nursing services based on parameters/ criteria.	<ol style="list-style-type: none"> 1. Specifies results, outcomes of specific components of community health programmes/ nursing services based on evaluation criteria/ parameters 2. Determines areas for program/service implementation re-planning based on evaluation outcomes/results
4.8. Applies management and leadership principles to ensure a complete, accurate and up-to-date documentation of activities and outcomes of managing a nursing service.	<ol style="list-style-type: none"> 1. Participates in developing and implementing documentation methods and tools to ensure a complete, accurate, and up-to-date information on activities and outcomes of managing a community, village-based facility, components of health program, and/or nursing service 2. Develops the competence of the nursing support staff to ensure a complete, accurate and up-to-date documentation of activities and outcomes of implemented components of a community, village-based health program, and/ or nursing service
4.9. Maintains a positive practice environment.	<ol style="list-style-type: none"> 1. Specifies strategies appropriate for the effective maintenance of positive practice environment 2. Carries out appropriate strategies to maintain a positive practice environment 3. Determines effectiveness of implemented strategies

TOPIC OUTLINE

1. Competencies of a Nurse Manager
 - Coordination
 - Collaboration
 - Communication
 - Group Process
 - Staffing
2. Maintaining Positive Practice Environments

TIPS FOR TEACHING

Suggested teaching-learning methods as well as evaluation methods to assess learners' achievement are included in this module to guide you in facilitating the development of the desired competencies of the learner in managing a nursing service in a hospital setting.

Vignettes based on factual cases or fictitious, but are structured to simulate actual case scenarios will be used for you to elicit information about the projected decisions or actions of the learners. Guide questions are found towards the end of the vignette, which will be graded accordingly.

Self-Assessment Questions (SAQs) are intended for the learner as a self-check on one's learning from this module. Answers to the SAQ are also provided at the end of the module.

Attachments/ Annexes are provided to give the learner the needed content since not one book available in the local bookstores contains in full all these materials needed to expound on Responsibility 4 Leader-Manager: Managing a Nursing Service. Further, some suggested online resources are included to guide the learner on the websites to visit to enhance one's development of the competencies.

MODULE CONTENT

COMPETENCIES OF A NURSE MANAGER

1. Coordination

In many health care facilities, you will function in a work group environment or as part of a team. Nursing, has at its core, both a caring and coordinative function. The nurse's coordinative function is at the hub of all patient information (Huber, 2010). It is imperative therefore that as leader/manager, you need to acquire knowledge base in coordinating the functions/tasks of the nursing personnel and collaborating with other interdisciplinary team members.

2. Collaboration

Collaboration enhances a person's participation in decision making to accomplish mutual goals (Marquis and Houston, 2009). You have to work collaboratively with interdisciplinary teams. Among the health professionals providing care for your clients, you are involved more intimately and more proximately in managing the total health care of the client. Understanding and developing the competence in group process and dynamics, therefore is essential, considering the group functioning and cooperative aspects of nursing practice (Huber, 2010).

As necessary competencies in collaborating with the interdisciplinary team, it is imperative that the nurse leader-manager develops the competencies in communication, team work and group processes.

3. Communication

Communication is vital for the effective management of services in the nursing unit. Nurse leader-managers need to develop competence on the communication process, the use of technology in communication and documenting accurately and completely what transpired during the communication process. Moreover, the nurse leader needs to be able to communicate with difficult people in the team. One requires special communication skills to deal with some personalities including hostile-aggressive, complaining, negative, unresponsive and super agreeable (Bramson, 1997; & Solomon, 2002, as cited by Huber, 2010).

4. Group Process

Collaborating with other members of the health team requires working with a group. This function shapes the essence of managing a nursing service as the nurse leader does not work in isolation. He/She must be able to effectively manage and set the direction of the collective work of the group. This necessitates basic knowledge of group process elements. Huber, 2010 cites Book and Galvin (1975) in describing the group process elements, which include:

- The process of working together
- The standards that regulate the group's behavior
- The process of problem-solving or decision-making that the group adopts
- The communication that occurs among group members
- The roles played by each member

Moreover, the nurse leader needs to acquire understanding of the various stages of group work and development. Farley and Stoner as cited by Huber (2010), emphasized that groups tend to go through a series of stages in their work and development. They identified these as:

- First Stage: **Orientation**. The group first forms and the members begin to relate to one another and the task.
- Second Stage: **Adaptation**. The group begins to develop a collective identity and differentiate roles.
- Third Stage: **Emergence**. The group reaches this stage as control issues arise. Disputes, disagreements, confrontations, alliances, and power struggles mark this stage of determining control over the group in order to emerge with a more consolidated identity.
- Fourth Stage: **Working**. The group enters this stage when conflict and dissent dissipate and the group achieves greater cohesion through negotiation. The group is now focused primarily on decision making and productivity.

5. Staffing

The delivery of nursing care and services is shaped by certain standards established by the regulatory and accreditation agencies, institutional policies, and nursing care delivery models. The major goal of staffing management is to provide the right number of nursing staff with the right qualifications to deliver high-quality, safe and cost-effective nursing care to a group of patients and their families (Smith, 1904; Warren, 2006 as cited by Huber, 2010).

You can read more about staffing and dealing with difficult people in the team in the annexes. You can also use Annex Z to discuss Management issues.

The Philippine Nursing law clearly stipulates that “The government and private hospitals are mandated to maintain the standard nurse-patient ratio set by the Department of Health (DOH)”. Based on an Administrative Order issued by the Department of Health, the standard nurse-patient ratio is 1:12 to 1:15.

Accreditation standards vary according to the regulation set by the agency. Both government and private accreditation agencies have included staffing standards to ensure safety and quality of care to patients. PhilHealth included the following goals relative to human resource management:

- The organization provides the right number and mix of competent staff to meet the needs of its internal and external customers and to achieve its goals.
- Recruitment, selection and appointment of staff comply with the statutory requirements and are consistent with the organization’s human policies.
- A comprehensive program of staff training and development meets individual and organizational needs.

Moreover, the Joint Commission used by some private tertiary hospitals in the country, requires quality and safety standards that must be observed. The agency noted the following (TJC, 2006):

“The goal of the human resources function is to ensure that the hospital determines the qualifications and competencies for staff positions based on its mission, populations, and care treatment and services. Hospitals must also provide the right number of competent staff members to meet the patients’ needs”.

Discussions on staffing, principles on staffing and staffing formula are presented in an attachment of the same title.

MAINTAINING POSITIVE PRACTICE ENVIRONMENTS

One of the projects of the International Council of Nurses (ICN) is the promotion of positive practice environments (PPE). The PPE Campaign aims to improve the quality of health services by raising awareness, identifying good practice and developing tools for managers and health professionals, and implementing national and local projects to improve practice environments (ICN, 2011).

SUGGESTED TEACHING-LEARNING STRATEGIES FOR THE LEARNERS

1. Self-assessment on readiness for group work.
2. Reflective journals on assigned competencies.
3. Vignettes are brief case reports or studies in which the learners are asked to react. For eliciting the projected actions of the learner, you will ask him questions to draw the competencies required.
4. Field visits. Visit a tertiary facility that is accredited by any accrediting body (PhilHealth, International Organization for Standardization (ISO), Joint Commission International Accreditation (JCIA), or similar agencies). Interview a nursing leader/manager about her experiences/practices/initiatives/opinions on promoting a culture of safety and a positive practice environment (PPE).
 - 4.1. What is the state of the nursing service in creating a culture of safety in the workplace?
 - 4.2. How far have the nursing leader/manager engaged herself/himself in championing PPE in the workplace?
 - 4.3. What strategies or initiatives can be done further to deepen the culture of safety among the nurses and other health care providers?
 - 4.4. What strategies or initiatives can be done to strengthen the campaign for PPE?
 - 4.5. Submit a written report of the interview/questionnaire responses and include a personal reflection on your findings.

SUGGESTED EVALUATION METHODS FOR ASSESSMENT OF LEARNER COMPETENCIES

1. Analysis of a reflective journal on the value of working as a team in the nursing unit
2. Graded reports based on criteria or rubrics - video presentation, written reports
3. Graded discussion of vignettes based on rubrics or criteria
4. Re-entry plan after a hospital visit on promoting a culture of safety in the workplace and campaigning for a positive practice environment
5. Written test using modified/situation-type multiple choice items

SELF-ASSESSMENT QUESTIONS (SAQs)

1. What are the strategies by which you coordinate the functions and tasks of other members of your team during your clinical duty as a team leader tasked to manage the nursing services to be rendered to your patients?
2. Who comprises the interdisciplinary team? What specific roles do they play in the health care system? Why is it necessary to form an interdisciplinary team? How do these teams develop? What strategies do you implement in collaborating with members of the interdisciplinary team in implementing the health services for the clients under your care?
3. What resources do you need in managing nursing services in terms of physical, technical, human and material resources? What are the four (4) Ms in management? How are these resources mobilized for effective delivery of nursing services?

4. What principles, policies and procedures are generally used to guide nurses in ensuring safe, ethical and evidenced-based nursing practice?
5. What patient outcomes that are nursing sensitive which are expected to be achieved as evidence that nursing care delivery was effective?
6. What are the different elements of positive practice environment? What strategies can be adopted to develop a PPE? What essential elements do we look for if there is a PPE in the workplace?
7. What evaluation methods can be used to determine if the expected competencies on managing a nursing service is effectively achieved?

APPLICATION IN PRACTICE

Managing a nursing service in a nursing care unit can be a daunting task if one is not prepared to assume the responsibility and accountability that go with it. One can be best prepared to carry out the responsibility if he/she demonstrates the necessary knowledge, skills, attitudes and values that underpin effective management performance.

VIGNETTE: MANAGING A NURSING SERVICE IN A HOSPITAL SETTING

Mr. Gian Carlos is the charge nurse of the morning shift in a medical-surgical nursing unit. The census for the day is 24 with and the nursing team is composed of three staff nurses (2 regular staff nurses, one trainee, who just came on board two weeks ago), one nursing assistant and 1 administrative assistant (ward clerk). The night shift endorsed that 2 patients are scheduled for surgery at 7:00 and 9: 00 in the morning; one will undergo hemodialysis at 8:00 and still another will be brought to the Ultrasound for pelvic sonography.

Two patients are scheduled for blood extraction for Complete Blood Count (CBC), Fasting Blood Sugar (FBS), cholesterol, triglycerides, Blood Urea Nitrogen (BUN), creatinine, and Total Albumin – Globulin (A/G) Ratio.

The staff in the Emergency Room called up to inform Gian that a 60 year-old female patient with chronic asthma is now ready to be transferred to one of the private rooms in the unit. She needs oxygen and a pulse oximeter to evaluate the oxygen saturation of the patient. How will you manage these services?

Useful Tip

As the master trainer, you will evaluate the effectiveness of the nurse trainee in managing the nursing services of the nursing unit by eliciting his/ her responses on how he/she will carry out the required competencies.

Below are exemplars of the appropriate decisions or actions to be taken by the learner.

1. Coordinates the task/functions of other nursing personnel.

The nurse assesses the workload that needs to be carried out. He/she needs to set priorities in terms of urgency and importance of the task. He/she coordinates the duties and tasks to be performed by assigning the individual health worker their functions and tasks according to their competence, level of knowledge and experience.

2. Collaborates with other members of the health team in the implementation of services.

- 2.1. She needs to collaborate with Operating Room staff to discuss the OR schedule, preoperative preparations of the two patients for surgery, doctors' orders and other matters relative to the needs of the patients.

- 2.2. She needs to collaborate with the Hemodialysis Center staff to confirm the schedule of the patient for dialysis.
- 2.3. She collaborates with the Ultrasound Section technologist to determine the time the patient will be brought for pelvic ultrasound.
- 2.4. She collaborates with the medical technologist to remind them of the scheduled blood extraction since the patient has been on nothing per oreum (NPO) for the past 12 hours.

3. Ensures adequate resources (e.g. human, material) to effectively implement services based on requirements, ratio and standards.

With 24 patients plus one more coming, the staffing requirement is not enough, considering the workload and the competence of the staff. One staff is a nurse trainee, who is still learning her way through her nursing practice and may not be capable of carrying a heavy work load. The prescribed nurse: patient ratio of 1 nurse to 12 patients by the Department of Health is too heavy for the private institution considering the level of care and the exacting demands needed by the patients. As a general practice among private tertiary institutions, the ratio of 1:6 or 1:7 is more acceptable, though there is no public policy that legitimizes it.

4. Mobilizes resources for effective service delivery.

Considering the nature of the needs of the clients, human, technical and material resources are needed to implement the delivery of services. Medical supplies to be used for patients are requested from the Central Supply Section; medications and solutions needed are requested from the Pharmacy; dietary prescriptions must be relayed to the Dietary Section; and office supplies needed in documenting care must be available when they are needed.

5. Supervises the implementation of the nursing services.

Supervise the staff and monitor whether they carry out their functions and tasks accordingly, having in mind the safety and quality of the service. The Nurse leader-manager provides guidance or oversight of the assigned nursing task. It is therefore imperative that she is available at all times to guide the staff through various means of communication, whether verbal or written.

6. Ensures that all nursing personnel adhere to the standards of safety, bioethical principles and evidenced-based nursing practice.

Every task that a nurse performs must be in accord with standards of safety such as the infection control and prevention policies and standards, universal protocols, National Hospital Patient Safety Goals principles of bioethics (beneficence, non-maleficence, autonomy, justice, fidelity, stewardship) and guidelines of evidenced-based practice in administering nursing and health care interventions to patients.

7. Evaluates nursing services based on parameters/criteria.

The nurse leader ensures that whatever has been planned is carried out by the members of the work group based on established rules and processes and desired outcomes. This requires that the desired results are achieved and, if these are not at par with predetermined standards and criteria, then taking actions to modify, correct or control variances.

8. Applies management and leadership principles to ensure a complete, accurate and up-to-date documentation of activities and outcomes of managing a nursing service.

The nurse documents the assessment data, interventions given and outcomes of care accurately and completely. Likewise, she maintains the integrity of records and safeguards its use and makes it available only to those who are professionally and directly involved in the care of the patients (Code of Ethics, 2004).

9. Maintains a positive practice environment.

The nurse leader-manager strives to champion a positive practice environment that supports excellence and decent work. In particular, they strive to ensure the health, safety, and personal well-being of staff, support

quality patient and improve the motivation, productivity and performance of individuals and organizations (ICHRN).

ANSWERS TO SELF-ASSESSMENT QUESTIONS (ASAQs)

1. What are the strategies/methods/tools by which you coordinate the functions and tasks of other members of your team during your clinical duty as a team leader tasked to manage the nursing services to be rendered to your patients?

Answer: Determine the nature of the work load to be done. Assign each member of the team his functions or tasks to be done according to his/her level of competence and the acuity of care needed by the clients. Give instructions particularly on special diagnostic or therapeutic procedures to be done and monitor and evaluate how these functions and tasks are implemented.

2. Who comprise the interdisciplinary team? What are the specific roles do they play in the health care system? Why is it necessary to form an interdisciplinary team? How do these teams develop? What strategies do you implement in collaborating with members of the interdisciplinary team in implementing the health services for the clients under your care?

Answer: The interdisciplinary team is composed of the nurse, physician, pharmacist, nutritionist-dietician, medical technologist, physical therapist, radiologist, and all those responsible and accountable for providing care to the clients. The role of the members of the interdisciplinary team is well-defined in their scope of practice stipulated in their practice acts. The nurse is legally mandated to provide nursing services by utilizing the nursing process as a tool in his/her service delivery and so with the rest of the members of the interdisciplinary team, who have their own professional practice acts and standards that serve as guideposts for their professional roles and duties. Interdisciplinary teams are developed to form synergistic efforts in meeting the health needs of the clients.

Nurses have to work collaboratively with others and these collaborative activities shape the essence of nursing practice. Therefore as the environment of health care becomes more collaborative, nurses need strong group process and interaction skills to communicate clearly and collaborate effectively with a variety of health care workers (Huber, 2010).

3. What resources do you need in managing nursing services in terms of human, material, physical, and technical resources? What are the 4 Ms in management? How are these resources mobilized for effective delivery of nursing services?

Answer: The resources in management include the 4Ms in management: manpower, materials, machine, and money. Among these resources, the human resource (manpower) is the most vital in bringing about patient care outcomes such as safety and quality of care, financial results and organizational outcomes. Staffing management is cited as the most critical yet highly complex and time-consuming activities for nurse leaders at every level of the health care organization today. The major goal of staffing management is to provide the right number of nursing staff with the right qualifications to deliver high-quality, safe and cost-effective nursing care to a group of patients and their families (Smith, 1994; Warner, 2006 as cited in Pickard and Birmingham, 2010).

Adequate staffing is therefore imperative in every nursing unit in order to avert any possibility of error related to understaffing. Principles of staffing serve as guides for every nurse leader-manager to abide in planning and organizing his or her nursing unit.

4. What principles, policies and procedures are generally used to guide nurses in ensuring safe, ethical and evidenced-based nursing practice?

Answer: Managing a nursing service in a particular nursing unit in the hospital or any health care facility requires adherence to regulatory or accreditation standards of safety, bioethical principles and guided by evidence-based practice in policy decisions and actions.

5. What nursing-sensitive patient outcomes are expected to be achieved as evidence that nursing care delivery was effective?

Answer: Effective management of nursing services leads to quality patient care. A significant number of research studies have linked higher numbers and a richer mix of qualified nurses to reduction in patient mortality, rates of respiratory, wound and urinary tract infections, number of patient falls, incidence of pressure sores and medication errors (ICHRN).

6. What are the different elements of positive practice environment? What strategies can be adopted to develop a PPE? What essential elements do we look for if there is a PPE in the workplace?

Answer: The different elements of Positive Practice Environments (PPE):

- Occupational health, safety and wellness policies that addresses workplace hazards, discrimination, physical and psychological violence and issues pertaining to personal security
- Fair and manageable workloads and job demands/stress
- Organizational climate reflective of effective management and leadership practices, good peer support, worker participation in decision-making, shared values
- Healthy a work-life balance
- Equal opportunity and treatment
- Opportunities for professional development and career advancement
- Professional identity, autonomy and control over practice
- Job security
- Decent pay and benefit
- Safe staffing levels
- Support and supervision
- Open communication and transparency
- Recognition programmes
- Access to adequate equipment, supplies and support staff

7. What evaluation methods can be used to determine if the expected competencies on managing a nursing service is effectively achieved?

Answer: The use of Patient Satisfaction Survey is one method of evaluating the effectiveness of managing a nursing service. This method is augmented by verbal accounts of satisfied clients and their families.

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Tomey, Anne M. (2009). *Guide to Nursing Management and Leadership*. (8th ed.). St. Louis, Missouri: Mosby Elsevier.

Online Resources

<http://www.ahrq.gov/research/findings/factsheets/services/nursestaffing/nursesatff.pdf>

<http://www.workingnurse.com/The-Nurse-Patient-Ratio-Five-Years-Later>

http://www.wpro.who.int/topics/nursing/ichrn_fact_sheet.pdf

<http://www.icn.ch/projects/positive-practice-environments/>

Community-Based Health Facility/ Health Program Management in the Community

ROSALINDA G. CRUZ, RN, MN, MPA

INTRODUCTION

Just as a review -- the National Nursing Core Competency Standards (NNCCS) enumerates professional responsibilities related to three roles of a beginning nurse – client care, leadership and management and research. The professional responsibilities and competencies related to the care of different types of clients have been covered by earlier modules. In relation to management and leadership, there are six professional responsibilities, which are:

1. Demonstrate management and leadership skills to provide safe and quality care;
2. Demonstrate accountability for safe nursing practice;
3. Demonstrate management and leadership skills to deliver health programs and services effectively to specific client groups in the community setting;
4. Manage a community/village-based health facility/ component of a health program or a nursing service;
5. Demonstrate the ability to lead and supervise nursing support staff; and,
6. Utilize appropriate mechanisms for networking, linkage-building and referrals.

This module focuses on (Leadership and Management) Responsibility No. 4 -- Manage a community/ village-based health facility/ component of a health program or a nursing service. In an earlier module -- Leadership and Management in the Community: Safe and Quality Care – the role of management and leadership in enhancing the primary function of the beginning nurse, which is client care was discussed.

This module, just like all the others aims to help master trainers like you to perform your functions related to the NNCCS which are: (1) train implementation facilitators who will implement the NNCCS in their work setting; (2) perform assessments and determine performance gaps; and, (3) prepare, train, and provide consultation to the organization implementing the NNCCS.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the beginning community health nurse's responsibility related to service/program management and its accompanying competencies.
2. Select learning activities that will enable the learners to implement the NNCCS on the beginning community health nurse's responsibility related to service/program management to enable the

- trainees to perform the specified competencies.
3. Apply nursing practice tools, guidelines and/or frameworks on service/program management.
 4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in service/program management.
 5. Demonstrate how the achievement of specified competencies of the NNCCS on service/program management will be assessed with appropriate methods and tools.
 6. State policies and actions necessary to facilitate implementation of the NNCCS on service/program management.

Table 12.2.1 Beginning Nurse's Role on Management and Leadership	
Responsibility 4 Manages a community/village-based health facility/component of a health program or a nursing service	
COMPETENCIES	PERFORMANCE INDICATORS
4.1. Coordinates the tasks/functions of other nursing personnel (midwife, BHW and informal health workers)	<ol style="list-style-type: none"> 1. Chooses appropriate strategies/methods/tools to ensure coordination of tasks/functions of other nursing personnel (midwife, barangay health worker, utility worker). 2. Implements chosen strategies/methods/tools. 3. Evaluates effectiveness of implemented strategies/methods/tools.
4.2. Collaborates with other members of the health team in the implementation of programs and services.	<ol style="list-style-type: none"> 1. Specifies appropriate strategies with other members of the health team in the implementation of programs and services. 2. Carries out appropriate strategies to collaborate with other members of the health team in the implementation of programs and services.
4.3. Ensures adequate resources (e.g., human, material) to effectively implement programs/services based on requirements, ratio and standards.	<ol style="list-style-type: none"> 1. Selects appropriate methods/tools to ensure adequacy of resources. 2. Uses appropriate methods/tools to ensure adequacy of resources for effective program/service implementation based on requirements, ratio and standards. 3. Determines effectiveness of methods in maintaining adequacy of resources.
4.4. Mobilizes resources for effective program implementation/service delivery.	<ol style="list-style-type: none"> 1. Specifies strategies necessary to mobilize resources for effective program implementation/service delivery. 2. Implements necessary strategies to mobilize resources for effective program implementation/service delivery.
4.5. Supervises the implementation of the nursing component of the health services/programs.	<ol style="list-style-type: none"> 1. Determines appropriate strategies to supervise implementation of the nursing component of the health services. 2. Uses appropriate strategies to supervise implementation of the nursing component of the health services.

COMPETENCIES	PERFORMANCE INDICATORS
4.6. Ensures that all nursing personnel adhere to standards of safety, bioethical principles and evidence-based nursing practice.	<ol style="list-style-type: none"> 1. Selects appropriate strategies/methods/tools to ensure that all nurses adhere to standards of safety, bioethical principles and evidence-based nursing practice. 2. Implements appropriate strategies/methods/tools that would ensure adherence of all nursing personnel to standards of safety, bioethical principles and evidence-based practice.
4.7. Evaluates specific components of health programs and nursing services based on parameters/criteria.	<ol style="list-style-type: none"> 1. Specifies results, outcomes of specific components of community health programs/nursing services based on evaluation criteria/parameters. 2. Determines areas for program/service implementation re-planning based on evaluation outcomes/results.
4.8. Applies management and leadership principles to ensure a complete, accurate, and up-to-date documentation of activities and outcomes of managing community-based facility, component of a health program and/or nursing service.	<ol style="list-style-type: none"> 1. Participates in developing and implementing documentation methods and tools to ensure a complete, accurate, and up-to-date information on activities and outcomes of managing a community/village-based facility, component of a health program, and/or nursing service. 2. Develops the competence of the nursing support staff to ensure a complete, accurate and up-to-date documentation of activities and outcomes of implemented components of a community/village-based health program and/or nursing service.
4.9. Maintains a positive practice environment.	<ol style="list-style-type: none"> 1. Specifies strategies appropriate for the effective maintenance of positive practice environment. 2. Carries out appropriate strategies to maintain positive practice environment. 3. Determines effectiveness of implemented strategies.

THE NNCCS: LEADERSHIP AND MANAGEMENT FOR BEGINNING COMMUNITY HEALTH NURSES

As a master trainer you must discuss the beginning community health nurse's responsibility related to service/program management and its accompanying competencies (Table 12.2.1). You must be able to impress on your trainees that the responsibilities and competencies of beginning nurses related to leadership and management help make safe and quality care a reality.

Managing a community-based health facility or a health program entails coordinating, collaborating, ensuring that there are adequate resources and mobilizing them effectively, supervision, adhering to standards, evaluation, documentation of activities and outcomes, and maintaining a positive practice environment. As a master trainer, you should be able to help your trainees select references for the theoretical requirements of the end-learners (beginning nurses and senior nursing students) to be able to perform the specified

competencies.

To start, you can ask them the books that they recommend to their learners, if there are. You should also emphasize the need for them to review the required concepts and processes in leadership and management within our specific context (the country, region, province, city or municipality). Note that a major consideration in teaching community health nursing is the fact that public health facilities and programs have been devolved to local government units. Management in public health, therefore, requires not only technical competence but social and political skills as well.

In the absence of a nursing administration book that contextualizes the processes of management in the Philippine public health system, a handout may be developed by the faculty members in charge of the subject (lecture and RLE). This handout should outline and briefly discuss the specific contexts and applications of the management processes in public health.

The competencies included in this module could be covered by integrating two major fields — nursing management/administration. Thus, you may want to refer to the following references on nursing management and community health nursing.

Recommended References

Nursing leadership and management:

- Grossman, S.C. and Valiga, T.M. (2009). *The New Leadership Challenge. Creating the Future of Nursing*. (3rd Edition). Philadelphia: F. A. Davis Company.
- Huber, D.L. (2006). *Leadership and Nursing Care Management*. (3rd Edition). Philadelphia: Saunders/Elsevier.
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- Roussel, L. (ed.) (2006). *Nursing Management and Leadership*. (4th Edition). Boston: Jones and Bartlett.

Community Health Nursing:

- Anderson, E.T. and McFarlane, J. (2008). *Community As Partner*. (5th Edition). Philadelphia: Wolters Kluwer/Lippincott, Williams and Wilkins.
- Clark, M.J. (2008). *Community Health Nursing. Advocacy for Population Health*. Upper Saddle River, New Jersey: Pearson/Prentice Hall.
- Cuevas, F.P.L. (ed.) (2007). *Public Health Nursing in the Philippines*. Manila: National League of Government Nurses in the Philippines.
- Maglaya, A.S. (ed.) (2009). *Nursing Practice in the Community*. 5th ed. Marikina City: Argonauta Corporation.
- Nies, M.A. and McEwen, M. (2011). *Community/Public Health Nursing. Promoting the Health of Populations*. St. Louis, Missouri: Elsevier/Saunders.

TOPIC OUTLINE

The following topics are covered in the classroom and knowledge gained is applied in their related learning experiences (RLE).

1. Management functions (planning, organizing, staffing, leading and controlling) and principles;

management activities of beginning nurses

- 1.1. Coordinating tasks/functions of other nursing personnel
 - 1.2. Collaboration with other members of the health team
 - 1.3. Ensuring adequate resources to implement programs/services
 - 1.4. Mobilizing resources for program implementation/service delivery
 - 1.5. Supervising the implementation of health programs and/or their nursing component
 - 1.6. Ensuring the adherence to standards of safety, ethical principles and research
 - 1.7. Evaluation of health programs and nursing component of these programs
 - 1.8. Documentation of activities and outcomes of managing community-based facility, health program and/or nursing component/ service.
 - 1.9. Maintaining a positive practice environment
 2. Leadership – influencing others in relation to the abovementioned management activities
 - 2.1. Leadership behaviors
 - 2.2. Strategies in influencing others
 3. Managing health programs – planning, implementation and evaluation
 4. How to apply or integrate critical thinking in the management and leadership competencies.
- (Note:** Critical thinking has been discussed and illustrated in previous modules such as the module on Leadership and Management Responsibility No. 1.)

Beginning nurses may need to review these aspects of management and you may assist the implementation facilitators in determining the contents of the handout or the resource materials that they could use.

At this point, there may be a need to distinguish for this module nursing services from Nursing Service, with the former referring to services provided by nurses and the latter, the nursing unit in the local health department.

TEACHING AND LEARNING ACTIVITIES

As a master trainer, you should be able to help your trainees in facilitating the adoption of the NNCCS. It is your responsibility as a master trainer to help them to fully understand and appreciate the importance of the competencies of beginning nurses in community settings related to management and leadership, especially within the context of a devolved public health system.

In planning for relevant or appropriate teaching-learning activities, you should primarily be guided by the competencies and performance indicators, that is, by what the “end-learners” could do after the training conducted by the trainers/facilitators (Table 12.2.1).

You may start by asking, what teaching-learning activities (refer to the performance indicators) could be done to ensure that the end-learners could perform the competencies. Consider, too, the context of the learning – the specific practice settings the learners are in (e.g., health centers, company clinic, school clinic). As discussed in previous modules, training-learning activities may include lecture discussions, use of vignettes or case studies and actual participation in health care delivery/program implementation. Study guides which direct the learners’ attention to important topics or concepts could be given to them before the scheduled learning activities so that they could review what they learned in the classroom. Questions and answers (Q and A) that stimulate critical thinking should be interspersed throughout the learning sessions.

Learners, in particular, must be given the opportunity to participate in the activities related to the implementation of health programs where they can observe and interact with nursing personnel and other members of the health team. An observation checklist on core leadership and management activities or behaviors could be provided to provide focus and guide learners’ observations.

The trainer/facilitator should arrange with the health center/ clinic nurses and orient them to what learners' learning activities are. For example, the learners will be shadowing each one of them when they are performing the identified competencies. In turn, the nurse who has been shadowed will supervise the junior nurse/learner.

The specific mix of teaching-learning strategies is determined by the learners' identified competencies -- the performance indicators (as a specific guide), their learning needs and characteristics, the trainer's/ facilitator's creativity and resourcefulness, and the specific learning context or situation. In all the learning activities, you should always pay particular attention to the development of critical thinking in the learners. Table 12.2.2 presents examples of teaching-learning activities.

Table 12.2.2 Professional Competencies and Sample Teaching-Learning Activities	
COMPETENCIES	SAMPLE TEACHING-LEARNING ACTIVITIES
4.1. Coordinates the tasks/functions of other nursing personnel (midwife, BHW and utility worker).	<p>Lecture-discussion may be used to review core management concepts and processes as applied in the public health setting.</p> <p>Study guides should be developed to promote greater participation among learners and for them to learn to work independently. Study guides should consist primarily of "why" questions and different scenarios in public health or community setting. These guide the learners in their preparation for their RLE.</p> <p>Implementation facilitators may review, as necessary, the different management processes and how these contribute to the goals/objectives of the facility (health center, clinic); or, how these could help meet program targets.</p> <p>Use the health program manuals (e.g., immunization, TB prevention and control, etc.) to illustrate these competencies and the roles/ functions/activities of public health nurses and other nursing personnel.</p> <p>Q and A – could be interspersed throughout the teaching-learning sessions</p> <p>Example of questions:</p> <ul style="list-style-type: none"> • How could nurses help ensure that there are adequate resources to provide health services and implement health programs? • Is there an identified or identifiable nursing component of the different public health problems? If there is none, can you identify what should be the nursing component? • Do nursing personnel adhere to standards of safety? Give your specific observations • How will you rate the documentation system at
4.2. Collaborates with other members of the health team in the implementation of programs and services.	
4.3. Ensures adequate resources (e.g., human, material) to effectively implement programs/ services based on requirements, ratio and standards.	
4.4. Mobilizes resources for effective program implementation/service delivery.	
4.5. Supervises the implementation of the nursing component of the health services/programs.	
4.6. Ensures that all nursing personnel adhere to standards of safety, bioethical principles and evidence-based nursing practice.	
4.7. Evaluates specific components of health programs and nursing services based on parameters/criteria.	
4.8. Applies management and leadership principles to ensure a complete, accurate, and up-to-date documentation of activities and outcomes of managing community-based facility, component of a health program and/or nursing service.	

COMPETENCIES	SAMPLE TEACHING-LEARNING ACTIVITIES
4.9. Maintains a positive practice environment.	<p>the health facility? As a learner, what is it that you appreciate most? What are the strengths and weaknesses/ problems in the documentation of the facility's/program's performance? How could it be improved?</p> <ul style="list-style-type: none"> • What are the ethical issues related to the delivery of health services? Have you observed violations of ethical principles in the workplace? Have the rights of clients been violated? Give your recommendations as to what should have been done. • What parameters or criteria should be used to evaluate health programs/health facilities/nursing services? • What does "positive practice environment" mean? <p>Group discussions to provide learners opportunity to demonstrate critical thinking, particularly challenging each other's ideas and opinions.</p> <p>Case studies or vignettes should be well-planned. These should in relation to problems/issues/concerns in managing health facilities and programs (and/or nursing component/service). Case studies or vignettes should be context-specific and deal with the common problems/issues/concerns.(Refer to the sample case study below.)</p> <p>Written assignments (for students) on new concepts such as evidence-based practice related to health facility/program management. Concept paper on nursing leadership in the implementation of public health programs.</p>

Case Study

The local health department of the municipality of San Dionisio has an Anti-Smoking Program because of the increasing number of smokers among children and adolescents. The health center staff are preparing for the launching of an Anti-Smoking Campaign among high school students. This campaign will target about 2000 high school students from all the schools in the municipality. The schools, local non-government-organizations (NGOs) and local officials committed their full support to the program.

Questions:

1. What activities need to be done to make the Anti-Smoking Campaign a success?
2. How could the tasks of health center staff be coordinated?
3. What are some possible collaboration strategies that could be utilized?
4. What resources need to be mobilized to ensure the success of the Anti-Smoking Campaign?

Case Study (Continued)

5. Can you identify a nursing component of the Anti-Smoking Program (in general) and Anti-Smoking Campaign (in particular)?
6. What are the possible ethical issues that need to be addressed in the Anti-Smoking Program?
7. What parameters/criteria are appropriate to use when the program will be evaluated?
8. What are the most important issues/concerns related to the documentation component of the program?

Recommended Reference

AJ Lowenstein and MJ Bradshaw (Eds) (2006). *Fuszard's Innovative Teaching Strategies in Nursing*. (3rd Edition). (Philippine edition). Sudbury, Massachusetts: Jones and Bartlett Publishers.

ASSESSMENT OF LEARNING

As a master trainer, you should be able to assist your trainee in assessing the learning that occurred in the end-learners. The assessment of the beginning nurse's learning should focus on the performance indicators. Table 12.2.3 shows a sample performance indicator and evaluation methods and tools.

In planning or designing evaluation methods and tools, you must: (1) highlight that the primary goal of performance evaluation is the improvement of the delivery of health services and implementation of health program; (2) use appropriate methods and tools to measure the different aspects of the competencies; (3) integrate the essence of critical thinking; and, (4) include a mechanism for feedback.

For example, in relation to competency 4.6 – “ensure that all nursing personnel adhere to standards of safety, bioethical principles and evidence-based nursing practice” – how will the performance of the beginning nurse be evaluated? (Please refer to Table 12.2.3)

Table 12.2.3	Sample Performance Indicators and Evaluation Strategies/Methods/Tools
PERFORMANCE INDICATOR	SAMPLE EVALUATION STRATEGIES/METHODS/TOOLS
4.6.1. Selects appropriate strategies/ methods/ tools to ensure that all nursing personnel, adhere to standards of safety, bioethical principles and evidence-based practice; and	<p>Performance checklist</p> <p>The performance (activities, behaviours) could be established by observing and/or by asking the nurse, and (if necessary) validating it with other sources of data (records, reports of the health facility; other personnel).</p> <p>Safety</p> <ul style="list-style-type: none"> • Is the nurse knowledgeable about the standards of safety? Does she know if there are health program manuals, protocols? (Yes-No) • Does the nurse adhere to the standards of safety? (specify behaviours, such as hand washing, disposing sharps, chemicals or vaccines properly, using gloves, labeling ampules, vials and fluids in the refrigerator, etc. (Yes-No)

PROFESSIONAL COMPETENCIES	SAMPLE TEACHING-LEARNING ACTIVITIES
	<ul style="list-style-type: none"> Does the nurse supervise other nursing personnel to ensure adherence to safety standards? (Yes-No) <p><i>Bioethical principles</i></p> <ul style="list-style-type: none"> Does the nurse ensure that all the requisites of informed consent are met before a procedure is done on a client? (Never-Always) Does the nurse show respect to the personal or religious beliefs of the client (e.g., reproductive health/family planning) (Never-Always) Is the nurse truthful to the client? (Never-Always) Does the nurse do what is beneficial to clients and not do them harm? (Never-Always) Is the nurse fair in treating her clients especially in allocating limited resources? (Never-Always) <p><i>Evidence-based practice</i></p> <ul style="list-style-type: none"> Is the nurse aware of researches done in different areas that could improve the provision of health services in community-based facilities and enhance the implementation of health programs, particularly the nursing component of these programs? (Yes-No) Can the nurse identify practical ways to access and share information on researches that could improve healthcare delivery/implementation of health programs? (Yes-No) Can the nurse identify the different levels of evidence needed to modify or change current practices in healthcare delivery and program implementation? (Yes-No) <p>Self-assessment</p> <p>The nurse can be asked (in a written form) to rate herself/himself in terms of safe practice, ethical practice and evidence-based practice.</p> <p>Example:</p> <p>Can you please rate yourself in the following areas in a scale of 1 (lowest) to 10 (highest)</p> <ul style="list-style-type: none"> Providing health care services safely Implementing health programs in accordance with standards Observing ethical principles in managing the nursing component of health program/service delivery Knowledge of evidence-based practice Using research findings in the performance of competencies related to the implementation of the nursing component of the health program/s

The success of any competency appraisal depends not only on the validity and reliability of the performance appraisal tools but also the manner of conducting it. Competency appraisal should reflect ethical and legal principles, professional standards and the health care and sociocultural contexts.

After the Training of Master Trainers, you will be better equipped in helping other nurses to adopt and implement the NNCCS.

Staff Management

DEOGRACIA M. VALDERRAMA, RN, MAN, MHA, DPA

INTRODUCTION

The module on leadership and management focuses on staff management where the learner would be able to demonstrate ability to lead and supervise nursing support staff. The learner will be introduced to the materials and he/she is expected to practice in a selected unit of a base/affiliate hospital to develop the beginning competencies on fundamentals of staff management. It is hoped that the learner will draw upon the texts, lecture, discussions, interactive sessions, case studies and related learning experiences to evaluate how he/she can contribute to the transformation of current structures of domination.

Suggested activity: Let the learners view “AN ANTS GUIDE TO MANAGEMENT THEORY”. It is available at <http://www.youtube.com/watch?v=dTzSkz9yrWo>.

Staff management has been defined as the management of subordinates in an organization. In large organizations, many of these functions are performed by a special department such as Personnel or Human Resources. However, all line managers are still required to supervise and administer the activities and well-being of the staff that report to them.

Staff Management maintains the proper balance between demand for labor and social responsibility. To maintain interactive relationships the use of social media/network has provided the opportunity to identify potential candidates available for the job. A powerful hub of professional's networks is LinkedIn, one of the oldest and largest organizational networks with about 200 million members in 200 countries around the world. It is expected to assist in potential job search and a medium to maintain valued connections, follow companies and join groups that discuss topics relevant to one's professional interests. Social media has become an important outlet for maintaining interactive relationships through online forums.

Heath field (2000), a management consultant mentioned that employee management is a first concern if you are a supervisor or manager at work. Effective management and leadership of employees allow one to accomplish goals at work because these capitalize on the strengths of other employees and their ability to contribute to the accomplishment of work goals. Successful employee management and leadership promote employee engagement, employee motivation, employee development, and employee retention.

This module is divided into five sections. The first section is principle of supervision; second is employee training and development; third is performance management; fourth is policies and standards in nursing practice; and the fifth is policy development related to Human Resource Management (HRM).

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the ability to lead and supervise nursing support staff.
2. Select learning activities that will enable the learners to implement the NNCCS on the management of staff.
3. Apply nursing practice tools, guidelines and/or frameworks on the assessment, planning, evaluating and monitoring performance of the nursing support staff
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in managing nursing support staff.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the learner's participation in improving policies and standards of nursing practice will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on staff management.

Table 13.1 NNCCS on Staff Management	
Responsibility 5 Demonstrates Ability to Lead and Supervise Nursing Support Staff	
COMPETENCIES	PERFORMANCE INDICATORS
5.1. Applies principles of supervision for effective and efficient delivery of health programs and services.	<ol style="list-style-type: none"> 1. Specifies supervisory techniques which meet the objectives of health programs and services given expected resources. 2. Uses appropriate supervisory techniques.
5.2. Assesses supervisory needs of the nursing support staff.	<ol style="list-style-type: none"> 1. Specifies the competency needs of nursing support staff given work-setting requisites. 2. Prioritizes supervisory needs of nursing support staff.
5.3. Participates in the planning and implementation of staff development activities to enhance performance of nursing support staff.	<ol style="list-style-type: none"> 1. Specifies opportunities to plan and implement staff development activities. 2. Involves self actively in the planning and implementation of staff development activities.
5.4. Monitors the performance of the nursing support staff.	<ol style="list-style-type: none"> 1. Specifies appropriate methods and tools to monitor the performance of nursing support staff. 2. Uses appropriate methods and tools to check/keep track of the performance of nursing support staff care and mentorship purposes.
5.5. Evaluates performance of nursing support staff using a standard evaluation tool.	<ol style="list-style-type: none"> 1. Specifies the nature/quality and extent of performance of nursing support staff. 2. Provides concerned staff feedback on results of performance evaluation. 3. Reports to appropriate authority results of evaluation.

COMPETENCIES	PERFORMANCE INDICATORS
5.6. Participates in improving policies and standards of nursing practice.	<ol style="list-style-type: none"> 1. Specifies areas for improvement on existing policies and standards of nursing practice. 2. Provides feedback regarding effect of new policies and standards of nursing practice
5.7. Disseminates policies, regulations, circulars and programs among nurses and nursing support staff.	<ol style="list-style-type: none"> 1. Provides nursing support staff with appropriate information/data on policies, regulations, circulars, and programs 2. Explains accordingly the given information.
5.8. Participates in developing policies and procedures relevant to human resource management.	<ol style="list-style-type: none"> 1. Gathers data/information relevant to human resource policies and procedures. 2. Presents performance data and other related information which reflect need to develop policies and procedures relevant to health resource management

TOPIC OUTLINE

1. Supervision
 - 1.1. Concepts and principles of supervision
 - 1.2. Functions of Supervision
 - 1.3. Forms of Supervision, Roles of Supervisors and Definition of Clinical Supervision
2. Employee training and development
3. Performance evaluation
4. Policies and standards in Nursing Practice
5. Developing policies and procedures relevant to human resource management
 - 5.1. Essential guidelines
 - 5.2. Mistakes to be avoided
6. Research Implications
7. Summary
8. References

Activity 1

(Please do take time to think about these questions because it will help you make a good start on the module. You might also find it useful to note down your thoughts on these questions, and you can return to these answers again and again as you progress through the module.)

1. Attracting and retaining staff in nursing practice is not always easy. What do you think you need to do to attract and retain the best clinical preceptor in your institution?
2. What do you think constitutes good staff management practice?

MODULE CONTENT

1. SUPERVISION

1.1. Concepts and Principles of Supervision

The immediate roots of what we have come to know as supervision originated in the human services development of social work and casework. We see this in the concern for the needs of clients; and ideas and practices that are tied up to the emergence of psychoanalysis. However, to make sense of supervision it is necessary to look at the various forms of apprenticeship that have existed in different societies. In ancient China, Africa and Europe (feudal and otherwise), there are numerous examples of how people new to a craft or activity reveal their work to, and explore it with and master the recognized skills. This process of being attached to an expert, of “learning through doing” allows the novice to gain knowledge, skill and commitment. It also enables them to enter into a particular ‘community of practice’ such as medicine & midwifery (Lave and Wenger, 1991). By spending time with practitioners, by “looking over their shoulders”, taking part in the routines and practices associated with the trade or activity, and having them explore our work, we become full members of the community of practice. The primary problem in administrative supervision is concerned with the quality of the supervisee’s practice in respect of professional standard and ethics. The primary goal is to ensure adherence to these standards.

The responsibility of the supervisor to protect the interests of the client emerges as a central component of trainee supervision. Attention to client welfare is equally important in practitioner supervision (Page and Wosket, 1994).

As Petes (1967) has pointed out, traditionally, part of the overseer’s job was to ensure that work was done well according to standards set. This can be viewed as an administrative task. However, overseers also had to be teachers and innovators. There were new forms of organization and intervention such as the development of standards and strategies to implement them.

Here is one model of supervision recommended that can be discussed. This is Kadushin’s model of supervision. He goes back to John Dawson (1926) who stated the functions of supervision in the following terms:

1.2. Functions of Supervision

Administrative - the promotion and maintenance of good standards of work, coordination of practice with policies of administration, the assurance of an efficient and smooth-running office;

Educational - the educational development of individual workers on the staff in a manner calculated to evoke them fully to realize their possibilities of usefulness; and

Supportive – the maintenance of harmonious working relationships, the cultivation of “esprit de corps”. This is Kadushin’s (1992) rendering of Dawson (1926).

Proctor (1987) uses the same basic split but uses different terms – formative (education), normative (administration) and restorative (support). This has the virtue of lifting the administrative category out of line-management and thus, allowing the model to be approached from a ‘non-managerial’ standpoint.

The essentially managerial aspects of managers’ work are their responsibility for monitoring and improving the work of others. Their managerial effectiveness is determined by their capacity to improve the work of

others. If managers are not able to make this contribution, then what value are they adding? The only ultimate justification of managers' existence is the improvement of the work of their subordinates. If managers fail in this way, they fail as managers. In a people-oriented, forward looking organization, you'll want to select managers who exhibit these characteristics.

Characteristics desired in Managers:

- Value people
- Believe in two-way, frequent effective communication and listening
- Want to create an environment in which employees are empowered to take charge of their jobs
- Able to hold people accountable and responsible without punitive measures
- Demonstrate leadership and clear direction
- Believe in teamwork

Place the customer at the center of their reason for existence and regard reporting staff as customer.

In this way managers are expected to develop relationships and environments that enable people to work together and respond to change. Such 'joint performance' involves having common goals, common values, the right structures, and continuing training and development (Drucker 1988: 75).

1.3. Forms of Supervision, Roles of Supervisors and Definition of Clinical Supervision

1. **Forms of supervision:** Kadushin (1992) points that the other two forms of supervision focus on instrumental needs, whereas supportive supervision is concerned with expressive needs.
2. **Roles of the supervisor:**
 - Prevent the development of potentially stressful situations
 - Remove the worker from stress
 - Reduce stress impinging on the worker
 - Help in the adjustment of individuals to stress. Frame the concern for the person of the supervisee within the larger concern for the service to the client (The supervisor is available and approachable, communicates confidence in the worker, provides perspective, excuses failure when appropriate, sanctions and shares responsibility for different decisions, provides opportunities for independent functioning and for probable success in task achievement. (Kadushin 1992: 292).
 - Act as teacher or mentor (Their task is not just to enable the supervisee to reflect on practice and to develop new understandings and ways of working, but also to teach in a more formal sense. Mentors and clinical preceptors need to instruct learners on how to proceed in a particular situation; or to provide theoretical insights.

Nurse Manager

A common concept of the Nurse Manager is:

"A nurse who manages one or more defined areas within organized nursing services whose primary activities are planning, organizing, leading and evaluating."

The 2008 Manual on Magnet Recognition Program corrected the definition as:

"A Registered Nurse with 24 hour/7day accountability for the overall supervision of all Registered Nurses and other healthcare providers in an inpatient or outpatient area. The Nurse Manager is typically responsible for recruitment and retention, performance review, and professional development; involved in the budget formulation and quality outcomes; and helps to plan for, organize and lead the delivery of nursing care for a designated patient care area."

3. *Clinical supervision*

Instruction and supervision can be confused as in the arena of educational supervision. This form of supervision is sometimes described as 'clinical'. This way of describing or approaching supervision derives from medical experience. It has been popularized in teacher training – especially in North America. As Cogan (1973), one of the pioneers of the approach in education commented, the use of the term 'clinical' involved some resistance, but what he particularly wanted to highlight was use of direct observation in the approach. Apprentice surgeons learn their trade by first observing the skilled practitioner at work; then by undertaking surgery under close surveillance. In this way they begin to develop their 'professional artistry' (Schön 1983; 1987).

A working definition of clinical supervision has been given by Goldhammer et al (1993) in what has become pretty much the set text on the field:

"A Clinical supervision is that aspect of instructional supervision which draws upon data from direct firsthand observation of actual teaching, or other professional events, and involves face-to-face and other associated interactions between the observer(s) and the person(s) observed in the course of analyzing the observed professional behaviors' and activities and seeking to define and/or develop next steps toward improved performance."

Activity 2

1. Assign the learners in a selected clinical facility as a head nurse, as a staff nurse and as a primary nurse. Compute the actual nursing personnel needed for all shifts using the formula discussed in your lecture.
2. Plan for the actual number of staff needed based on assessed patient acuity.
3. Rank assigned items so that staff can view prioritized list of assignments on the staff board.
4. Enable the staff to view their schedules, workloads, items in the work.
5. Manage and schedule staff assignments (scheduled phone calls, meetings and inventory of activities).

2. EMPLOYEE TRAINING AND DEVELOPMENT

How you welcome a new employee into your organization is critical. Your employee orientation or on boarding process forms the foundation for a lasting, successful employment relationship. Effective ongoing training and development, whether in the classroom or on-the-job, ensures employee success in their current role. Effective employee training and development guarantees that you have employees ready for their next promotion or lateral move. Your succession planning for each position depends on training and development.

3. PERFORMANCE MANAGEMENT

Managers cite performance appraisal or annual review as one of their most disliked tasks. Performance management eliminates the performance appraisal or annual review and evaluation as the focus and concentrates instead on the entire spectrum of performance management and improvement strategies. These include employee performance improvement, performance development, training, cross-training, challenging assignments, 360 degree feedback and regular performance feedback. It also includes assessments of individuals, unit or other aggregated levels of performance to measure and improve the performance of the staff.

4. POLICIES AND STANDARDS IN NURSING PRACTICE

The Magnet Recognition Program® recognizes healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice. Consumers rely on Magnet designation as the ultimate credential for high quality nursing. Developed by the American Nurses Credentialing Center (ANCC), Magnet is the leading source of successful nursing practices and strategies worldwide.

The ANCC Magnet Recognition Program® is the most prestigious distinction a healthcare organization can receive for nursing excellence and quality patient outcomes. Achieving Magnet recognition is a rigorous process, but organizations seek to join this esteemed group because of the benefits and status it conveys. From initial recognition and through the renewal process — Magnet recognition is a credential that reaffirms the hard work and dedication of the entire nursing staff and reinforces the development and use of evidence-based criteria to achieve nursing excellence.

The Philippine Nurses Association (PNA) is as well dedicated to standards development since 1973 and published seven volumes of Standards in Nursing. We work hard to elevate the nursing profession by defining the values and priorities for registered nurses across the country. Through this work, PNA is supposed to be providing direction to nurses across the country, influence legislation, and implement a framework to objectively evaluate nursing excellence. The PNA standards used the Structure-Process-Outcome (SPO) as framework in its development.

5. DEVELOPING POLICIES AND PROCEDURES RELEVANT TO HUMAN RESOURCE MANAGEMENT

This section will describe guidelines for effective management and mistakes of management which one should avoid. Here are some essentials to be included in the development of Competency no. 5 which is to demonstrate ability to lead and supervise nursing support staff.

5.1. Essential Guidelines

1. Manage day-to-day employee performance

Managing employee performance every day is the key to an effective performance management system. Setting goals, making sure your expectations are clear, and providing frequent feedback help people perform most effectively. Learn more about managing performance.

2. Coaching and mentoring

Employees are developed and educated through methods other than training classes and seminars, among these are management responsibilities of coaching, mentoring, and building your organization into a learning organization. Find and build resources for coaching, mentoring, consulting, knowledge management.

3. Interpersonal communication

Face-to-face or person-to-person interpersonal communication is the most frequent communication method most people use at work. Additionally, people communicate via email, newsletters, phone messages, presentations and meetings. Poor communication is the most frequently cited problem in organizations. Learn how to communicate effectively. Introduction, Situation, Background, Assessment and Recommendation (ISBAR) is a recommended format of communication in health

care to avoid medication errors. ISBAR mnemonic was created to improve safety in the transfer of critical information. Adapting the ISBAR (Identify/Introduction, Situation, Background, Assessment, and Recommendation) during clinical handover gives the health care team and patients time to decide what the essential information should be handed over. (From PDF ISBAR Australian Commission on Safety and Quality, 2009).

4. Leadership

Employees have the opportunity to both lead and impact the leadership skills of others. Use these ideas to further develop leadership skills. Every employee has the potential to be a leader.

Activity 3

Activity on the style of leadership of a manager:

- Observe one clinical nurse manager (CNM).
- Based on the observation, the learner is asked to submit a critique on the leadership and management style of the the clinical nurse manager.

5. Employee motivation and engagement

Employee motivation, employee engagement, positive employee morale, rewards and recognition are explored in these resources. How do you create engaged, motivated, contributing people? How do you maintain high employee morale when people work long hours? Does your reward and recognition system contribute to or deflate employee motivation, positive morale and retention? Here are some guides for discussion during interactive sessions.

1. **Employee Involvement/Empowerment** are strategies and philosophies that enable employees to make decisions about their jobs. Employee empowerment and involvement help employees own their work and take responsibility for their results. Employee empowerment and involvement help employees serve customers/clients/other stakeholders at the level of the organization where the customer interface exists.
2. **Employee retention**, especially of your best, most desirable employees, is a key challenge in organizations today. Use these tips, articles, tools and ideas to learn employee retention strategies that will help you retain your best staff. Learn loyalty strategies for employee retention.
3. **Manage Change** as a manager or leader in a work environment that is constantly changing, change management is a crucial skill. Find what you need to know about how to manage change, address employee resistance to change, and how to ensure employee ownership of organization goals. Change management is a skill that is worth your time to develop.
4. **Team building and work teams**: Employee involvement, teams, and employee empowerment enable people to make decisions about their work. Employee involvement, teambuilding approach, and employee empowerment increase loyalty and foster ownership. Many ideas in related literature tell you how to do team building and effectively involve people.

Activity 4

Show the video “The flight of the geese – Building a winning team”. It is available at http://www.youtube.com/watch?v=XT_DZrnqJlg.

5. **Meeting Management:** Ineffective meetings use critical resources, sap organizational energy and movement, and affect employee morale. Find out how to make your meetings work for you. Learn what to do before, during, and after a meeting to produce results. Deal with difficult people in meetings. Learn the art and science of meeting management.
6. **Rewards and Recognition:** Looking for ideas about employee recognition, employee rewards, employee awards or just thanking employees? Look for further ideas for both formal and informal employee recognition and employee rewards, etc. Your only limit in employee recognition and in rewarding and thanking employees is your imagination. Be creative.
7. **Progressive Disciplinary Action:** Progressive discipline is a process for dealing with job-related behavior that does not meet expected and communicated performance standards. The primary purpose for progressive discipline is to assist the employee to understand that a performance problem or opportunity for improvement exists. You may craft documents for each employee indicating the timeframe by which the negative behavior and performance will be expected to improve.
8. **Ask for feedback,** too. Ask people for their opinions, ideas, and continuous improvement suggestions, and if you fail to implement their suggestions, let them know why, or empower them to implement their ideas themselves.

An effective manager pays attention to many facets of management, leadership and learning within organizations. Here are some suggestions culled from literature review. The most important issue in management success is being a person that others want to follow. Every action you take during your career in an organization helps determine whether people will one day want to follow you.

A successful manager, according to GURUS in Management, whom others want to follow is someone who:

- Builds effective and responsive interpersonal relationships. Reporting staff members, colleagues and executives respect his or her ability to demonstrate caring, collaboration, respect, TRUST and attentiveness.
- Communicates effectively in person, print and email. Listening and two-way feedback characterize his or her interaction with others.
- Builds the team and enables other staff to collaborate more effectively with each other. People feel they have become more effective, more creative, and more productive, MORE PROACTIVE in the presence of a team builder.
- Understands the financial aspects of the business and sets goals and measures and documents staff progress and success.
- Knows how to create an environment in which people experience positive morale and recognition and employees are motivated to work hard for the success of the business.
- Leads by example and provides recognition when others do the same. WALK THE TALK.
- Helps people grow and develop their skills and capabilities through education and on-the-job learning.

APPLICATION: The most important issue in management success is being a person that others want to follow. “Trust Me” Never jeopardize the chain of relationship linking management practices to employee satisfaction.

Competency is most useful in maintaining the proper balance between demand for labor and social responsibility.

Activity 5

1. Recall an observation on a nurse manager's decisions which you disagreed on. Do you want to become a better manager?
2. Describe the area of disagreement.
3. Enumerate some of the managing mistakes you most want to prevent and avoid.

5.2. Mistakes to Avoid

Here are some examples of manager's mistakes observed and discuss them with the learners after activity.

- Failure to get to know employees as people. Developing a relationship with reporting employees is a key factor in managing. Try knowing what's happening in their lives. When you know where the employee is going on vacation or that his kids are engaged in sports, you are taking a healthy interest in your employees' lives. Knowing that the dog died, expressing sympathy, or that her daughter won a coveted award at school makes you show interest as an involved boss. Knowing employees will make you a better manager, a manager who is more responsive to employee needs, moods, and life cycle events.
- Failure to provide clear direction. Managers fail to create standards and give people definite and clear expectations so they know what they are supposed to do, and wonder why they fail. Within your clear expectations, if you are either too rigid or too flexible, your reporting employees will feel rudderless. You need to achieve an appropriate balance that allows you to lead employees and provide direction without dictating and destroying employee empowerment.
- Not treating all employees equally. You don't necessarily have to treat every employee the same, but they must feel as if they receive equal treatment. The perception that you have pet employees or that you play favorites will undermine your efforts to manage people. This goes hand-in-hand with why befriending reporting employees is a bad idea. Employees who are not in your inner circle will always believe that you favor the employees who are - whether you do or not. This perception destroys teamwork and undermines productivity and success.
- Throw employees under the bus. Rather than taking responsibility for what goes wrong in the areas that you manage, blame particular employees when asked or confronted by executive leadership. When you know the responsibility is ultimately yours if you are the boss, why not act with dignity and protect your employees? When you blame employees, you look like an idiot and your employees will disrespect and hate you.

Trust me. They will find out and they will never trust you again. They'll always be waiting for the other shoe to fall. Worst? They'll tell all of their employee friends about what you did. Your other staff members will then distrust you, too. Your senior managers will not respect you either. They will question whether you are capable of doing the job and leading the team. When you throw your employees under the bus, you jeopardize the chain of relationships linking management practices to employee satisfaction, long term profitability and growth.

- Failure to trust. When managers don't trust people to do their jobs, this lack of trust plays out in a number of injurious ways. Micromanaging is one example. Constant checking up is another. Treat people as if they are not trustworthy - such as watching them, tracking them, admonishing them for every slight failing.

- Failure to listen. Active listening is a critical management skill. Listening is a way to demonstrate that people are valued. When employees feel heard out and listened to, they feel important and respected.
- Make decisions and then ask people for their input as if their feedback mattered. You can fool some of people but your best employees soon get the nature of your game and drop out. Along the same lines, create hierarchical permission steps and other roadblocks that teach people quickly that their ideas are subject to veto and wonder why no one has any suggestions for improvement. Enabling people to make decisions about their work is the heart of employee empowerment and the soul of employee engagement.
- Failure to react to problems and issues that will soon aggravate if ignored. Managers have a habit of hoping that an uncomfortable issue, employee conflict or disagreement will just go away on its own if they don't provoke it or try to resolve it. Issues among people just get worse unless something in the mix changes. Proactive intervention from the manager to coach and mentor, or to make sure employees have the skills necessary to resolve the issue, is imperative. Drama and hysteria do interrupt productivity, motivation, and employee engagement.
- Trying to be friends with employees who report to you. You can develop warm and supportive relationships with employees who report to you. But, you will have difficulty separating the reporting relationship in a friendship. Friends gossip, go out together, and complain about work and the boss. There is no room for their manager in these kinds of relationships.
- Failure to communicate effectively and withhold important information. The best communication is transparent communication. Sure, some information is company confidential. You may have been asked to keep certain information under wraps for a while, but aside from these rare occasions, share what you know.

Activity 6

Discuss ISBAR to show how one can improve in communication with staff.

RESEARCH IMPLICATIONS

There are various areas in this responsibility number 5 where studies can be undertaken such as the best way of supervising learners in relation to their needs; development of pedagogy of supervision; or a style of supervision preferred by learners.

SUMMARY

The topics covered by the module focus on five major elements in supervision of support staff in leadership and management. These are (1) supervision including principles; (2) employee training and development; (3) performance management; (4) policies and standards in nursing practice; and (5) policy development related to human resource management.

SELF-ASSESSMENT QUESTIONS AND ANSWERS (SAQs and ASAQs)

1. What is the best nursing care modality?

Answer: The commonly used nursing care modality is the TEAM NURSING.

- The personnel work together to identify, plan, implement and evaluate comprehensive client centered nursing care towards a common goal of providing quality patient care
- Comprehensive nursing care becomes the responsibility of the entire team.
- It involves all team members in planning patients' nursing care through team conferences and written nursing care plans.
- It provides the best care at the lowest cost.

Other nursing care modality may be used like FUNCTIONAL NURSING and PRIMARY NURSING depending upon the situation in the clinical area, a combination of two nursing care modalities may also be used.

2. What is the best conflict management that may be used in the clinical area?

Answer: Conflict management such as: DISCIPLINE, CONSIDERING LIFE STAGES, COMMUNICATION, ACTIVE LISTENING AND ASSERTIVE TRAINING are some effective conflict management strategies, while some techniques also work such as Accommodating, Avoiding, Compromising, Collaborating, Negotiating, Competing. These methods are all successful strategies. The key is to be skilled in each of these methods and to know when to apply each strategy.

3. What are the qualifications necessary to be accepted as staff nurse in a hospital?

Answer:

- Must be a Registered Nurse
- Must have seminars related to nursing care like Intravenous (IV) therapy, Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS)

4. What is the staffing pattern commonly used in government hospitals? In private hospitals?

Answer:

REPUBLIC ACT 5901 – THE FORTY – HOUR WEEK LAW

- Provides that employees working in hospitals with 100 bed capacity and more will work only 40 hours a week.
- Employees working in agencies with less than 100 bed capacity or in agencies located in communities with less than one million population will work 48 hours a week and therefore will get only one off-duty a week.

ALTERNATING WORK SHIFTS

- The frequency of alternating between days and evening, or days and nights, or rotating through all three shifts may vary among institutions. Some nurses may work all three shifts within 7 days.
- Alternating and rotating work shift creates stress for staff nurses, environmental cues, such as sunrise and sunset, fluctuate in a predictable cycle.

BLOCK OR CYCLICAL

- Uses the same schedule repeatedly. With a 6-day forward rotation, personnel are scheduled to work 6 successive days followed by at least 2 days off. The schedule is repeated every 6 weeks or the length of cycle depends on the institution

- 8 hours per day schedule
- 12 hours per day schedule

VARIABLE STAFFING

- Use census to determine number and mix of staff-little need to call in unscheduled staff

5. What is Patient classification system?

Answer:

- Is the method of grouping the patient according to the amount and complexity of their nursing care requirements and the nursing time and skills they require
- The primary aim is to be able to respond to the constant variation in the care needs of the patient

6. What shift is usually requested by staff nurses? Why?

Answer:

- The commonly requested shift depends on many factors like civil status, age, personality, engagement and other factors
- Commonly, single and young nurses prefer night shifts so they can do other things in the morning or hold other job in the afternoon
- Married nurses generally prefer afternoon or morning shift so they will be able to take care of the family's needs when they come home from work and school
- Engagement like educational, those staff nurses having post graduate studies, seminars and other professional advancement courses would request particular shift suitable for their class schedule.
 - According to Bonner et al. (1996) rostering staff is one of the most complex and important management functions performed by nurses. Rostering skills affect patient care, health budgets, and most importantly the welfare of staff. Street, Cuddihy, Best, Wilks, Geladas and Chew (1997) argue that 'rosters' are pivotal to nursing practice. They are intrinsically linked to many variable factors, and tipping the scales in one direction can cause an imbalance in other areas.
 - Further, in meeting Queensland Health's corporate objectives, managers are obligated to ensure that resources are allocated to meet demonstrated need and principles of equity (Queensland Health, 2000). This document recognizes that rostering is a fundamental activity often performed in a dynamic, changing and demanding environment (Bonner et al., 1996). The activity of rostering extends beyond matching names to shifts. It requires critical-thinking and good decision-making skills to develop a roster that effectively balances patient care, employee and organizational needs. It also means taking a whole organization approach to matching nursing resources to service demand.

7. What activities are commonly done during orientation period?

Answer:

- Induction is the first 2 to 3 days of orientation. It can be done by personnel department employees for all new employees. It includes a history of the organization, vision, purpose, structure, working hours, holiday time, vacation, sick time, paydays, performance standards, parking facilities, eating facilities, health services, education opportunities
- Orientation is important, and the manager who does not take the time to assist a new employee is making a serious mistake. Because of the information overload, induction and further orientation should be conducted over time. A checklist for orientation that indicates the content, time frame, and who is responsible to teach it can be helpful.

8. How are staff development activities done and evaluated?

Answer:

- Goes beyond orientation. It is a continuing liberal education of the whole to develop her potential full. It deals with aesthetic senses, as well as technical and professional education. It is also related to retention, raises, advancement to other positions or termination.
- Staff development can be viewed as the activities and programs (formal or informal and on or off campus) that help staff members learn about responsibilities, develop required skills and competencies necessary to accomplish institutional and divisional goals and purposes, and grow personally and professionally to prepare themselves for advancement in the institution or beyond the campus.
- Because job descriptions, individual goals and even the mission of the institution, division or department may change, staff development plans will be reviewed on a regular basis. Changes to the staff development plan shall be made as needed. Both the supervisor and the staff member must agree upon changes.
- Staff development policy should be directed towards the following objectives:
 - Clarify expectations for the continued professional education of each staff member.
 - Specify the options available for staff improvement.
 - Make clear the connection between continuous professional development and institutional rewards.
 - Ensure adequate funding for staff development activities.
 - Purposefully determine staff development activities based upon a careful assessment of staff member needs.
 - Employ accepted methods of teaching and learning in staff development activities.

9. What Decision making model is applicable in clinical decision making?

- The Descriptive Model is the best when making clinical decision, it is based on the assumption that the decision maker is a rational person, looking for acceptable solutions based on known information
- This model allows for a fact that many decisions are made with incomplete information because of time, money or personnel limitations
- It allows for a fact that people do not always make the best choices
- Simon wrote that few decisions would ever be made if people always sought optimal solutions, instead he contended that people often identify acceptable alternatives

10. How is risk management useful to nursing?

Answer:

- Risk Management is the process that centers on identification, analysis, treatment and evaluation of real and potential hazards
- Risk for Financial loss (Hayden)
- 3 aspects of risk identification that should be monitored on a continuous basis:
 - Clinical settings, clinical problems, and specific incidents involving patients, employees and visitors
 - Safety management
 - Procedures for evaluation and follow up on identified risks
- The JCAHO recommends the establishment of an integrated risk management – quality assurance program that would provide a more efficient and cost effective method of evaluation than having 2 separate functions. Specific emphasis has been on the patient safety goals which are updated

annually and are program specific

- The following parameters are incorporated into the JCAHO model for risk management:
 - Continuing education and in service training program
 - Use of data from a variety of sources such as patient surveys and feedback from other providers
 - Improvement of credentialing protocols for practitioners
 - Development and enforcement of rules, regulations, policies and procedures
 - Establishment of written criteria to evaluate risk factors, including follow up on conclusions reached
- Bennett further describes the importance of both quality improvement and risk management, identifying issues associated with quality patient care, collecting and analyzing data, making recommendations and evaluating outcomes to prevent re occurrences and upgrade quality.

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Networking, Linkage Building and Referral

DEOGRACIA M. VALDERRAMA, RN, MAN, MHA, DPA

INTRODUCTION

With an increasingly complex and dynamic health care system and a change in the demographic profile, the need is growing for an informed group of health advocates who are qualified to advise patients and their families about health care issues. Learn about the health insurance industry as well as the key provisions of both Medicare and Medicaid/Medi-Cal or PHILHEALTH legislation. With the Professional Program in Health Advocacy, you gain an in-depth understanding of the continuum of options available for both inpatients and outpatients, including rehabilitation settings, skilled nursing facilities, and home health and hospice services. Explore some of the key policy and ethical challenges in serving in a variety of roles as health advocate, geriatric case manager, discharge planner and family adviser. Specific services may include:

- Professional advice (e.g. marketing, financing, legal, etc.);
- Problem identification and solving;
- Research and development support;
- Technology partnering;
- Transfer of knowledge;
- Networking opportunities and linkages;
- Community specific opportunities
- Effective business and management skills development

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on the coordination, networking, and collaboration with health resources, GOs, NGOs and socio-civic agencies.
2. Select learning activities that will enable the learners to implement the NNCCS on the appropriate mechanics for networking linkage building and referrals
3. Apply nursing practice tools, guidelines and/or frameworks on the on coordination, networking, and collaboration essential to ensuring clients support
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills.
5. Demonstrate how the achievement of specified competencies of the NNCCS on the appropriate utilization of health resources (community and hospitals) will be assessed with appropriate methods

and tools.

6. State policies and actions necessary to facilitate implementation of the NNCCS on the coordination, networking, and collaboration with health resources, GOs, NGOs and socio-civic agencies.

Table 14.1 NNCCS on Networking, Linkage Building and Referral	
Responsibility 6 Utilizes Appropriate Mechanisms for Networking, Linkage Building and Referral	
COMPETENCIES	PERFORMANCE INDICATORS
6.1. Applies principles of partnership and collaboration to improve delivery of health services.	<ol style="list-style-type: none"> 1. Uses appropriate principles of partnership and collaboration which would improve delivery of health service delivery. 2. Carries out appropriate strategies/activities that are applications of partnership and collaboration intended to improve delivery of health service delivery.
6.2. Determines resources available for networking, linkage building, and referral necessary for improving delivery of health services.	<ol style="list-style-type: none"> 1. Selects appropriate strategies for networking, linkage building, and referral necessary to improve delivery of health services. 2. Uses appropriate strategies for networking, linkage building and referral.
6.3. Collaboration with government organizations (GOs), non-government organizations (NGOs) and other socio civic agencies to improve health care services, support environment protection policies and strategies, and safety and security mechanisms in the community.	<ol style="list-style-type: none"> 1. Chooses appropriate partnership strategies with government organizations, non-government organizations and other socio-civic agencies to improve health care services, support environment protection policies and strategies, and enhance safety and security in the community. 2. Carries out appropriate partnership strategies with government organizations, non-government organizations and other socio civic agencies to improve health care services, support environment protection policies and/or efforts, and maintain safety and security mechanisms in the community.
6.4. Engages in advocacy activities to deal with health related concerns and adopts policies that foster the growth and development of the nursing profession.	<ol style="list-style-type: none"> 1. Specifies appropriate advocacy strategies to address health related concerns and policy adoption to foster growth and development of the nursing profession. 2. Implements appropriate advocacy strategies to address health related concerns and policy adoption to foster growth and development of the nursing profession.

The contents of this module were adapted from **Chapter 3 Service Integration, Linkages and Triage** of the WHO because there are no references on networking in books on leadership and management. **Service Integration, Linkages and Triage Chapter 3** of the operations manual An Oracle White Paper January 2013 “Social Networking with a Purpose: Building Your Referral Machine”

An integrated approach to providing services at various clinics organized at health center level. Most patient types can receive „one-stop-shop” care with this approach. This requires expanding health worker capacity

to provide key interventions.

TOPIC OUTLINE

1. Principles of partnership, networking and collaboration and their importance
 - 1.1. Process of collaboration
2. Resources for networking and building linkages
 - 2.1. Types of organizational network
3. Referral process
4. Advocacy

DEFINITION OF TERMS

To understand the module better, we offer this “definition of terms” which we adopted from Operations Manual for Staff at Primary Health Care Centers.

- Integration – Delivery of services or multiple interventions together on the same patient visit by the same health worker or clinical team
- Coordination - Linkages to provide access for clients to “seamless” continuum of services
- Collaboration – A process of participation through which people, groups of people and organizations work together to achieve desired results
- Linkages – Formal networks of organizations, agencies and communities which facilitate referrals of clients and their families for needed services. Linkages also refer to relationships between the health center and services at the hospital or in the community, or between separate clinics organized within the same health center, or between clinicians and the laboratory or pharmacy.
- Triage – Sorting of patients into priority groups according to their needs and the resources available
- Referral – Intervention made when a health care or social worker guides a client to obtain services that will meet the client’s need for continuity of care
- Community – A group of people with shared resources, a common interest, shared goals, or shared tradition and culture. It can be defined by its geographical location, its social interactions or social organization.
- Service integration – The blending of either some elements or all aspects of one service into the regular functioning of another service. A key prerequisite to successful integration is the strength of the primary service into which the elements of another service are to be integrated. Annex AW is an example of a functional integration between education and service. It illustrates the organizational structure and the roles of the participants.

MODULE CONTENT

PRINCIPLES OF COLLABORATION AND NETWORKING

The goal of any collaboration effort within the school is to bring the stakeholders and the school together in an atmosphere to support the learning and development of the student.

(National Commission on Children, 1991; Dryfoos, 1990; Meszaros, 1993; Ministry of Education, 2001).

Partnership and Collaboration Principles

The diagram on the Process of Collaboration found in one of the publications of the Ministry of Education,

Singapore clearly illustrates the process of collaboration, a focus of the responsibility no. 6 of this module under leadership and management. Below is the reference for these collaboration principles.

Additional Resource

Principles for Partners Collaboration. (n.d.). In *Ministry of Education Singapore*. Available at <http://www.moe.gov.sg/compass/files/principles-of-collaboration.pdf>

The principles of collaboration outlined in the diagram aims to build on existing successes achieved by the schools in any country. It is created with the following intent:

Firstly, it is designed to assist schools to “take stock” of their collaborative journey (National Network for Collaboration, 1995). It allows schools that are embarking on new areas of collaboration or are in the process of strengthening the existing collaboration to be aware of the factors and the processes that may promote or hinder them from achieving their desired outcome.

Secondly, it aims to help schools create the link between their collaborative activities with the mission, vision and values of the schools.

Thirdly, the principles outlined in the diagram also serve to provide various “points of references” to guide schools along the collaborative journey. The provision of these reference points would allow schools to evaluate whether they are moving in the right direction as they move along the collaborative journey.

Finally, it may serve as a diagnostic tool to evaluate the continued development of collaborative efforts within the school.

The three principles that bring about a collaborative process in educational institutions are: **collaborative climate**, **purposeful collaboration** and **sustainability**.

1. Collaborative Climate

Schools need to build a climate of collaboration through two attributing factors of *Leadership and Culture*. School leaders provide the direction for establishing a positive culture of collaboration with stakeholders which include supporting teamwork and capitalizing on diverse strengths to achieve the desired outcomes as set out in the mission, vision and values of the school.

The *culture* of the school sets the backdrop for building relationships of mutual trust and reciprocity through increased interaction and involvement in school life as well as identifying areas of common interests or outcomes. The establishment of this culture is dependent on open and clear communication between the school and its stakeholders (Ministry of Education, Singapore 2000).

Formal, informal and non-formal channels of communication all play critical roles in consensus building, clarification of expectations and rapport building to establish a culture of trust and commitment (Ministry of Education, Singapore, 2000). These are in line with the philosophy held by the school and stakeholders of having a shared vision and purpose for collaboration to focus on achieving desired outcomes (Teo, 2000, cited in Ministry of Education, 2000). A memorandum of understanding or a memorandum of agreement should be signed by the president of the university and the chief medical officer of the hospital or & mayor of the city who is the official representative of the Department of Interior and Local Government (DILG).

2. Purposeful Collaboration

It is critical that schools seek alignment of their processes, programs and activities to their vision and purpose for collaboration (Epstein, 1997). Through strategic planning and effective allocation of resources (human, physical and financial), schools and stakeholders demonstrate their commitment to collaborative efforts. Regular monitoring and evaluation on the effectiveness of these efforts will be necessary to help schools review their progress and plan for future developments (Ministry of Education, 1998, 2000, 2001; Conference Board of Canada, 1998; The Council for Corporate & School Partnership, 2001).

3. Sustainability

To ensure that schools and stakeholders continue their collaborative efforts to sustain the desired outcomes, plans are drawn up together with structures and processes to explore new resources and enhance existing ones. By identifying emerging trends and developing strategies to meet the demands of these trends, schools and stakeholders will be in a better position to expand their collaborative capacity and work towards the total development of the student.

According to Baggs and Schmitt (1988), collaboration involves coordination of individual actions, cooperation in planning and working together, and sharing of goals, planning, problem-solving, decision-making, and responsibility. Collaboration can happen between two people who represent the same or different disciplines, or among small groups of people representing one or a range of disciplines. In general, health care providers tend to strongly identify with their own discipline and its language, values, and practices (Furnham, Pendleton, & Manicom, 1981; Kreps, 1988) and to relate best to members of their own discipline (Siegel, 1994). Collaboration may be very difficult to negotiate effectively because of differences in disciplinary socialization.

Cross-disciplinary communication can be complex for a myriad of reasons, but it also can be professionally rewarding and beneficial to patients' and their companions' experiences. Different professions have some unique issues in collaboration. Research on health care collaboration is very physician-centric, with most studies investigating how physicians work with members of other disciplines; it rarely specifies how non-physicians from different disciplines communicate with members of other discipline or even physicians from different specialties (Atkinson, 1995). Still, a good deal of research has been conducted with the goal of improving communication between physicians and nurses, nurse practitioners, social workers, pharmacists, and, to a lesser extent, other physicians in order to uncover some of the challenges associated with collaboration.

RESOURCES FOR NETWORKING, LINKAGE BUILDING

Collaboration is about involving the home and community (HOSPITALS AND COMMUNITY AGENCIES) in the education of nursing students (MOE, 2000). If done effectively, it will create a positive environment for learning and enable us to really mold the future of our nation. It is essential to discuss concerns and projects with those concerned in the community to create a **CORE GROUP** in the community to continue with the project/programs. The CORE GROUP to be tapped shall consist of the retired employees of the community who should be involved in the beginning of the projects conceptualization so that they are made to feel that they own the project/program.

The principles of collaboration allow us to tap on our stakeholders meaningfully and enable schools to be more effective in achieving their desired outcome in their collaborative efforts. (Please refer to Annex AW "Functional Integration of Nursing Education and the Community (Hospital and Community Agencies)" written by the author of this module for the Nursing Roadmap 2030)

Formal networks of organizations, agencies facilitating referral of client and family for needed services are referred to as linkages. The aim of coordinating services by establishing linkages is to provide access for clients to a “seamless” continuum of services. Many factors facilitate the building linkages. Some of these are formal organizational structure, informal relationships, transport systems, integration of management and support functions in planning, education and training as well as supplies and maintenance. It is a fact that if networks/referrals/linkage are well in place, this will result in improved coverage of the underserved and marginalized populations, improved quality of care and enhanced program effectiveness and efficiency.

The table of Types of Interorganizational Relationships developed by Dawes et al presents an intersection of the scope and purpose of different types of networks. It could provide a useful framework for understanding interorganizational relationships more generally.

Additional Resource

Dawes, S.S., Cresswell, A.M. & Pardo, T.A. (2009). From “Need to Know” to “Need to Share”: Tangled Problems, Information Boundaries, and the Building of Public Sector Knowledge Networks. *Public Administration Review*, 69(3), 392- 402. Available at http://www.ctg.albany.edu/publications/journals/par_knowledgenetworks_may09/

All organizations have a blend of these relationships in place. What is less frequently discussed are the governance and management structures of these relationships, and the paperwork (memorandums of understanding, secretariats, etc.) that support them.

A few common operating models are useful to understand. Common to all of these approaches is the need to address the dynamics of the relationships promoting ownership of the shared purpose, describing and accepting roles and responsibilities, understanding where authority to decide and to act rests, and ensuring accountability for performance:

- Point-to-point knowledge exchange is governed typically under the terms of an exchange of letters or an Memorandum of Understanding (MOU) between the two institutions. It has no staff personnel assigned to manage the relationship.
- A strategic alliance with real value appropriation between the partners is governed typically under the terms of a memorandum of understanding (MOU) between the two institutions. Staff is assigned to manage the relationship, and there are informal networks of staff who are engaged.

The information hub which we refer to in the article “Functional Integration of Nursing Education and the Community (Hospital and Community Agencies)” is the **CORE GROUP**. The CORE GROUP is the primary driver serving to centralize information on a specific topic/program/project etc. and encouraging other institutions and researchers to contribute. Contributors may agree to follow editorial policies or other guidelines for contributing to the hub; and may expect in return greater visibility for their own work as well as a mechanism to easily access the work of others.

Service integration is important because it can improve care since it:

- Provides more comprehensive care to the patients;
- Improves patient adherence to treatment when multiple interventions are required.

Other advantages of integration are summarized as follows:

- Avoids missed opportunities for key interventions and minimizes patients being “lost” in the system;
- Makes visits more efficient for the patient (avoids costly, time consuming, multiple visits by the patient and his/her family);
- Makes visits more efficient for the clinical team, particularly at health center level;

- Reduces waiting times during a visit.

In a recent technical brief, WHO defined integrated service delivery as “the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money”. The district health team has a central role in fostering and overseeing integration at health center level.

Another aspect of integration is the psychological integration of care into the patient’s life. Encouraging patient self-management and actively engaging the patient and their family in long-term care is essential. Therefore, it is crucial to understand and relate how services are delivered and integrated in order to support patient self-management. The time spent receiving care in the health center is small compared to self-care at home.

REFERRAL PROCESS

This section will discuss the referral process and development of referrals. It will also distinguish community outreach, community mobilization and community education which are processes or activities that require network and linkages.

A **referral** is made when a health care or social service worker guides a client to obtain services that will meet the client’s need for continuity of care.

The criteria for referrals are:

1. Client has unmet needs
2. Services are unavailable or inaccessible at the facility
3. Client requests for it

Referrals include these parts:

1. Assessment of client’s needs
2. Documentation of referral, including date, to whom client was referred to and any additional information provided to facilitate referral
3. Issues of confidentiality and privacy should be clear to the client and the staff at partner organizations
4. Feedback from referrals are important as quality assurance mechanism
5. Organization making the referral should assess the success and appropriateness of referrals.

Guidelines in a referral system:

1. Referral networks take time and commitment to create and maintain.
2. The first step is to list all referral resources in a directory.
3. A referral network includes:
 - A lead organization to coordinate the referral system
 - A way of providers to communicate regularly
 - A designated contact person at each organization
 - A standard referral form
 - A system that tracks referrals

Referrals, networking and linkages are activities that take place in organizations and communities. Let us recall the definition of a community as a group of people with shared resources, a common interest, shared goals, or shared tradition and culture who may be defined by its geographic location, its social interactions or social organizations. Health is a common goal and services are among the social interactions in a community.

The sharing and provision of these services and resources include:

1. Referrals
2. Community outreach
3. Community mobilization
4. Community education

Health Care Workers (HCW) do not only provide health care and services, they are also expected to perform these roles:

1. Inform communities of new health problems
2. Share information on the practices that can address these problems
3. Help the communities adopt practices and behaviors to prevent and overcome these problems.

Community outreach is a formal attempt to increase public awareness and support for service. Outreach work may also aim to bring tailored health education to specific populations with the goal of changing knowledge and behaviors.

The goal of community outreach programs is to ensure that the community participates in:

1. Identifying health problems and their solutions
2. Developing possible solutions
3. Identifying resources necessary to implement solutions

The value of community participation is that if community members are involved, they will have a feeling of ownership of the program and are likely to cooperate and sustain it.

Community outreach is usually done through:

1. Health education talks in communities
2. Theater skits and role plays
3. Brochures, pamphlets, posters, informational videos, comic books (what are referred to as Information Education Communication (IEC) materials)
4. Radio and television messages

Community mobilization is distinguished from health education and outreach.

1. Community mobilization aims to empower community members to state and address their own problems using their own resources.
2. Long-term process involving intensive, participatory work with community members (COPAR)
3. Health education activities are a normal part of the duties
4. HCWs may want to consider partnering with government and non-government organizations that specialize in community mobilization and health communication
5. Linkages are formal networks between organizations or agencies and the communities
6. The aim of coordinating services through linkages is to give clients access to a seamless continuum of care.

ADVOCACY

With an increasingly complex and dynamic health care system in the world today, and the demographic shift in population, there is a need for an informed group of health advocates who are qualified to advise individuals/families/population at risk and community about health issues and concerns. Learn about the health insurance industry as well as the key provisions of both PHILHEALTH and National Health Insurance Program (NHIP) legislation. With the Professional Program in Health Advocacy, you gain an in-depth understanding of the continuum of options available for both inpatients and outpatients, including rehabilitation settings, skilled nursing facilities, and hospice services. Explore some of the key policy and

ethical challenges in serving in a variety of roles as health advocate, geriatric care manager, discharge planner and family adviser.

SELF-ASSESSMENT QUESTIONS AND ANSWERS (SAQs and ASAQs)

1. Discuss roles and linkages between two health workers in different clinics.
2. Linkages refer to the relationships that the health centre maintains with other facilities and organizations in a barangay that provide services needed by patients, but are not provided directly by the health centre. What should linkages include?

Answer: The systematic and effective referral of patients and their families from one service to another within the district health system or network. Effective referral systems are important to ensure that a client receives the designated services.

3. How can you make sure that quality integration, linkages and triage are taking place at your health centre?

Answer: Improvements in quality need to be fully integrated with service delivery. Achieving and improving quality of care is a slow, persistent process. Several types of information can help. Assess what happens when specific types of patients and/or families attend your health centre. Then assess what happens by patient type:

- Are integrated care and adequate triage and linkages being provided?
- Use relevant routine data you are already collecting with the patient monitoring system on the patient cards; focus on just one or two indicators.
- Use a simple patient mapping tool. (How long is the visit? Is the visit “one-stop” or multiple stops? Is there engagement in the next leg of the service?)

APPLICATION

APPLYING BEST PRACTICES IN INTEGRATION/COLLABORATION & NETWORKING

Health center staff can do a great deal to integrate health care services. Strive for these basic principles when reorganizing health center services:

- Each health worker should be trained to provide multiple services which deliver multiple interventions/services by a single provider.
- Health workers should be able to provide key interventions during the same visit for different types of patients.

These may require additional training. Training courses that integrate multiple interventions are available. Mentorship and supportive supervision are also essential, in addition to clinical training.

A NEW DATA REVOLUTION

“Too often, development efforts have been hampered by a lack of the most basic data about the social and economic circumstances in which people live... Stronger monitoring and evaluation at all levels, and in all processes of development (from planning to implementation) will help guide decision making, update priorities and ensure accountability. This will require substantial investments in building capacity in advance

of 2015. A regularly updated registry of commitments is one idea to ensure accountability and monitor delivery gaps. We must also take advantage of new technologies and access to open data for all people.”

Bali Communiqué of the High-Level Panel, March 28, 2013

In Bali, Indonesia, the basic Communique of the High Level Panel on March 28, 2013 declared that “We envision a world in 2030 where a renewed global partnership, building on the solid foundations of the Millennium Declaration and the Rio principles and outcomes, has transformed the world through a universal, people-centered and planet-sensitive development agenda achieved with the shared commitment and accountability of all.”

SUMMARY

The major topics covered in this module are:

- Principles of Partnership, Networking and Collaboration
- Resources for Networking and Link aging
- Advocacy
- Application
- Self-Assessment Questions and Answers

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BEGINNING NURSE'S ROLE ON RESEARCH

Module 15: Research Engagement under Supervision

Module 16: Evaluation of Research Study/Report Utilizing
Guidelines in the Conduct of a Written Research
Critique

Module 17: Research Application and Quality Improvement

Research Engagement under Supervision

CORA A. AÑONUEVO, RN, PhD

INTRODUCTION

In this module, we will discuss the role of a beginning nurse in research, specifically, her/his engagement under the supervision of an experienced researcher. We conduct research in order to improve nursing practice, that is, we use evidence from studies to rationalize nursing interventions and to ensure client's safety and well-being.

Research is both exciting and challenging. Many of the issues and problems we encounter in the clinical (hospital or community) setting can be addressed by finding answers through research, that is, by "examining carefully" these problems and conducting the inquiry in a systematic way. It is important therefore that nurses have a thorough understanding of the research concepts and processes, and recognize the value of teamwork and collaboration in a successful research endeavour.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Describe the nurse's responsibility in engaging in nursing or health-related research under the supervision of an experienced researcher.
2. Discuss the steps in preparing a research proposal including compliance with the ethical principles.
3. Describe the process of conducting a research as a member of a research team.
4. Discuss how to clearly communicate results by writing a research report and presenting this in oral and poster forms.
5. Appreciate the use of research findings in evidence-based practice and influencing policies related to client care, health system and health organization.

Table 15.1	NNCCS on Engaging in Nursing or Health-Related Research under Supervision	
Responsibility 1	Engages in Nursing or Health-Related Research with or under the Supervision of an Experienced Researcher	
COMPETENCIES		PERFORMANCE INDICATORS
1.1. Participates in preparing a research proposal complying with the ethical principles in nursing research.		1. Reviews research literature to determine knowledge on the topic of interest to identify context and justify the need for the study.

COMPETENCIES	PERFORMANCE INDICATORS
	<ol style="list-style-type: none"> 2. States research problem, purpose of research, or hypothesis. 3. Identify a theoretical framework or create a conceptual model to provide an organizing framework for the research study. 4. Formulates with the research team the research design, specifying the sample and setting, data collection methods and tools, data analysis procedures and plan for data interpretation/synthesis and presentation. 5. Prepares a work plan with the research team, specifying the sequence of tasks to be performed, the anticipated length of time required for their completion and personnel required for their accomplishment.
1.2. Conducts research study as a member of a research team	<ol style="list-style-type: none"> 1. Participates in the following activities: <ol style="list-style-type: none"> 1.1. Implementation of the appropriate sampling procedure 1.2. Collection of data utilizing methods such as self-report technique, observation, biophysiologic measures, focus group discussion and others 1.3. Statistical analysis of quantitative data 1.4. Analysis of qualitative data 1.5. Synthesizing data 1.6. Deriving conclusions and implications of research findings 2. Applies ethical principles and ethical guidelines throughout all the phases of the conduct of the research study.
1.3. Presents the research study conducted in partnership with a research team	
1.3.1. Prepares a written research report	<ol style="list-style-type: none"> 1. Prepares a research abstract consistent with the specified guidelines. 2. Includes in the written report the introduction, problem statement, theoretical framework or conceptual model, hypothesis, significance of the research, summary of related literature, definitions of variables, process used by researchers to resolve the research problem, findings, interpretations, recommendations and summary of findings.

COMPETENCIES	PERFORMANCE INDICATORS
1.3.2. Conducts an oral and or poster presentation	<p>Oral Presentation</p> <ol style="list-style-type: none"> 1. Plans for the oral presentation taking into consideration, audience, time allotment, venue and audio-visual resources. 2. Uses appropriate audio-visual materials to enhance clarity and impact of the oral research presentation. 3. Presents the research study within the required time allotment, allowing for a question-and-answer period to expand on the pertinent aspects of research. 4. Obtains early feedback about the research presentation. <p>Poster Presentation</p> <ol style="list-style-type: none"> 1. Plans for the poster presentation taking into consideration audience, facility, and resources. 2. Uses appropriate, simple, and vivid visual materials to maximize clarity and impact of the poster research presentation. 3. Designs an effective poster which conveys essential information about the study background, design and results/findings in a format which can be perused in minutes.

TOPIC OUTLINE

This module will cover the following:

1. Importance of research in evidence-based nursing practice and the role of the nurse in nursing research
2. Planning and preparing a research proposal: Conceptualizing and designing a study
3. Conducting research with a team: Implementing the research proposal
4. Analyzing quantitative and qualitative data
5. Writing the research report and communicating the results

Thus, this module aims to enhance the beginning nurse's:

- Understanding of the research concepts and processes, and
- Appreciation of the value of teamwork and collaboration in a successful research endeavour.

TEACHING-LEARNING STRATEGIES

Teaching-Learning Strategies for this module will consist of the following.

- “How you feel” activity (individual seatwork)
- Self-assessment questions or SAQs (Please take note that these are only examples of questions that you have to prepare related to the content being discussed.)
- Case scenario on research proposal making; preparing a research work plan (groupwork)

- Lecture-discussion and case examples
- Directed further readings

MODULE CONTENT

We'll begin with an "ice breaker". [Note: This aims to offer an interactive opportunity and help relax participants (you!), and open up discussion on some research concepts.]

"How do you feel about research?" Describe your positive feelings as well as your negative feelings in one sentence. Write them on a piece of paper then candidly share these with other participants in this training: "I feel _____ because _____."

Then rate how positively or negatively you feel overall about nursing research.

Please circle a number from 0 to 10:

	1	2	3	4	5	6	7	8	9	10
Extremely negative										
	Neither									
	Negative nor positive									
										Extremely positive

Is your score above 6? Well, congratulations! This means that you can engage in a research activity with enthusiasm and you're open to work with and learn from other researchers.

Is your score below 6? Hmm...you need to examine why you rated yourself that way. It's not too late to catch up with an optimistic mind-set about research.

1. IMPORTANCE OF RESEARCH IN EVIDENCE-BASED PRACTICE

"How you feel?" activity illustrates (1) types of research questions that could be addressed (e.g., meaning, description); (2) types of data that can be generated (qualitative versus quantitative) and (3) how to collect data (self-report: open/closed versus observation).

There are types of research questions and these can be related to therapy/intervention, etiology, process, descriptive, and meaning. The exercise you just had pertain to **meaning question** (What does it feel like to be doing research?) and **descriptive question** (What is your numerical rating about your feeling?). Your answers to the questions are the study data. Two broad categories of data for research studies are the **qualitative** data or the narrative, verbal information, and the **quantitative**, or the numerical data. Different types of data can address different research questions. It is important that researchers ask well-worded questions that are answerable with research evidence. The method of data collection for responding to the above-stated questions is the self-report. There are other data gathering methods such as observation.

Why conduct a research study?

Asking this question might give us a range of responses: "I need to because my supervisor told me so"; "I'm just curious"; "It's a requirement for promotion"; "I'm excited to know the answers to a bothering issue." There are as many reasons to do research as there are many researchers. Yet, we may categorize the purposes of research into four groups based on what the researcher want to accomplish – **describe** a phenomenon, **explore** a new topic, **explain** why something is occurring, and make prediction of an outcome and **control** or manipulate to produce desired outcome.

Remember that research is a human activity. In general, we conduct it to discover new knowledge and to gain a richer understanding of a phenomenon. Through nursing research, empirical knowledge can be developed to improve nursing care, patient outcomes, and the health care delivery system (Burns and Grove, 2013, p.7).

As Master Trainer, prepare Self-assessment Questions (SAQs1), examples of which are shown below.

Self-Assessment Questions (SAQ 1)

Choose the best or correct answer for the following questions.

1. The expected research role for a novice nurse researcher is to:
 - A. acquire the role of a clinical expert
 - B. acquire funding for research projects
 - C. identify clinical nursing problems in practice
 - D. develop methods of inquiry relevant to nursing
2. In general, the concept of research is synonymous to:
 - A. Knowledge
 - B. Systematic inquiry
 - C. Empirical process
 - D. Abstract thought process
3. Nursing research is a scientific process that:
 - A. validates existing knowledge
 - B. refines existing knowledge
 - C. generates new knowledge
 - D. all of the above
4. The ultimate goal of nursing is an evidence-based practice that is derived from the following except:
 - A. Clinical expertise
 - B. Traditional practices
 - C. Patient needs and values
 - D. Best research evidence
5. Description, exploration, explanation, prediction and control are referred to as:
 - A. Theoretical models
 - B. Research guidelines
 - C. Research purposes or goals
 - D. Research designs

You'll find the answers to the above questions at the end of this module.

2. PLANNING AND PREPARING A RESEARCH PROPOSAL

The research process has five phases as shown in the box below. This section of the module is about conceptualizing, planning and designing a study.

Box 15 - 1 The Phases of the Research Process

THE RESEARCH PROCESS

- 2.1. Conceptualization Phase
 - 2.1.1. Problem identification
 - 2.1.2. Literature Review
 - 2.1.3. Ethical Concerns
 - 2.1.4. Developing a Framework
- 2.2. Planning and Designing Phase
- 2.3. Implementation or Data Collection Phase
- 2.4. Analytic or Discussion Phase
- 2.5. Writing the Report, Dissemination and Utilization of Research Findings

2.1.1 Identifying the Problem and Purpose

Problem identification starts by having a research topic, a concept or a broad issue that is important in nursing. Next, you formulate a research problem and purpose. A research problem is an area of concern where there is a gap in the knowledge base needed for nursing practice. It indicates the significance of the problem and the background for the problem. A research purpose is a clear statement of the specific goal of a study. You may suggest to the learner to read Burns and Grove's *Understanding Nursing Research* (2013), Chapter 5, pp.155-163). It gives examples to help the learner differentiate a research problem from a research purpose. You can also refer to the same Chapter (pp. 169-187), to assist the learner identify and formulate objectives, questions (and hypotheses in a quantitative study).

Learner's Activity

Now, give the learner an activity to formulate a problem statement, research purpose and research questions. Use the scenario in the box below.

You are very much concerned about the reported injuries in your health care facility that have been attributed to medication errors. These errors have been committed by doctors, nurses and pharmacists. Gladstone (1995, in Mayo and Duncan, 2004) stated that medication errors negatively affect nurses. The psychological trauma caused by committing a medication error can be overwhelming to nurses. They may worry about the patient, may feel upset, guilty, and terrified about making a medication error. They can experience a loss of confidence in their clinical practice abilities. Further, they can be angry at themselves as well as the system.

No studies have demonstrated relationships between nurse characteristics (ie, age, years of practice, and education) and number of medication errors.

On the other hand, several studies have demonstrated underreporting of medication errors among nurses.

To the Learner:

1. State the research problem.
2. Formulate the research purpose.
3. Formulate the research questions.

Suggested answers are found at the end of this module, after ASAQs 1.

Then, ask the learners to identify problems in their work setting (community, hospital, or institution) that are researchable. Encourage them to explain why they are interested in those topics. Does the phenomenon excite them or challenges them? Or is it because the topic is about a phenomenon that bothers them and they want to look for possible solutions?

Examples of topics in the community setting may pertain to the health-seeking behaviour of patients with chronic conditions like COPD. Or, the study can be an evaluation research of a community program/project.

Let's now proceed to the next step of the conceptualization phase.

2.1.2 Reviewing the Literature

After focusing your problem into a specific research question, you need to find out what others have reported regarding the problem of interest, that is, to review the literature to identify the context, the knowledge gaps, and justify the need for study.

To help you address some concerns of the learner like: Where to find the research literature? How to conduct a systematic literature review? What does a good review look like? I suggest that you get hold of W. Lawrence Neuman's book, *Social Research Methods: Qualitative and Quantitative Approaches*, 2003, Chapter 5, The Literature Review and Ethical Concerns.

2.1.3 Ethical Concerns

Now, you need to think about what the researcher must do to handle the respondents of a study in an ethical manner. Ethical research is important in any conduct of research involving the human subjects. What does ethical conduct of research involve? I advise that you go over the ethical codes and regulations, specifically the Belmont Report. This report explains the three basic ethical principles: Beneficence, Respect for Human Dignity, and Justice. The learner may access this on-line: <http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>.

The learner may also use the National Ethical Guidelines for Health Research published by the Philippine Council for Health Research and Development (PCHRD, 2011).

2.1.4 Research Framework

Every study has a framework which defines the concepts and the relational statements or propositions being tested. It sometimes includes a **model or map** that graphically shows the interrelationships of the concepts and relational statements. According to Burns and Grove (2013, pp. 243-244), a framework is an abstract, logical structure of meaning, such as a portion of a theory, that guides the development of the study and enables the researcher to link the findings to nursing's body of knowledge. In a quantitative study, the variable is a central idea in a framework that is tested and measured. In many quantitative studies, the framework is derived from a well-tested theory. This is referred to as the theoretical framework. Chapter 7 of Burns and Grove (2013, p 242 and p. 245), gives an example of a framework based on a middle range theory of Nola Pender.

In qualitative research, frameworks are used in a different sense. Instead of identifying hypothesis and testing this based on theorized relationships, qualitative researchers use theories during data analysis to further expand their understanding of the data. As a result of the study, the analyzed data in the form of themes or patterns may develop to a new theory.

On the other hand, a conceptual framework or model is created by the researcher to graphically show the interrelationships of the concepts and relational statements. It should be supported by references from the literature. An example of a conceptual framework is by DiNapoli, Fig. 7-2, in Burns and Grove (2013, p.238).

Self-Assessment Questions (SAQ 2)

Here are examples of Self-assessment Questions (SAQs 2) you may ask.

Answer briefly the following questions:

1. Any research undertaking is guided by ethical principles; hence a nurse needs to examine

Self-Assessment Questions (SAQ 2) (Continued)

- the ethical implications of his/her research. What are the basic ethical principles discussed in Belmont Report?
2. A good research requires a thorough review of the literature. What is the first step in searching for literature to locate all pertinent sources?
 3. You develop a framework as an overall guide of your study. In a framework, all concepts should be defined. What is more specific than a concept that is measurable or observable called?

Find the answers to SAQs2 at the end of this module. We move on to phase two of the research process.

2.2 Designing a Research Study

The nurse formulates with the research team the research methodology specifying the design, sample and study setting, data collection methods and tools, and plan for data analysis.

A research design is the overall plan and strategy of the investigator for answering the research questions. Neuman (2003, p.137) states that **quantitative researchers** are more concerned about issues of design, measurement, and sampling because their deductive approach emphasizes detailed planning prior to data collection and analysis. Examples of quantitative designs are the cross sectional, correlational, case control, experimental and quasi-experimental. **Qualitative researchers** are more concerned about issues of richness, texture, and feelings of raw data because their inductive approach emphasizes developing insights out of the data collected (see discussion at the beginning of this module about types of data). Ethnography, phenomenology, grounded theory, and case study are some of the commonly used qualitative research designs.

Below is an example of a qualitative research methodology.

Box 15 - 2 Sample Qualitative Research Methodology

Title: Redefining Nursing from a Filipino Perspective

Design: Husserl's descriptive phenomenology will be used to describe and explore the lived experiences of nurses working in the hospital setting.

Sample and study setting: Full-time staff nurses in four tertiary hospitals in Metro Manila, to be chosen purposively with assistance of the Directors of Nursing and Nurse Supervisors until saturation of data would have been achieved.

Data collection Method: In-depth interview will be conducted to generate data about the nurses' personal and professional experiences in nursing.

Plan for data analysis: Colaizzi's 7-step of analysis will be used since this will identify the phenomenon as it is experienced. Constant validation of responses will be done to identify the meaning and essence of nursing.

Source: Rivera, AF.(2011). Redefining Nursing from a Filipino Perspective. *Philippine Journal of Nursing*, 81 (1), 4-11.

I suggest that you read Chapter 8 of Burns and Grove (2013), on Clarifying Quantitative Research Designs for you to appreciate and appraise quantitative designs and methodology of published studies.

Next, you prepare a work plan with the research team, specifying the sequence of tasks to be performed, who will do them, the anticipated length of time required for completion, other resources required for accomplishment of the research project and anticipated output. You can use a table to make a work plan, an example of which is shown below:

Table 15.2		Matrix for Developing a Research Work Plan		
Tasks/Activities	Responsible Person	Time Frame	Resources Needed	Anticipated Outcome (direct, tangible result of activity)
1. Submit research proposal to Ethics Review Board for approval	Lead investigator	08/12/2013 to 09/13/2013	10 printed copies of the proposal	Proposal approved by ERB
2. Get informed consent from selected study participants	Research team	09/15/2013 to 09/22/2013	Informed consent forms and research protocol	Informed consent obtained
3. other tasks				

3. IMPLEMENTATION OR DATA COLLECTION PHASE

As a member of a research team, the nurse participates in the carrying out of a research work plan, applying the ethical principles and guidelines throughout the phases of the conduct of research.

In either quantitative or qualitative research, the team performs five tasks (Burns and Grove, 2013, p 368):

1. Selecting subjects or participants (sampling)
2. Collecting data in a consistent manner
3. Maintaining research controls as indicated in the study design (quantitative research)
4. Protecting the integrity (or validity) of the study
5. Solving problems that threaten to disrupt the study

Using appropriate sampling procedure (probability sampling methods, non- probability sampling methods), the researchers collect data for the study using appropriate quantitative and qualitative methods such as biophysiologic measurement, interview, questionnaire, observation, focus group discussion, conversation, and others.

It may help to read the research example on data collection and data analysis in Burns and Grove (2013, pp. 370-372) and the critical appraisal of the case presented.

Learner's Activity

Using the same scenario above, and the problem statement, purpose and questions you have formulated, make an abridged or outline of a research proposal specifying the design, study setting, sample, data collection methods, and plan for data analysis.

Learner's Activity (Continued)

You may look at a sample at the end of this module, after ASAQs 2.

4.THE ANALYTIC PHASE

The tasks of the research team after data collection is to make sense of the data. In quantitative study, data are subjected to statistical treatment analysis such as the t-test, analysis of variance (ANOVA), analysis of covariance (ANCOVA) and Chi-Square test of independence depending on the levels of measurement (nominal, ordinal, interval, and ratio).

Analysis of qualitative data includes content analysis that allows the researchers to reveal the messages and meanings, etc. Content analysis is done until the data has been collected. The most common method of doing this is by coding, the process of combining data for themes, ideas, and categories. Other types of data analysis in qualitative study are thematic analysis, comparative analysis, and discourse analysis. You may need to refresh yourselves with analysis of qualitative data and Chapter 15 in W. Lawrence Neuman book will be very useful.

You move on to the next step of the analytic phase which is to state your conclusion which is the synthesis of the study findings. Using the study cited above on Redefining Nursing by AF. Rivera (PJN, p.10), the following conclusions and implications were formed, based on the study findings:

The lived experiences of twelve staff nurses that explored nursing as practiced in their workplaces confirmed that caring is still the ultimate unifying factor. The findings revealed that cultural factors, rooted to Spanish colonial influence, underpinned the Filipino nurses' conceptualization of nursing which are reflected and valued in our present society. Care towards the older persons and valuing the family translates to caring for their patients. One reason why nurses leave for employment abroad is because they care for the welfare of their family... The ability of nurses to provide an improved social status to their families increases the respect towards the professions in the country even further...

The findings of this study have provided an insight into nursing as practiced and experienced by nurses in the hospital setting. The themes generated through the descriptive phenomenological approach enriched the understanding of nursing with the potential benefit to nurses, educators, administrators and nursing leaders.

Self-Assessment Questions (SAQ 3)

1. What are the five tasks of the researcher during data collection process that will provide evidence for the soundness of the methods and validity of measuring tools?
2. A qualitative analysis is more concerned with what?
3. In contrast, a quantitative analysis involves what?

Go to the end of this module to check your answers.

5. WRITING THE RESEARCH REPORT AND DISSEMINATING THE RESULTS

The research team is tasked to write the research report using the principles of good writing with the aim of clearly communicating the research process and the study findings through the process. The parts of a report differ depending on whether the research is quantitative or qualitative.

The quantitative research report uses the IMRAD format: Introduction, Methodology, Results, and Discussion. This report usually begins with a short summary or abstract which is prepared consistent with the specified guidelines.

You may refer to Table 2-4, page 60 of Burns and Grove (2013) on the section, the IMRAD report.

The qualitative research report, on the other hand, has fewer rules and less structure. However, it tends to be longer as data are in the form of words, pictures or sentences and include many quotes as examples. Detailed descriptions of specific settings and situations are written to help readers better understand or get a feel of the phenomenon that was studied.

Now, what do you do with your research findings? The research process is said to be fully completed when findings are disseminated and the best clinical evidence are used by nurses. The report can be presented in various venues or purposes: oral presentation and poster presentation. It can also be submitted for publication in a peer-reviewed journal.

Should you intend to publish your report, bear in mind that each journal has its own set of manuscript submission requirements for authors in terms of format, style, and content of a typical manuscript.

Box 15 - 3 Tasks of the Research Team in Oral and Poster Presentations

Tasks in Oral and Poster Presentations

Oral Presentation:

1. Plans for oral presentation taking into consideration audience, time allotment, venue, and audio-visual resources.
2. Use appropriate audio-visual materials to enhance clarity and impact of the presentation.
3. Presents the study within required time allotment, allowing for a question-and-answer period to expand on the pertinent aspects of the research.
4. Obtains early feedback about the research presentation.

Poster Presentation:

1. Plans for poster presentation factoring in the audience, facility, and resources.
2. Uses appropriate, simple, and vivid visual materials to maximize clarity and impact of the presentation.
3. Designs an effective poster which conveys essential information about the study background, design, findings, and conclusions which can be perused in minutes.

Self-Assessment Questions (SAQ 4)

1. The answer to the question, "What did you study?" is basically found in what section of a research report?
2. The answer to the question, "What did you find?" will be presented in what section of the report?
3. The answer to the question "How did you do it?" appears in which section of the report?
4. The answer to the questions "What is the meaning of the study findings and what are conclusions?" are found in what section of the report?
5. When do we say that a research is fully completed?

SUMMARY

This module discussed the role of the nurse in research and the research processes he/she will undertake as a member of the research team. Research is important to the nursing profession and is necessary for providing evidences and for continuing advancement that promote quality of care.

Novice nurses should be given opportunity to become team members in research projects and to use research findings as bases for practice. They also have a responsibility to contribute to the development of the profession's knowledge through research.

ANSWERS TO SELF-ASSESSMENT QUESTIONS

ASAQs1

1. C - identify clinical nursing problems in practice
2. B - systematic inquiry
3. D - all of the above
4. B - traditional practices
5. C - research purposes or goals

Learner's Activity on Medication Errors

Problem Statement:

Earlier studies showed that committing medication errors could be psychologically overwhelming to nurses. They may worry about the patient, feel upset, guilty, and terrified about making a medication error. They can experience a loss of confidence in their clinical practice abilities. Further, they can be angry at themselves as well as the system (Gladstone 1995, in Mayo and Duncan, 2004).

Research Purpose:

This study will examine the perceptions of nurses on medication errors, what they believe constitutes a medication error, what is reportable, and what barriers to reporting exist.

Research Questions:

1. What are the perceptions of nurses about the causes and reporting of medication errors?
2. What are the barriers to reporting medication errors?
3. What is the relationship between the characteristics of nurses in terms of age, length of service, and education and the number of medication errors?

ASAQs2

1. Beneficence, Respect for Human Rights, and Justice
2. Identify key words and concepts to be searched
3. Research variable

Learner's Activity (continuation of the case on Medication Errors)

Research Design: This is a descriptive correlational study. It will describe the perceptions of the nurses on medication errors and their characteristics in terms of age, educational background, and years of practice

Study Setting: This study will be conducted in a tertiary hospital or the learner's health care facility

Sample: Randomly selected nurses from the different wards of a hospital

Data Collection Method: A Self-report survey will be used to measure: nurse demographics; nurse views about reporting medication errors; nurse perceived cause of medication errors; percentage of medication errors reported to nurse supervisors.

Plan for Data Analysis: This study will use descriptive statistics and the Pearson product moment correlation coefficient To determine the relationship between nurse demographics and number of medication errors committed.

ASAQs 3

1. The five tasks are: (a) recruiting subjects or participants, (b) collecting data in a consistent way, (c) maintaining research controls according to the study design, (d) protecting the integrity (or validity) of the study, and (e) solving problems that may disrupt the study.
2. Qualitative analysis is more concerned with words, meanings, norms and values, and meaning.
3. Qualitative analysis is more concerned with summarizing data with statistical measures, hypotheses, and causality.

ASAQs4

1. Introduction section
2. Results section
3. Methodology section
4. Discussion section
5. When findings of best clinical evidence are disseminated and utilized by nurses.

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Evaluation of Research Study/Report Utilizing Guidelines in the Conduct of a Written Research Critique

FELY MARILYN E. LORENZO, RN, DrPH

INTRODUCTION

In the practice of nursing, it is inevitable that one will go through several research reports in search of studies that will be utilized to solve a problem at hand. The research articles may point to ways of better understanding a patient-related issue or problem or identify possible effective solutions that may be adopted. In the process of effectively utilizing research reports, nurses in beginning practice must hone the skill of evaluating several studies that have been identified, and select that which seem to have the greatest promise for relevance and effectiveness to the problem or issue at hand. In addition, the nurse must have the capability of writing a research critique so that one's impressions of the strengths and weaknesses of the research articles might be communicated to others who need to similarly utilize research results in their practice setting.

On the other hand, in the nursing education milieu, the competency of research evaluation towards writing a research critique is just as valuable if not more so. In the teaching-learning process, new knowledge gleaned from research reports is critical in informing and enriching educational processes. Research study results utilization strengthens the facilitation of cutting edge development of knowledge, skills and appreciation of the need to disseminate new knowledge (research results) effectively.

Research evaluation is a competency that must be honed until it becomes a skill that is part and parcel of a nurse's repertoire. Evaluating research reports for applicability to nursing practice is a necessary skill that will enable a nurse to touch base with a wealth of new knowledge and experience that may assist him/her to provide high quality care.

This module focuses on imparting techniques of engaging beginning nurses to evaluate research reports comprehensively towards a preparation of a clear and lucid research critique.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Differentiate the processes of research critique from research review;
2. Describe the process of systematically conducting a research evaluation;
3. Apply guidelines in constructing a meaningful research critique that is constructive rather than destructive;
4. Identify usefulness of the critique in its application to specific nursing issues or problems.

These module objectives support the need to address the development of the following research competencies of a beginning nurse in any setting as embodied in the National Nurse Core Competencies.

Table 16.1 NNCCS on the Evaluation of Research Study/Report	
Responsibility 2 Evaluates Research Study/Report Utilizing Guidelines in the Conduct of a Written Research Critique	
COMPETENCIES	PERFORMANCE INDICATORS
2.1. Determines if the research problem/ questions, objectives and/or hypotheses are clearly and logically linked to the research purpose, concepts and relationships, and propositions generated from the study framework.	Specifies if there is : <ol style="list-style-type: none"> 1. Clear identification of the research problem and its scope and limitation. 2. A clear link between the theoretical framework/ conceptual model and research question/purpose. 3. Clear, concise and logical statement of purpose, research question or hypothesis. 4. Justifiable basis for the hypotheses.
2.2. Analyzes if the conceptual framework the summary of review of related literature, research design, and data analysis procedure are logically linked with the research purpose, problems/questions, and hypotheses.	<ol style="list-style-type: none"> 1. Explains if the concepts in the framework are clear and consistent with the operational definition. 2. Cites how the review of literature provides rational direction and basis for the study. 3. Shows how the study framework is linked with the research purpose, objectives, and/or study hypotheses. 4. Specifies if the: research design provides the correct direction that addressed the research problems, questions and hypotheses. 5. States if the data collection procedure is the best approach in obtaining the key research variables. 6. Determines if the instruments/tools measure adequately the study variables. 7. Specifies if data analysis report offered evidence of reliability and validity of measurement utilized.
2.3. Establishes if the interpretation, implications and recommendations are consistent with the results considering the limitations of the study.	Specifies if: <ol style="list-style-type: none"> 1. Evidences are offered in support of the interpretation. 2. Important results are interpreted in terms of the research questions or hypotheses and the conceptual framework. 3. The stated implications are appropriate given the study's limitations. 4. Recommendations are consistent with the findings and existing body of knowledge.
2.4. Analyzes the research study/report for the adherence to standards of writing mechanics, ethical principles and guidelines in all phases of the research study.	<ol style="list-style-type: none"> 1. Specifies if the research study/report conforms to standards of writing mechanics 2. Describes how the rights of human subjects are protected. 3. Identifies which ethical principles in nursing research were followed.

MODULE CONTENT

RESEARCH EVALUATION: ACCOMPLISHING A COMPREHENSIVE CRITIQUE

Effective nurses are expected to participate in research activities by evaluating and interpreting research reports for applicability to nursing practice. Decisions on the appropriateness, adequacy, and applicability of research findings are important to determine how research results can be used effectively in patient care decisions. Publication of research results does not always guarantee quality, value or relative worth of research reports. Determining the overall usefulness of a research report requires systematic review and critical appraisal. Failure to adequately evaluate and critique research reports may adversely affect the outcomes of care of individual patients or even populations of patients.

A critique is a critical appraisal of the strengths and weaknesses of a research report. Critiquing or evaluating a research report involves evaluating aspects of the research process. Considering that all research studies have strengths and weaknesses, it is important that these be objectively verified to determine the applicability of findings in a given situation. A thoughtful research critique is a careful complete examination of a study to judge its strengths, weaknesses, logical links, meaning and significance. The process of objectivity and critically evaluating a research report's content for scientific merit and application to practice, theory or education is critical to ensuring that nursing practice and education is evidence-based.

Research reports are evaluated based on how well the research process was designed and executed. Using specific criteria and guidelines, the evaluator makes precise and objective judgments about the research study, determining its strengths and weaknesses. It does not include correcting grammar or making comments regarding syntax and writing style. This module emphasizes how both research reviews and research critiques are crafted.

GUIDELINES FOR CRAFTING A RESEARCH CRITIQUE REPORT

The purpose of accomplishing a research critique in the nursing care areas is not to offer advice to researchers as one would do in a peer review but to determine which research reports are suitable for consideration in utilizing the research reports. Hence the guidelines offered here are adapted for this purpose.

1. Identify clearly the nursing issue that requires evidenced based solutions. This may be a nursing care or administrative issue.
2. Identify parts of the research report that need to be critiqued to determine if the research report is robust and its results are valid. The following are critical components of the research report that need to be appraised.
 - A. Problem Statement**
 - Clarity of problem
 - Significance of problem for nursing
 - Purpose of study: whether it is applicable for the nursing issue or problem for which a solution needs to be found
 - Conceptual/theoretical framework
 - Literature review
 - Hypotheses/research questions
 - B. Research Methodology**
 - Research design
 - Sample/setting
 - Data collection procedures
 - Data collection instruments

- Data analysis

C. Result, Conclusion, and Interpretations

- Result of data analysis
 - Discussion of findings
 - Recommendations/implications for further study in practice, education, research
3. Analyze the strengths and weakness of each of the research components identified above using a research appraisal tool to determine whether the results may be considered for application in the identified nursing issue or problem. An example of a research appraisal tool is given below.
 4. Appraise the context of the nursing issue where the evidence will be applied. One needs to determine the similarities or differences between the contexts of research evidence and utilization so that the research application will be relevant.
 5. Analyze the results of several researches to determine the recommendation directions considering effect size and other factors. In other words, one must determine if competing recommendations may be rationalized so that it can be determined whether the research evidence is sufficient to warrant its application or not. For this purpose, it may be necessary to do a research meta-analysis when there are a large number of researches on the same problem with divergent results and recommendations.
 6. Determine how the research results will be utilized by crafting a research utilization plan.

RESEARCH APPRAISAL TOOLS

Research appraisal tools are useful for making objective judgments about certain parts of the research report being evaluated. They will make research evaluation easier to accomplish and will also be a concrete reminder of what needs to be considered in the research evaluation.

There are several research appraisal tools that may be adopted from the literature but it may be more useful to devise or adapt a tool that may be more relevant to the presenting needs for research utilization.

The following is a suggested tool that was adapted from several sources that may be used in accomplishing a research appraisal.

Table 16.2		Research Assessment Tool				
RESEARCH COMPONENTS/ CRITERIA		ASSESSMENT SCORE*				COMMENTS
		1	2	3	NA	
1. Abstract: Completeness includes problem definitions, key methods, findings, conclusion and recommendations						
2. Problem statement: Problem statement is clear						
• Limitations of the study can be identified						
• Assumptions of the study are identified						
• Study Variables are operationalized						
• Significance of the problem is discussed						
Section Score						
3. REVIEW OF LITERATURE: Cited literature is relevant to research problem addressed by the study						
• Cited literature provides rationale for the research						

* A score of 3 means all criteria are present and clearly stated. A score of 2 means some criteria are missing or not clearly stated. A score of 1 means all criteria are missing. NA means not applicable to the situation or item.

RESEARCH COMPONENTS/ CRITERIA	ASSESSMENT SCORE				COMMENTS
	1	2	3	NA	
<ul style="list-style-type: none"> Studies are critically examined 					
<ul style="list-style-type: none"> Relationships of the problem to previous research is made clear 					
<ul style="list-style-type: none"> A conceptual framework is clearly stated 					
<ul style="list-style-type: none"> Review concludes with a brief summary of relevant literature and its implications to the research problem under study 					
Section Score					
4. METHODOLOGY					
Design					
<ul style="list-style-type: none"> Design is appropriate to study questions and/or problem, hypothesis 					
<ul style="list-style-type: none"> Confounding/moderating variables are/can be identified 					
<ul style="list-style-type: none"> Description of design is explicit enough to permit replication 					
Section Score					
Subjects/ Study Participants					
<ul style="list-style-type: none"> Subjects/ Study Participants/ Subject population (Sampling Frame) is described 					
<ul style="list-style-type: none"> Sampling method is described 					
<ul style="list-style-type: none"> Sampling method is justified (especially for non-probability sampling) 					
<ul style="list-style-type: none"> Sample size is sufficient to reduce type 2 error 					
<ul style="list-style-type: none"> Possible sources of sampling error 					
<ul style="list-style-type: none"> Protection of subjects are discussed in ethical review procedures 					
Section Score					
5. INSTRUMENTS					
<ul style="list-style-type: none"> Reliability data pertinent to the present study are reported 					
<ul style="list-style-type: none"> Validity data pertinent to present study are reported 					
<ul style="list-style-type: none"> Methods of data collection are clearly described to permit judgment of their appropriateness to the present study 					
Section Score					
6. DATA ANALYSIS					
<ul style="list-style-type: none"> Information presented is sufficient to address research questions/problem 					
<ul style="list-style-type: none"> Statistical tests are identified and obtained values are reported and explained 					

RESEARCH COMPONENTS/ CRITERIA	ASSESSMENT SCORE				COMMENTS
	1	2	3	NA	
Reported statistics are appropriate for hypothesis/ research questions/problems					
Tables and figures are presented in an easy-to-understand, informative way					
Section Score					
7. DISCUSSION					
Conclusions are clearly stated					
Conclusions are supported by the evidence presented					
Methodological problems in the study are identified and discussed					
Findings of the study are specifically related to conceptual/theoretical basis of the study					
Implications of the findings are discussed					
Results are generalized only to population on which study is based					
Recommendations are made for further research					
Section Score					
8. FORM and STYLE					
The report is clearly written					
The report is logically organized					
The tone of the report displays an unbiased, impartial, scientific attitude					
Section Score					
GRAND TOTAL					

HOW TO COMPUTE AND INTERPRET SCORES

1. Add scores and divide this by the number of items scored (Subtract NA responses.). This is the mean score for the section.
2. A section with a mean score of 2.50 or higher is acceptable.
3. A section with a mean score of 2.00 - 2.49 may be useful but interpreted with caution.
4. By referring to the section mean score, the strong and weak areas of the research study will be identified.
5. For the overall quality of the research report, compute for the overall mean. A mean score of 2.50 or higher is acceptable.

LEARNING ACTIVITIES

CONDUCTING RESEARCH CRITIQUE

The following steps may be accomplished individually or in a team. However, the results of the research critique is most useful when discussed among member of a research utilization team.

1. Read and critique the entire study. A research critique involves examining the quality of all steps of the research process
2. Examine the organization and presentation of the research report.
 - completeness
 - conciseness
 - clarity of presentation
 - logical organization
 - jargons
 - reference
3. Examine the significance of the problem studied for nursing practice.
4. Identify strengths and weakness of a study.
5. Be objective and realistic in identifying the study's strength and weaknesses.
6. Be balanced in the critique.
7. Provide specific examples of the strengths and weaknesses of a study.
8. Provide a rationale for your critique.
9. Suggest modifications for future studies
10. Discuss the feasibility of replication of the study
11. Discuss the usefulness of the findings for practice.

EVALUATING A RESEARCH ARTICLE

Choose a qualitative and quantitative research report to critique:

1. Analyze the title of the article.
2. Critique the problem and purpose statements
3. Critique the conceptual framework and literature review
4. Evaluate the research questions/hypotheses
5. Critically evaluate aspects of the research methodology (i.e. design, sampling, data collection procedures and instruments, data analysis, quality of written report)
6. Critique results
7. Examine study discussion and conclusions

Recommended Resources

1. Listed below are tables and tools that may be helpful to you as a master trainer. You may check them on pages 308 – 310 of the the book **Reading, Understanding and Applying Nursing Research: A Text and Workbook** written by James Fain.
 - a. Do's and Don't's for Sensitive Critiques
 - b. Critical Components of the Research Process to be Evaluated on
2. You may want to view ANA's Research Toolkit - <http://www.nursingworld.org/research-toolkit>. Please also take time to check their Toolkit on Appraising Research Evidence at <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/Improving-Your-Practice/Research-Toolkit/Appraising-the-Evidence>.

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- Moody, L.E. (1990). *Advanding Nursing Science Through Research*. (Volume 1). Newbury Park, California: Sage Publications.
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Research Application and Quality Improvement

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INTRODUCTION

Healthcare delivery is a dynamic arena where continual improvements and audits are necessary in order to achieve quality and safe health care provision. It involves rendering care that meets an appropriate standard through a continuous process of problem identification and resolution while collaboratively involving every member of the health care institution (Moran & Johnson, 1992).

In line with this, the nurse's participation in quality improvement in health care delivery is becoming increasingly substantial since they are the key caregivers in hospitals who can greatly affect the provision of quality care and consequently the patient's treatment and health outcomes (Draper et. Al, 2008). Also, because they are the direct provider of patient care, they are at the advantage of identifying main areas of change in their course of practice which when investigated can initiate and sustain actions that can lead to the improvement of care. Given this capacity of nurses for quality assurance and improvement, they must be adequately equipped with the right amount of knowledge and skills in performing sound problem identification and resolution. According to Draper et. Al. (2008), in order to optimize the role of nurses in quality improvement, it is important to strengthen their skills and emphasize on the concepts of quality improvement in patient care.

Thus, guided by the 2012 National Nursing Core Competency Standards (NNCCS), this module is crafted to guide master trainers who can lead the entire nursing service along with the Quality Assurance and improvement team in establishing sustainable improvement. This will be done through an interactive lecture in a workshop setting which will focus on the utilization of the research process in improving client care.

MODULE OBJECTIVES

After going through the module, you, the Master Trainer, will be able to:

1. Define specific sets of competencies in the NNCCS on research process utilization in health care quality improvement.
2. Select learning activities that will enable the learners to implement the NNCCS on research process utilization in health care quality improvement.
3. Apply nursing practice tools, guidelines and/or frameworks on on research process utilization in health care quality improvement.
4. Utilize teaching-learning strategies that will develop in the learner critical thinking and decision-making skills in research process utilization in health care quality improvement.

5. Demonstrate how the achievement of specified competencies of the on research process utilization in health care quality improvement will be assessed with appropriate methods and tools.
6. State policies and actions necessary to facilitate implementation of the NNCCS on research process utilization in health care quality improvement.

Table 17.1 NNCCS on Research Application and Quality Improvement	
Responsibility 3 Applies the Research Process in Improving Client Care in Partnership with a Quality Improvement/Quality Assurance/Nursing Audit Team	
COMPETENCIES	PERFORMANCE INDICATORS
3.1. Participates as a member of a quality team in implementing the appropriate quality improvement process on identified improvement opportunities.	
3.1.1. Prepares a data collection and analysis plan as a member of the quality improvement/quality assurance/nursing audit team.	<ol style="list-style-type: none"> 1. Identifies opportunities for improvement of systems or processes in the delivery of health care services. 2. Reviews related literature, procedures, and other documents to clarify current knowledge regarding the problem. 3. Prioritizes identified opportunities for continuous quality improvement taking into consideration those which occur frequently and affect large number of patients, high risk problems, and aspects of care that produce problems to patients and staff. 4. Selects appropriate methodology in collecting and analyzing data. 5. Undergoes training as necessary regarding utilization of appropriate data collection and analysis methods/ tools.
3.1.2. Conducts collection and analysis of data with the team members based on the agreed plan.	<ol style="list-style-type: none"> 1. Collects data using appropriate methods and tools 2. Analyzes with the team data gathered using appropriate methods/models, examples include: <ol style="list-style-type: none"> 2.1. Flow charts for laboratory data, test results and medication review. 2.2. Monthly multidisciplinary progress notes 2.3. Cause and Effect diagram (fish bone) 2.4. Pareto chart 2.5. Histogram 3. Evaluates with the team, the identified variations that requires investigation.

COMPETENCIES	PERFORMANCE INDICATORS
3.1.3. Implements with the team the developed action plan for the identified variance to improve the system or process.	<ol style="list-style-type: none"> 1. Selects an appropriate model that would be appropriate to change and improve the system or process (e.g. the Plan-Do-Check-Act cycle (PDCA). 2. Develops an action plan with the goal of changing the system or process. 3. Carries out the change in a small scale as in a pilot study. 4. Checks the effects of the change by collecting data and information utilizing appropriate methods and tools. 5. Implements change in the system or process based on the results of the pilot study.
3.1.4. Communicates, both in oral and written form, the results of the quality improvement project in partnership with the quality improvement team/quality assurance/nursing audit team.	<ol style="list-style-type: none"> 1. Plans for the presentation of the results of the quality improvement project. 2. Includes in the report, conclusion, recommendations, actions and follow up, specifying the appropriate individuals, and group to whom the report will be submitted. 3. Designs both the oral and written report utilizing appropriate materials and tools to communicate the message. 4. Presents report simply, clearly and receiver-centered.

TOPIC OUTLINE

1. Introduction: The Nurse, The Research Process and Quality Improvement
 - Role of the Nurse in Quality Improvement (Note: tackle the challenges and barriers re the involvement of the nursing service to quality improvement as this nurse's role involving QI is highly dependent on the support of the top level managers and the hospital administration)
 - Overview of the Research Process
2. Problem Identification and Literature Review
 - Identification of improvement opportunities and Prioritization of problems
 - Literature review
 - Procedures and Documents Review
3. Selection of Methodology in Data Collection and Analysis
 - Types of methodologies
 - Application scenarios of different methods
4. Data Collection and Analysis
 - Data Collection
 - Data Analysis Tools and Methods
 - Flow charts
 - Monthly multidisciplinary progress notes
 - Cause and Effect Diagram (Fishbone)
 - Pareto Chart
 - Histogram
5. Development of an Action Plan
 - Selection of a guiding model for action plan

- Creation of Action Plan
6. Implementation of the Action Plan
- Doing a Pilot Study of the Plan
 - Large Scale Implementation based on Pilot Study : Factors that can Affect Data During Data Collection
7. Presentation of Results
- Uses proper communication scheme to report results

INSTRUCTIONAL DESIGN

TASK: Explain and utilize the research process in improving client care in partnership with a quality improvement/Quality Assurance/Nursing Audit Team.

Table 17.2		Instructional Design		
COMPETENCY	PERFORMANCE INDICATOR	INSTRUCTIONAL STRATEGIES	RESOURCES	EVALUATION
Understands the need to collaborate with quality assurance teams during the research utilization process.	Explains the roles of the nurse in quality improvement.	Introduction on the roles of the nurse in quality improvement in order for the learner to be motivated to learn as he/she understands that the skills and knowledge in QI can be used in their practice. ACTIVITY: Presentation of video on the role of the nurses in quality improvement. (The Sutter Health Nurses Initiative)	LCD projector Video	Discussion on the need for nurses to be in QA/QI teams, and explication on the roles that nurses take in such teams
Utilizes appropriately the research process for quality improvement.	Delineates the research process in the context of quality improvement.	Review of the research process Using Clinical Quality Improvement Strategies in Nursing Research. Activity: Read article and discuss using guide questions to enhance learner's learning of CQI and research process. Read and review article on QI researches and methods used. Activity: After reading the articles, learners will be asked to adopt the QI and research methodologies to an identified QI problem in their work setting.	Article: "Integrating Clinical Quality Improvement Strategies with Nursing Research" by King, KM and Koon, KT, West J Nurs Res, 2000; 22:596 Article: "What Can We Learn From Quality Improvement Research?: A Critical Review of Research Methods" by Alexander, JA and Hearld, LR. Med Care Res Rev 2009 66:235	QI and research methodologies appropriately applied to the learner's work setting

COMPETENCY	PERFORMANCE INDICATOR	INSTRUCTIONAL STRATEGIES	RESOURCES	EVALUATION
Participates as a member of a quality team in implementing the appropriate quality improvement process on identified improvement opportunities.	Identifies opportunities for improvement of systems or processes in the delivery of health care services.	<p>Presentation of common areas for improvement in the hospital. Facilitation of brain storming on other opportunities for improvement.</p> <p>ACTIVITY: Presentation of the video on the impact of medical and nursing problems in the hospital setting. Identify 5 people who can volunteer and ask them for a specific problem area that they think is a problem in their respective hospitals. *note: problem identification is for educational purposes only, not meant to put their hospital's reputation at stake* Goal is to make nurses realize that they do know the problems and now is the right time to act on it.</p>	<p>LCD projector and Video player</p> <p>Whiteboard and white board marker</p>	Presentation of 5 identified problems
	Prioritizes identified opportunities for continuous quality improvement taking into consideration those which occur frequently and affect large number of patients, high risk problems, and aspects of care that produce problems to patients and staff.	<p>Problem prioritization through the problem matrix using different sets of criteria in a workshop/ group activity session.</p> <p>ACTIVITY: Case Study presentations. Provide a set of problems that the facilitators and the master trainers can use to identify which should be prioritized based on the criteria that they will also determine. The identified problem by the five participants earlier are excluded in this activity.</p>	White board and white board marker	Literature Review

COMPETENCY	PERFORMANCE INDICATOR	INSTRUCTIONAL STRATEGIES	RESOURCES	EVALUATION
	Reviews related literature, procedures and other documents to clarify current knowledge regarding the problem.	<p>Discussion on types of literature that can be used for QI. Proper way of doing literature/ document review and its importance. Do's and Don'ts.</p> <p>ACTIVITY: Use the 5 previously identified problem areas for each of the hospital to identify what are the possible documents that they could gather data from.</p> <p>Computer lab: Access the electronic databases (e.g., SAGE, Proquest, Pubmed, Google Scholar) for articles published on the problem identified.</p>	<p>Powerpoint Presentation</p> <p>Sample of literature review for QI</p> <p>Computer terminals Electronic databases (e.g. UP databases)</p>	Written literature review synthesized from the documents and journal articles gathered
Prepares a data collection and analysis plan for the problem on hand.	<p>Selects appropriate methodology in collecting and analysing data.</p> <p>Identifies resources and agencies for quality improvement.</p>	<p>Discussion on the factors to consider for planning data collection methodology and the data collection tools that they may use.</p> <p>Activity: Group the participants into 5 and assign them different case studies. Ask them to devise their own plan for data collection depending on their problems identified. A group representative will justify their tool and plan.</p>		
Performs actual collection and analysis of the data gathered.	<p>Collects data using appropriate methods and tools.</p> <p>Analyzes with the team data gathered using appropriate methods/ models.</p>	Discussion of the models that can be used for data analysis according to the NNCCS.	<p>Internet</p> <p>Manila Papers Permanent Markers</p> <p>Papers Writing Tools</p>	Identification or creation of an appropriate data collection tool.

COMPETENCY	PERFORMANCE INDICATOR	INSTRUCTIONAL STRATEGIES	RESOURCES	EVALUATION
	Evaluates with the team, the identified variations that requires investigation.	Activity: The group will then identify the deviations from the standards that needs action.		Deviation from stand-ards identi-fication
Implements with the team the developed action plan for the identifies variance to improve the system or process	Selects an appropriate model that would be appropriate to change and improve the system or process Develops an action plan with the goal of changing the system or process.	Discussion of the samples of the different models and methods that can be used to analyze the data gathered with the QA team. Creation of a suitable and sustainable action plan based on the data on hand and the standards that must be reached. Activity: The groups will start to devise their action plan based on their data gathered.	Pointer	Action plan presentation

This instructional design provides at a glance the instructional activities and tools for the identified specific competencies and performance indicators. The master trainer could be guided on what the learning activities aim to achieve and how to measure that these are attained by the learners.

As this module tackles a process, prior competences should be ensured before the learner can move on to the next. For example, the learner should have a good grasp of the research process before he can understand how research is applied in the quality improvement process. Also, delineation of the problem is important before the plan and implementation of data collection. Hence, it is important for the master trainer to be able to assess if the learner has achieved the foundational competencies before moving to the next level. Otherwise, he will need to spend more time and devise more effective strategies to achieve this, considering the characteristics of the learners. It is beneficial then to assess the entry competencies the learners have and then group them homogenously and keep to their pace. The instructional activities presented in the instructional design above serves as a guide and may be modified to suit the learners. The same applies to the tools, journal readings, etc. The list of references and materials are provided in this module for the master learner to have some ready materials at hand. S/he may however build his/her own set of materials according to the needs of the learners.

MODULE CONTENT

1. INTRODUCTION: THE NURSE, THE RESEARCH PROCESS AND QUALITY IMPROVEMENT

Role of the Nurse in Quality Improvement (Moran & Johnson, 1992)

- i. Identifies and assesses the need for change in health care service delivery processes

- ii. Acts on the assessed deficiency in their health care setting
- iii. Facilitates other nurses' ability to undertake constructive action for improving care by inspiring and empowering them
- iv. Utilizes quality circles, quality councils or quality improvement forums to facilitate coordination of quality improvement efforts to other units/ departments of the hospital
- v. Documents the outcome of the quality improvement efforts

Overview of the Research Process

Table 17.3	Comparison of the Research and the Nursing Process
NURSING PROCESS	RESEARCH PROCESS
Assessment	Identifying a topic – a researcher identifies a problem that he would like to solve or a problem that he would want to answer (Polit & Beck, 2006) Review of Literature – a discussion of the published information in a particular subject area (Rickert, 2008)
Diagnosis	Problem Statement Identification/Hypothesis Formulation – articulates the problem that needs to be addressed (Polit & Beck, 2006)
Planning	Methodological plan to undertake during the research – determines a systematic way to solve the research problem
Implementation	Data Collection – actual implementation of the research design
Evaluation	Conclusion/Discussion/Analysis

With this, the learners can easily compare a vague concept to a concept i.e the nursing process that is highly familiar and is utilized in their everyday practice. Although the learners have been exposed to research as graduates of BS Nursing, it is better to use an analogy that includes a concept that is a part of their profession.

2. PROBLEM IDENTIFICATION AND LITERATURE REVIEWS

Improvement Opportunities Identification and Prioritization

Common areas for improvement in the health care setting:

- i. Failure to pass on important information (e.g proper endorsement) (Medical Protection Society, 2013)
- ii. Failure to arrange appointments, investigations or referrals with the appropriate degree of urgency (e.g referrals) (Medical Protection Society, 2013)
- iii. Failure to review the results of investigations (Medical Protection Society, 2013)
- iv. Failure to arrange follow-up and monitoring (Medical Protection Society, 2013)
- v. Mislabelling, misfiling and failure to check labels (Medical Protection Society, 2013)
- vi. Too many avoidable patient days (Fields, 2011)
- vii. Desire for physician integration but very few employed physicians (Fields, 2011)
- viii. Unhealthy community (Fields, 2011)
- ix. Physician and nurse shortages (Fields, 2011)

Hospitals and healthcare institutions naturally have myriad problems that need to be addressed. However,

depending on the severity of the problem or the availability of resources for solving the problem or anything that may affect the issue at hand, the list of problems must be arranged according to the institution's priority. There are several methods that can be used to do this, but an easy and convenient way of deciding on which to prioritize is by a problem prioritization matrix which has been used by hospital administrators in their decisions for prioritization.

The following are the steps in creating a prioritization matrix (New Prioritization matrix, 2013) (Note: the steps are altered for ease of use and instruction).

Steps in Creating a Problem Prioritization Matrix

- Generate a set of criteria to be used in establishing the quality of the decision. (e.g Budget, Compliance, Feasibility)
- Construct a matrix with options down the left panel of the table and the criteria across the top. For example,
 - o Red ink – Criterion
 - o Blue Ink - Option

Table 17.4	Problem Prioritization Matrix			
	BUDGET	COMPLIANCE	FEASIBILITY	TOTAL
Option 1				
Option 2				
Option 3				
Total				

- Going one criterion at a time, rank order all of the options, with respect to the criterion using the Nominal Group Technique. Sum the vote totals for each option and then rank order the options. Enter the rank order for each option under that criterion into the matrix. For example:

	BUDGET	COMPLIANCE	FEASIBILITY	TOTAL
Option 1	1	1	2	4
Option 2	2	3	1	6
Option 3	3	2	3	8

- Add the ranks.
- The rows with the highest sums are the items of highest priority. In this case, option 3 had the highest priority.
- This may be done by several people to know the consensus of a group deciding on the prioritization plan.

Literature and Document Review

- Clarifies the current knowledge on the identified problem

Common Documents that can be utilized to gather information for quality improvement:

- Evidence-based researches/papers
- Benchmarking tool
- Performance assessment tool

- Time in and time out of patients
- Patient Charts
- Endorsements sheets
- Patient Turn around time
- Incident Reports
- DO
- Time in and out of employees etc.

According to Levy & Timothy (2006) and Polit and Beck (2008), there are some do's and don't's that must be considered in the review of literature. These are as follows:

1. The goal is to summarize and evaluate critically the overall evidence in order to reveal the current state of knowledge on the identified topic with regard to the themes. There should not be a series of quotes or abstract strung together.
2. Be as objective as possible and avoid omitting study results that are contradicting. Inconsistent information should be evaluated and analyzed objectively. Gaps of evidences must also be noted.
3. Conclude the review of literature with a concise summary of current evidence on the topic and be sure to state it in your own words.
4. If conducted as part of a new inquiry, it should demonstrate the need for an action and should clarify the context within which any problems were developed
5. Use phrases indicating the tentativeness of the result such as: several researchers have found..., the documents suggest that..., results from a study indicated... Hypothesis cannot be proved or disproved by empirical testing and no research question can be answered with only one research study, hypothesis are supported by research findings, not proved. Hence, it is important to avoid assuming the conclusiveness of a study or information.

(Levy & Timothy, 2006 & Polit & Beck, 2008)

Recommended Resources

- Levy, Y., & Timothy, E. (2006). A Systems Approach to Conduct and Effective Literature Review in Support of Information Systems Research. *Informing Science Journal*, 181-212. Available at <http://inform.nu/Articles/Vol9/V9p181-212Levy99.pdf>.
- Polit, D., & Beck, C. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. New York: Lippincott Wilkins and Williams.

3. SELECTION OF DATA COLLECTION TOOL/METHOD

Types of Data Collection Tools (O'Leary, 2005)

1. Surveys
 - Aims to describe and explain
 - Involves populations or samples
 - Presents moments and trends
 - May be conducted in several ways
2. Interviews
 - May be formal or informal, structured or unstructured and can involve one or groups of people
 - Generates standardized, quantifiable data and more in depth qualitative data
 - At risk of miscommunication and misinterpretation due to complexities of people
3. Observations
 - May be non-participant or participant, candid or covert, structured or unstructured
 - Data is gathered through the researcher's senses
 - Actual behavior is documented rather than the responses related to the behavior

- Observations can be tainted by a researcher's worldview
- 4. Unobtrusive methods
 - Involves the exploration of official data and records, corporate data, personal records, the media, the arts and social artefacts
 - Capitalizes on existing data but researchers need to scrutinize more for possible data biases
 - One must know first the following: what to look for, where to find trust worthy sources and what to do with it
- 5. Experimentation
 - Determines cause and effect relationships by controlling variables
 - Can be a challenge in human centred experiments conducted in the real-world

Furthermore, to guide you more on the decision for the selection of a data collection method, the following questions are considered: (Ontario Human Rights Commission, 2013)

- Who will the data be collected about?
- Who will the group of interest be compared to?
- What locations or areas will the data be gathered from?
- What categories will be used to identify the group of interest and the group that the latter will be compared to?

Note: The best data collection strategy is one that is seamlessly integrated into your day-to-day operations in the unit (Craig, 2013).

Other data collection tools include: Administrative/clinical database, chart abstraction, focus group, diary/logbooks, interviews, process mapping, simulated patient encounters, survey, patient assessment, surveillance/observation. (Alexander, JA and Hearld, LR., 2009)

Guidelines for Critiquing Data Collection Procedures (Polit and Beck, 2006)

1. Who collected the research data? Were the data collectors qualified for their role or is there something about them that could undermine the collection of unbiased, high quality data?
2. How were the data collectors trained? Does the training appear adequate?
3. Where and under what circumstances were the data gathered? Were other people present during data collection? Could the presence of others have created distortions?
4. Did the collection of data place any undue burdens (in terms of stress and time) on the participants? How might this have affected the data quality?

4. DATA COLLECTION and ANALYSIS

Tips in Carrying Out Data Collection Plan (Craig, 2013)

- Be systematic and have close attention to detail.
- Record keeping is very essential. Keep protocols and plans at all times.
- Be efficient and effective. Manage time and stick to the planned schedule of completion of the data collection.

Data Analysis Tools and Methods

i. Flow charts (Institute for Healthcare Improvement, 2011)

- Allows visualization of the way a process actually works so that one can understand the existing process and develop ideas about how to improve it.
- Promotes shared understanding of the process among the readers in order for them to utilize it to collect data, identify problems, focus discussions and identify resources
- Creates a foundation for designing new processes.

ii. Monthly multidisciplinary progress notes (Chapter 1: Charting Basics, 2008)

- Describes as observations of the patient are made by a health care provider such as a physician, relating to the patient's care.
- In this case, all providers from the healthcare team will chart their observations on the same record.
- Teams can utilize the notes of each of the healthcare provider in order to improve the care and condition of the patient.

iii. Cause and Effect Diagram (Fishbone) (Institute for Healthcare Improvement, 2011)

- Also known as an Ishikawa or "fishbone" diagram, is a graphic tool used to explore and display the possible causes of a certain effect.
- Use the classic fishbone diagram when causes group naturally under the categories of Materials, Methods, Equipment, Environment, and People. Use a process-type cause and effect diagram to show causes of problems at each step in the process.
- Presents causes that contribute to an effect.
- Graphically displays the relationship of the causes to the effect and to each other.

iv. Pareto Chart (Institute for Healthcare Improvement, 2011)

- Works on the premise that in any event there are contributors that account for its totality
- Arranges the different factors contributing to an effect according to the former's magnitude. This way, the factors that warrants most attention is identified.
- Aids in refocusing on the factors with the highest effect and helps in communicating the rationale for doing so.

v. Histogram (Institute for Healthcare Improvement, 2011)

- Presents the differences in continuous data like time, weight, size, or temperature.
- Aids in identifying patterns in data that are hidden within a table of data

5. DEVELOPMENT OF THE ACTION PLAN

Models for Change Implementation

The action plan can be created by selecting a model that would be appropriate to change and improve the system such as:

1. Plan- Do-Check-Act (PDCA) cycle (American Society for Quality, 2013)

- Is a four-step model for change that should be done repeatedly in order to achieve continuous improvement
- It is utilized as a model for continuous improvement, when starting a new improvement project, when creating a new or revised design for a process, product or service, when delineating a work process, when planning to determine root causes of problems to prioritize them and when implementing change.
- It consists of the following process
 - o Plan - Identify an opportunity and plan a change.
 - o Do - Test the plan and perform a small-scale study.
 - o Check- Review the trial, analyze the results and determine learning points.
 - o Act - Create action based on the evaluation of the trial. If there was no significant change, redo the PDCA cycle. When it is successful, utilize learning points to promote wider changes.

2. Lewin's Change Management Model (Change Management Consultant, 2012)

- Consists of the concepts of Unfreeze – Change – Refreeze
 - o Unfreeze - eliminates status quo and challenges the current mindset. Usually done by presenting an event or problem that would stimulate people to recognize the need for change.
 - o Change - Creation of new behaviors, values, and attitudes through the planned change. May encounter confusion due to disruption of what people are used to.
 - o Refreeze - The final stage of retaining change activities in such as way that change is

“crystallized” in order to avoid reverting to previous state.

The mentioned models are only two of the several models that can be identified when it comes to quality improvement. The application of the model depends on the goal and context of the problem at hand. Once the models are identified, one could then create the action plan and do a pilot study for a small group of people.

Other QI Methodologies include Continuous QI, Six Sigma. “Six Sigma, developed by Motorola in 1986, focuses on defects, variation reduction, and customer satisfaction. In the health care setting, it can be used to reduce medical errors while maintaining patient and provider satisfaction through the development of a sustainable patient care model” (Neufeld, et al., 2013). A newly developed QI method is the Lean Six Sigma (LSS). “LSS is a progressive hybrid of Lean Thinking and Six Sigma process improvement methods. Lean Thinking, coined by Toyota in the 1950s as part of their Toyota Production System, focuses on the streamlining of system processes by waste reduction.” (Neufeld, et al., 2013).

6. IMPORTANCE OF DOING A PILOT STUDY

Pilot Study

- Is a smaller form of a full-scale study otherwise known as feasibility studies which may be used to pre-test a research instrument such as questionnaires and interview schedules (van Teijlingen & Hundley, 2002)
- The importance of a pilot study are the following: (Altman, et al., 2006)
 - Confirm that the directions for the investigators are clear
 - Confirm the skills of the investigators in conducting the study
 - Verify working condition of the equipment
 - Check the reliability and validity of the results
 - Detect a floor of ceiling effect such as if a task is too difficult or too easy)
 - Determine whether intervention is appropriate
 - Identify the adverse effect or effectiveness that may be caused by the action plan/ intervention

Large Scale Implementation of the Action Based on Pilot Study

Factors that can affect the data during data collection (Newsawdomy, 2008 & Polit & Beck, 2004):

1. Selection Bias
 - This occurs when individuals are not randomly assigned to intervention groups that may cause biased responses
 - It may be avoided by random assignment of people into groups of the intervention. It is also helpful to know the general characteristics of the people involved in the study.
2. History Bias
 - It occurs when an external event affects the results of the action/ intervention performed (e.g spread of the news that a nurse was fired because of hurting a patient)
 - Resolve this by randomly assigning people into groups of the intervention.
3. Maturation Bias
 - This happens when a change in the subject has occurred due to the passage of time rather than as a result of the intervention (e.g fatigue, emotional maturity)
 - Use comparison groups because the maturation is likely to occur in one group as in another.
4. Testing Bias
 - This occurs when pre tests and post tests are used as the measure of intervention (e.g questionnaire). The result of post test may be influenced by the result of the pre test.
 - Use a comparison group to avoid testing bias

5. Instrumentation change
 - Occurs when mechanical instruments or judges are used in the pretest and posttest phases of a study (e.g blood pressure manometer, judges)
 - Training sessions for judges and trial runs to check for fatigue factors may help control for instrumentation changes. Also, if mechanical instruments are used, such as sphygmomanometers, these instruments should be checked for their accuracy throughout the study
6. Mortality
 - Occurs when a study is conducted for a long time and participants drop out from the study.
 - This can be avoided by establishing a relationship with study participants and helping them recognize the relevance of their continued participation in the project.
7. Hawthorne effect
 - Occurs when study participants respond in a certain manner because they are aware that they are being observed or because they are aware of their participation in a study
 - As much as possible, use blinding techniques wherein the participant or/nor the researcher knows about who is in the intervention and the non-intervention group.
8. Experimenter effect
 - Occurs in when the researcher characteristics or behaviors influence subject behaviors. Examples are facial expressions, clothing, age, gender and body build
 - Proper training of data collectors is vital to avoid this.

7. PRESENTATION OF RESULTS

Guidelines and Tips for Oral Presentation of Results (James Madison University, 2013)

- Due to the usual limit of time when presenting the results of a quality improvement study, the report must be succinct and substantial thus, prepare the talk by careful planning.
- Remember that oral presentations must be concise and to the point as compared to the written paper which is detailed as necessary to fully explore the subject.
- Clearly state the study topic
- Concisely explain what you are trying to accomplish in the research
- Clearly state the scope of the study.
- One may start by giving the conclusion right away or start with the details and construct an argument leading to the conclusion.
- Present the result of the study in an objective and balanced manner
- Draw and present clear conclusions about the results of the research.
- Don't lean, slouch or hide behind a podium.
- Project your voice clearly and distinctly in relation to the environment.
- Avoid filling the pauses with "Ahhh" and "Uhhhh"
- Make sure slides are readable.

SUMMARY

This module utilizes an interactive lecture providing the participants (i.e the master trainers) the tangible experience of the actual brain storming for the identified problems using the systematic approach of the research process. Thus, adequate time is needed for this training module in order to provide the participants ample time to provide their best possible answers.

SELF-ASSESSMENT QUESTIONS AND ANSWERS

These questions are to be answered by the Master Trainers:

1. What teaching-learning strategies/activities have been discussed that can be used to develop critical thinking in the learner.

Answer: Reading of the journal articles would gain insights on the global trends on Quality improvement and what would be applicable in their work settings. Critical analysis of the case studies would elevate their theoretical knowledge into application to case scenarios. The group discussions would further enrich their QI plans based on the experiences and inputs of other members of the group.

2. What evaluation tools can be used to determine achievement of competencies in the learners at the end of the activity?

Answer: As this is a process-oriented learning, you would need to assess the learner if they achieved the competency prior to the succeeding one. For example, they should have a good grasp of research process before they can discuss the research application in quality improvement. Their appreciation of the significance of the quality assurance team and the nurse's role in it, can be gleaned on how they see it applied in their work setting or in local organizations. The learners should be able to identify QI problems in their actual work, delineate the appropriate QI methodologies and interventions given their peculiar circumstances. Ultimately, the learner should be able to present a full proposal and implementation scheme for quality assurance in their setting.

3. How do you plan to cascade what you learned in this module to your "end-learner"?

Answer: In the instructional design, there are a number of instructional activities that were discussed which will help learners assimilate and apply the content of the module. The end goal of this module is for the learners to gain the core competencies. Check this out by reviewing the competencies and performance indicators listed in the table at the beginning of this module. If the indicators are exhibited by the learners, then you have achieved the purpose of NNCCS on research application in quality improvement.

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SUMMARY

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Your experience in training to be a Master Trainer is about to be completed. We hope that it has been meaningful, enlightening and inspiring. At this point let us pause and recall what you should have accomplished. We expect that through these modules and the reference materials, you have enhanced your:

1. Understanding of the roles, responsibilities and competencies required in nurses;
2. Appreciation of the importance of:
 - 2.1. responding to the needs of a variety of clients
 - 2.2. practicing leadership and management skills in different work situations
 - 2.3. doing and utilizing research for quality improvement;
3. Application of legal, ethical and moral principles in decision-making;
4. Performance in all work settings according to the standards of competent education and practice;
5. Ability to be agents of change as nurse educators, managers of health facilities and nurse practitioners.

The modules are organized into *three main clusters*, namely:

1. **Client care** which focuses on the practice of nursing and use of the nursing process. A module on personal and professional growth is included to stress that life-long learning is a responsibility of any professional.
2. **Management and leadership** modules are for competent delivery of health services and implementation of programs. These modules include ways of developing interpersonal skills and learning to be members in an interdisciplinary team.
3. **Research** for continuous generation of knowledge and utilization of knowledge applies the scientific method in nursing practice and education.

As Master Trainers, you are also expected to use different appropriate *teaching and learning strategies*. These include:

1. **Lectures** are used to impart, organize, elaborate and elucidate information. Lectures are given not only to give information but also to clarify and challenge the learners' understanding, application, analysis, synthesis and evaluation of information.
2. **Small group discussions** are sessions for learners to think more critically about information. Preceptorship is a form of small group discussion. Interactions among the learners promote cognitive skills, attitudes and values on the topics and issues discussed. Discussions likewise enhance communication and listening skills for teachers and learners.
3. **Case studies** are presentations of true-to-life cases. Guide questions encourage learners to relate,

react and propose solutions to the situation. Case studies may be about individual patients, special groups of clients or communities. These are opportunities to discuss the client in the context using the holistic approach to nursing care. Cases may be given as individual assignments or topics for group discussions.

4. **Demonstrations** by the teachers or a return demonstration by learners show performance in actual or simulated situations. Demonstrations focus on development of skills. This strategy includes “telling what, showing how and explaining what and why”. After a demonstration by the learners, it is very important to give feedback on “what was done properly, what was not done properly and how it should be improved, what alternative ways of doing may be acceptable”. The performance indicators and the assessment tools in the modules should guide you in the use of this strategy.

5. **Questions** given orally or in writing are effective tools to require the learners to recall, interpret, analyse, synthesize and evaluate information or performance. These are essential cognitive skills and as Master Trainer you should use a variety of questions such as the following:

5.1. *Recall of information*

- What...?
- Who...?
- When...?
- Where...?

5.2. *Relate and interpret information*

- What is the meaning of...?
- What is an example of...?
- What illustrates the principle of ...?
- How do these... compare?

5.3. *Apply what has been learned*

- Compute for...
- Use the given data to illustrate...
- Given a situation, what principle should be applied?
- From the given data, what should be done?
- Given the data, explain...

5.4. *Analysis*

- How do you explain ...?
- Why do you think...?
- What are the reasons ...?
- Given the data, how will you solve...
- Which is not relevant in this case?
- How will you classify...?

- How will you distinguish...?

5.5. *Synthesis*

- What alternatives can you suggest...?
- What could happen if...?
- What are the possible causes of...?
- What are possible courses of action to...?
- Organize the data according to...
- Design a training program for a group.
- Write a case report.

5.6. *Evaluation*

- Is the information correct? Accurate? Why or why not?
- What do you think is more likely to happen?
- What data suggests...
- What conclusion can you make...?
- What evidence will support your answer?
- Justify your choice...

In asking questions, Trainers can start with simple questions that require only recall and progressively ask questions that require higher order thinking skills (HOTS). Follow up or probing questions develop thinking abilities and encourage the learners to explain, justify and seek additional information as needed. As Master Trainers, you should learn and hone your skills in the “Art of Questioning”, an important technique of teaching. Formulating a good and challenging question is the first step but learning to ask questions in a non-threatening but encouraging manner is another skill to be mastered.

Assessment of learners

Your stated objectives should be used in the assessment or learning. The performance indicators of the NNCCS serve as a good guide to determine the extent of learning and quality of performance. The methods of assessment include:

1. Written tests consists of questions which learners answer in writing, may be given in large groups.
2. Oral exams consist of questions which learners answer individually.
3. Practical exams are done by observing performance of learners in given situations.
4. The Objective Structural Clinical Examination (OSCE) is a type of examination that includes all of the first three mentioned exams.
5. Projects and written reports.
6. Role plays: Yes! Role plays can also be a

- method of assessment of learning.
7. Portfolio assessment is a combination of outcomes of all or some of the above and the evidences of learning.

Armed with a “repertoire” of teaching and assessment strategies, continue on your journey for your personal and professional growth as a Master Trainer. It will prove to be a challenging and rewarding undertaking.



NEXT STEPS

Module 19: Managing Transition Issues: From 2003 to 2012

Module 20: CPR (Classroom, Practicum and Reflection)
Training Framework Module

Managing Transition Issues: From 2003 to 2012

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INTRODUCTION

“A change can work only if the people affected by it can get through the transition it causes successfully.”
(Bridges, 2004)

The question of why there is a need for a new set of core competencies in nursing is an issue that will need to be addressed early on, if the transition to the new 2012 National Nursing Core Competency Standards (NNCCS) is to occur. Questions of this nature are inevitable and the proper handling of these issues is necessary. While many unanticipated issues may arise in the course of this change, the concerns arising from transition must be immediately tackled. The Master Trainer must be able to effectively deal with potential issues, concerns, and difficulties that may arise from challenges posed by the very act of changing what is perceived to be well-entrenched.

Cognitively, the reason for the change to the new 2012 NNCCS is two-fold: 1. Core competency standards are due to be evaluated every 5 years to ensure that new workplace competency requirements are addressed and filled. 2. There were structural inconsistencies noted with the 2003 NNCCS, specifically in the levels of performance indicators, that needed to be fine-tuned. 3. The lack of representation of community-based competencies was also noted.

For the transition to the 2012 NNCCS to occur, a process framework for managing the transition may be beneficial. The transition process framework provides a conceptual approach toward the change and has the potential for effecting a smooth turnover to the new set of nursing core competencies. This passage from old to new may be handled more efficiently and successfully by the use of a process framework.

The psychological issues in dealing with change need to be addressed in order to overcome barriers to acceptance. This module aims to assist Master Trainers to guide the trainees through their psychological transition issues.

MODULE OBJECTIVES

After going through the module, you, the master trainer, will be able to:

1. Differentiate between change and transition.
2. Explain the need for a new set of national nursing core competencies.
3. Identify appropriate tools, guidelines and/or frameworks to manage the transition process from the

2003 to 2012 NNCCS.

1. Describe teaching/learning strategies/activities to guide learners through the chosen transition framework.

DIFFERENTIATING BETWEEN CHANGE AND TRANSITION

The important, but often overlooked, distinction between change and transition needs to be drawn. There is a difference between change and transition. Change is situational; transition is psychological (Bridges, 2004). It is not outside events that make the transition; it is the inner-reorientation and meaning-redefinition that needs to happen for people to be able to incorporate those changes. Transitions are times of crossing over or traveling from something old and familiar to something new and unfamiliar (Quick, Fetsch & Rupured, 2014).

Change occurs when something old stops and something new starts. Therefore, transformation is a fundamental value that occurs with all change, as one goes from one way of being into another. Transition is a gradual psychological and emotional process through which individuals and groups reorient themselves in order to function and find meaning in a situation that has changed (Winfield, 2002).

Making these transitions may be difficult for some people as they have to let go of the past. The past is familiar and may have already been incorporated in one's comfort zone. There is no formal rite of passage from unfamiliar to familiar.

For the difference between change and transition, you may want to play a video about William Bridges' Transition Theory. It is available at <https://www.youtube.com/watch?v=r55XJqyyrlc>. In the video, change and transition are differentiated:

- Change is the way things will be different; transition is how one gets people through those phases to make the change work.
- Change is made of events; transition is an ongoing process.
- Change is visible and tangible; transition takes place inside people.
- Change is about the outcome; transition is about the journey, how we get there.

TRANSITION: THE EMOTIONAL DIMENSION OF CHANGE

Change is about the emotions. Many thought leaders of change management and leadership are now identifying the need to address the emotional dimension of change (Bridges, n.d.). For example, the Kubler-Ross Grief-Cycle, also known as the "change roller coaster," maps out all the emotional changes that people have to go through in their transition through change. Goleman (1995) stressed the importance of the leader inspiring the followers with a message that resonates with the followers' emotional reality and their sense of purpose that motivates them to move in a specific direction. Kotter (1996) asserts that people change behavior when they are motivated to do so, and that happens when feelings are addressed.

It is not what happens, but what one chooses to think about that affects one's feelings and behaviors.

BRIDGES' NAVIGATING THE TRANSITIONS OF CHANGE

William Bridges (1991), in his book, "Managing Transitions," introduced a framework for managing peoples' feelings as change proceeds. The model focuses on transitions, not change. He explained that change is something that happens to people, even when they do not agree with it. Transition, on the other hand, is what happens in people's minds as they go through change. Change can happen quickly, while transition may be a slower moving process.

The model highlights three stages of transition that people go through when they experience change. These are:

1. Ending, Losing, and Letting Go
2. The Neutral Zone
3. The New Beginning

According to Bridges (1991), people will go through each stage at their own pace. Those who are comfortable with the change will move on ahead to Stage 3, while others will linger in Stages 1 and 2. Examining the stages and the different emotions they provoke may be helpful in helping to deal with each stage and move on to the next. (Bridges' Transition Model at <http://www.mindtools.com/pages/article/bridges-transition-model.htm>.)

Stage 1: Ending, Losing, and Letting Go

When a change is first presented, people initially go through this stage. This stage is marked by resistance and emotional upheaval because people are being forced to let go of something that they have become accustomed to and feel comfortable with.

At this stage, the following emotions may be felt:

- Fear
- Denial
- Anger
- Sadness
- Disorientation
- Frustration
- Uncertainty
- A sense of loss

Guiding Trainees Through Stage 1

Every transition begins with an ending. Before the new can be embraced, the old must be let go. People should be helped to accept that change is afoot and they must let go. It is best to acknowledge the emotions that people are going through so that less resistance will be encountered throughout the change process. Ask the trainees how they feel about the change to the 2012 NNCCS. Listen empathically and communicate openly about this transition.

Emphasize how the trainees will be able to apply their skills, experience, and knowledge once the change is implemented. Communicate how the knowledge and skills that are being learned in the seminars and workshops, are able to help the entire nursing community move toward aligned beginning nurse competencies. The Board of Nursing will be able to use the new NNCCS as basis for test questions for the National Licensure Examinations. Hospital and community administrators will be able to apply the new NNCCS in new-hire orientation, incorporate the standards in job descriptions, and evaluate according to the new indicators.

Three simple questions have been proposed by Bridges (2004) to help people understand the changes with clarity. These are:

1. What is changing?

When encouraging the trainees to “let go,” the following must be considered:

Consider what they are letting go:

- Describe change in as much detail as possible
- Identify the ripple effects of change
- Identify who has to let go of what
- Notice intangible losses

- Notice whether there's something for everyone

How can we get nurse administrators, nurse educators, and nurses, in general, to embrace the change, eliminate their fear and develop a sense of purpose in it?

2. What will actually be different because of the change?

Here address the impact of the change on the trainees. A change may seem important and very real to the trainer/facilitator, but to the people who have to make it work, it may seem abstract and vague until the actual differences are made clear.

3. Who is going to lose what?

Situational changes are not as difficult to manage as the psychological transitions that people have to make. Bridges (2004) suggests to start with a loss or a "letting go" of the old ways and of how things were before. This perspective is based on empathy and recognizes and affirms people's realities, and works with them so that transition is not a painful and anxiety-producing process. Failure to do this and to deny the losses sows the seeds of mistrust and defiance.

People who have unresolved transition issues involving the NNCCS have three choices (Quick, Fetsch & Rupured, 2014):

1. Do nothing and continue to avoid the issue of the new 2012 NNCCS
2. Squarely face the need to move on to the new 2012 NNCCS and deal with unresolved issues relating to the need to transition
3. Relate familiar aspects of the 2003 NNCCS to similar aspects of the 2012 NNCCS and successfully bridge the two

Stage 2: The Neutral Zone

During this stage, people affected by the change become confused, uncertain, and impatient. Since transitioning will entail an overhaul of what is already in place, they may also experience an increase in workload as they transition forms, syllabi, policies, procedures, etc. to conform with the new standards. This is the phase that bridges the old with the new.

Here, people might experience:

- Resentment toward the change to the 2012 NNCCS
- Low morale
- Self-doubt
- Anxiety about the change
- Skepticism about the change

During this stage, anxiety rises and motivation falls. People feel overloaded, mixed signals are received and confusion is high. People become polarized, some rush forward, others stay back and hang on. But this stage also holds the potential for great creativity, innovation, and renewal.

Guiding People Through Stage 2

This is a time to encourage people through new ways of thinking or working, if they are ready. But this period can also be an uncomfortable time, as progress may seem slow. People might feel a bit lost, with no sense of direction. Still, the best thing is to encourage people to share what they are feeling.

During the series of seminars and workshops to introduce the new NNCCS, it is imperative that their work or output is given acknowledgment and encouragement. This is to help them experience some quick wins which helps to improve motivation. Their continued role in contributing to the success of the change should be emphasized.

Stage 3: The New Beginning

The last transition stage is a time of energy and acceptance. The ability to make transitions successfully frees up precious energy to more fully face the here and now. People in this stage are beginning to embrace the change. They are building the skills needed to accomplish the institutionalization of the new NNCCS and are starting to get some recognition for their efforts.

At this stage, people are likely to experience:

- High energy
- Openness to learning
- Renewed commitment to the group or their role

Guiding People Through Stage 3

Adopting the change is difficult, but sustaining the change is even more so. This is a time for celebration and reward. Not everyone will reach this stage at the same time and people can revert back to the old ways if obstacles or barriers are presented along the way, so vigilance is key.

It may also be useful to present the 4Ps during this stage:

Purpose: Explain why

Picture: Share vision of how it will look and feel

Plan: Lay out a detailed step-by-step plan

Part: Give people a part to play in the transition and the new beginning

For a more detailed description of the stages, it would be helpful to view the following: Bridges and Change at <https://www.youtube.com/watch?v=r55XJqyyrlc>.

STRATEGIES FOR DEALING WITH TRANSITION

1. Bring the ideas that worked well for you in planning for the 2003 NNCCS to the 2012 NNCCS.
2. Surrender. Give in to your feeling of loss. Stop avoiding them.
3. Increase your self-awareness.
4. Learn to look at the transition as a loss and a gain. Loss: Leaving the old and familiar. Gain: opportunity to learn new things.
5. Develop supportive professional relationships.

In summary, much is to be gained from the transition to the new 2012 NNCCS. However, change is never easy because of the emotions and feelings that might come with the change. Bridges' Transition Model is a useful framework for guiding people through the often difficult process of change.

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CPR (Classroom, Practicum and Reflection) Training Framework Module

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INTRODUCTION

This module discusses the framework for training used in this entire series and identifies both the participants of the Training and the Training Framework. There will be two different participants for this workshop:

1. Those who will be Master Trainers, responsible for training others to become Master Trainers or Implementation Facilitators.
2. Those who will be Implementation Facilitators for specific organizations.

Master Trainers are trainers who are responsible for teaching the 2012 National Nursing Core Competency Standards (NNCCS) to other participants who desire to be, or are chosen to be, Master Trainers or Implementation Facilitators. These Master Trainers have the experience and interest to work with adult learners. They have excellent communication and interpersonal skills. Master Trainers are charged with maintaining the integrity of the 2012 NNCCS and are responsible for carrying out the “Spread” strategy of the 2012 NNCCS.

Implementation Facilitators are execution experts. They facilitate the embedding of the 2012 NNCCS in the structure, processes, procedures, and forms of the institutions they represent. Implementation Facilitators are change agents and act as catalysts for change. They are also experts at influencing leadership and staff to move towards a desired future. They must also be familiar with the Stages of Change Model.

This workshop is unusual because the instructor and the participants are actually doing what is being learned about. The participants will need to develop an awareness that will help one learn the instructor’s role and what problems or challenges the participants may face through observing the instructor, themselves, and fellow participants. Participants are enjoined to be observant about how the course is introduced. They can observe how the course is organized, and how the instructor (trainer) deals with problems that arise while the course is being delivered. It will be worth noting when they are bored, anxious, or satisfied, and the techniques that are effective and ineffective.

The Training Framework is CPR (Classroom, Practicum, and Reflection) which has 3 components: classroom (didactic) learning, a practicum (micro-teaching demo), and reflection.

There is a solid body of evidence pointing to different processes that enhance learning. There is, for example, a shift away from the traditional role of the teacher as primarily a purveyor of subject knowledge to a FACILITATOR of learning, where participant learning is managed using a variety of instructional methods, information sources, and course planning.

An important component of this framework is the REFLECTION that occurs during the teaching-

learning process and after each module. Reflecting on one's own experience is an effective and lasting form of learning.

MODULE OBJECTIVES

To prepare participants to become Master Trainers and/or Implementation Facilitators for the 2012 NNCCS.

SPECIFIC LEARNING OBJECTIVES

At the end of the module, participants will be able to:

1. Build an array of strategies to introduce participants to each other
2. Define the participants' expectations of the course
3. Determine the participants' needs
4. Establish a positive climate for team learning that leads to action
5. Introduce the exercises, "Where Are We?" and "Reflections"
6. Identify the 3 basic principles of adult learning
7. Differentiate the "Traditional Trainer" from the "Experiential Trainer"
8. Demonstrate application of adult learning theory to the training process
9. Choose an appropriate tool for evaluating the training program with improvement as the end-in mind

These specific objectives are presented with the corresponding content and Teaching-Learning Activities in the Matrix that follows. This Matrix serves as a plan for instruction/training.

Specific Objective 1 Build an array of strategies to introduce participants to each other	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
Introducing Trainers and Participants	<p>Introduction (10 minutes)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Greet participants, introduce oneself and the participants. • Use an appropriate introduction or icebreaker • Use appropriate strategies to draw out participants so that they stand out in the minds of other participants.

Specific Objective 2 Specify strategies to identify the participants' expectations of the course	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
<p>Retrospectively, assist the participants in reflecting on their expectations of the course</p> <p>1. What did you hope to accomplish during this seminar/workshop?</p>	<p>Expectations (10 minutes)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask the group to pair off.

CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
2. Did you anticipate any difficulties during this seminar? 3. How do you think this training will help you?	<ul style="list-style-type: none"> • Ask each pair to spend 5 minutes interviewing each other to answer the questions. • Have the persons write her/his partner's expectations on an index card or post-it. • Take note of all the expectations so that you can refer to them throughout the course

Specific Objective 3 Identify ways to determine the participants' needs	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
Training Needs Assessment	Assessment (10 minutes) The trainer should: <ul style="list-style-type: none"> • Pass out copies of Handout 1. (See Appendix AX) Training Needs Assessment (Best if this handout is completed as a pre-course requirement). • Ask each participant to fill out the questionnaire • Review the participants' questionnaires to best determine where emphasis is needed.

Specific Objective 4 Establish a positive climate and spirit of team learning that leads to action	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
Establish a positive climate	Group Exercise (10 minutes) The trainer will: <ul style="list-style-type: none"> • Divide the participants into several group with 5 to 6 participants for each group. • Ask the group to spend the first 5 minutes discussing what changes they hope will be made in the hospitals/schools/clinics where they will be providing training or acting as implementation facilitator. • Ask them to record some of the changes they hope to make. They should limit their answers to 5 – 10 important changes. • Each group should select one participant to record their answers and present their answers to the group.

Specific Objective 5	Introduce the exercises, "Where are We?" and "Reflections"	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)	
<p>Where are We?</p> <p>Starting each day with "Where are we?" is our opportunity to share insights, clarify issues, resolve problems, and review important materials we need to remember so that each of us can get the most out of the course and each day's experiences.</p>	<p>Trainer Presentation (15 minutes)</p> <p>The trainer will:</p> <ul style="list-style-type: none"> • Explain that "Where are We?" Handout 2 (Appendix AY) requires the active cooperation of the participants, so be certain to make their role clear. • Explain that "Where Are We?" will be a regular feature of the beginning of each day during the seminar/workshop. • This activity should be used as an opportunity to share insights, clarify issues, resolve problems, and review important material that the participant needs to remember so that everyone can get the most out of each day. • Problems identified during the "Where Are We?" session should be resolved before continuing on with the day's work (whenever possible), since unresolved issues may hinder the learning process for the participant. 	
<p>Reflections</p> <p>After a full day of activities, we need to take time to look over what we have done and examine what it means to us individually. This is a method to explore how what we have learned can be applied in a broader setting, or in our particular settings.</p> <p>The "Reflections" activity will be our opportunity to make these analyses. It is also an opportunity for the trainers and participants to share feedback on the training activities and to identify areas that need reinforcement or further discussion. Therefore, at the end of each day, we will use various methods of conducting this activity to reflect on the day's work.</p> <p>For the first session of "Reflections," each participant then should answer the following questions and share responses with the group:</p> <ul style="list-style-type: none"> • What did I like about today and why? • What did I not like about today and why? • What did I learn and experience today that I will be able to use? 	<p>Trainer Presentation (15 minutes):</p> <p>The trainer will:</p> <ul style="list-style-type: none"> • Explain that at the end of the day's activities, the "Reflections" activity will be performed. • Be sure to close each day's activities with a session of "Reflections" on the day. • Make a note of the participants' and trainers' feedback, and attempt to address ideas and concerns during the discussion and during the following days' sessions. 	

Specific Objective 6 Identify the 3 basic principles of adult learning	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
<p>Adult Learning</p> <p>The 3 basic principles of adult learning are:</p> <ol style="list-style-type: none"> 1. Active learner participation in the learning process significantly increases the learner's ability to retain and use knowledge. 2. One of the keys to successful learning is a "supportive" environment in which the learner receives positive (praise encouragement), rather than negative, reinforcement (scolding/criticism). 3. Independent learning experiences increase the learner's confidence and sense of responsibility. 	<p>Think – Pair - Share (15 minutes)</p> <p>The trainer will:</p> <ul style="list-style-type: none"> • Ask each participant to think about the best learning experience s/he ever had as an adult. • Then, find a partner, and relate their answers with each other. • Lastly, share their experiences with the entire group.

Specific Objective 7 Differentiate the "traditional trainer" from the "Experiential trainer"	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
<p>The Traditional Trainer focuses on:</p> <ul style="list-style-type: none"> • Passing on information from trainer to trainee. • Assuming responsibility for trainee needs. • Focusing "one-way" communication from trainer to trainee. <p>The Experiential Trainer believes that:</p> <ul style="list-style-type: none"> • Trainees learn from experience. • Trainees should be actively involved in the training process. • Trainees learn best by exploration and discovery, asking questions, formulating and testing hypotheses, and solving problems. 	<p>Discussion (5 minutes)</p> <p>The trainer will:</p> <ul style="list-style-type: none"> • Discuss the differences between the Traditional Trainer and the Experiential Trainer. • Ask the participant where they would rate themselves on a scale of 1 (traditional trainer) to 10 (experiential trainer). • Participants share where they are on the traditional and experiential scale.

Specific Objective 8 Demonstrate application of adult learning theory to training process	
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
Applying Adult Learning Theory	Group Exercise (15 minutes)

CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
<p>A variety of activities, based on the characteristics of adult learning, can be used in the teaching process. Some of these characteristics are listed below:</p> <p>Adult have a need to know why they should learn something.</p> <ul style="list-style-type: none"> • Provide real or simulated experiences through which the learners experience the benefits of knowing and the costs of not knowing. • Start training by creating a climate of mutual trust and by discussing expectations with the learner. <p>Adults have a deep need to be self-directing.</p> <ul style="list-style-type: none"> • Allow for as much choice as possible in making decisions during the learning experience. • Create a mechanism for mutual planning. Help adults diagnose their needs. Set objectives and design learning activities suited to their needs. <p>Adults have a greater breadth and a different quality of experience than younger learners.</p> <ul style="list-style-type: none"> • Encourage participants to share their experiences. • Try to link new learning activities to the participants' experiences. <p>Adults become ready to learn when they experience a need to know or be able to do, in order to perform more effectively.</p> <ul style="list-style-type: none"> • Any training course will be more effective if the content is related to meeting their need for knowledge or a particular skill. Often participants are sent by their institution/organization and do not "choose to attend." When participants are "sent" for training, there are two mechanisms for reducing their resistance: <ol style="list-style-type: none"> 1. State publicly that you realize that there may be some participants who are not in the course because they want to be, this is an unfortunate situation because this usually gets in the way of learning, and; 2. Explain that since they have no choice but to be in the course, to try to find some value in learning what the course has to offer. 	<p>The trainer will:</p> <ul style="list-style-type: none"> • Divide the participants into groups of 5 to 6 people. • Ask them to spend 5 minutes discussing how they might practically apply each feature of adult learning theory when conducting training. • Have one participant from each group present their list of practical applications. • If necessary, supplement the lists after all the groups have presented. • Ask participants to cite examples of adult learning experiences that they have used in teaching the 2003 NNCCS for the adult learning principles.

CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
<ul style="list-style-type: none"> Participants should be told why a particular topic or session is included and why they are expected to learn a particular skill or adopt a certain attitude. <p>Adults enter into a learning experience with a task-centered orientation to learning.</p> <ul style="list-style-type: none"> Case studies and role play techniques help participants feel they are working with “real” problems and accomplishing “real” tasks. Developing and carrying out “re-entry” plans help participants learn how to apply the lessons learned. 	

Specific Objective 9	Choose an appropriate tool for evaluating the training program with improvement as the end-in-mind
CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
<p>How Is Training Evaluated?</p> <p>Possible Responses:</p> <ul style="list-style-type: none"> Daily participant evaluation sheets (AKA feedback sheets) Pros and cons list “Where Are We?” Daily reflections Written pre- and post-tests Surveys Interviews Questionnaires Focus groups 	<p>Group Exercise (10 minutes)</p> <ul style="list-style-type: none"> How can informal conversations be employed to identify problems, needs, and issues early? Someone who is shy or too polite to give formal feedback might mention something important in private conversation. <p>The trainer will:</p> <ul style="list-style-type: none"> Divide the participants into small groups of 5 or 6 to work on the following tasks: <ol style="list-style-type: none"> Design an overall evaluation form for a Training the Trainers course. Share your design with the other groups for feedback and additional ideas. Agree on one final design. How does your design compare with the Final Evaluation Handout 3 (Appendix AZ)? Ask the following questions about the experience of designing an evaluation form: <ul style="list-style-type: none"> What did you find difficult about the task? What would have made it easier? Draw conclusions about the evaluation session by asking the following questions:

CONTENT Knowledge/Attitude/Skills	TRAINING/LEARNING METHOD (Time Required)
	<ul style="list-style-type: none"> o What have you learned about the evaluations today? o What else about training evaluations are you interested in? o How do you make sure that your evaluations are valid and reliable?

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Methodology

MODULE DEVELOPMENT METHODOLOGY

The module development encompassed the following steps: planning, writing, pilot testing and evaluation, revision, editing, lay out and reproduction. The module development spanned ten months. It started with a series of meetings by the project team and communicating with prospective stakeholders.

The project team invited nurse educators and practitioners from the academe, hospitals and community health facilities to a workshop in the University of the Philippines (UP) Manila College of Nursing on April 25, 2013. In this workshop, the resource persons presented the overview of the project, the highlights of the National Nursing Core Competency Standards (NNCCS), and the criteria and responsibilities of writers. The criteria for the selection of writers were: expertise in nursing, writing ability and commitment to the improvement of nursing. A line up of writers and topics were formulated.

On May 9 and 16, 2013, the recommended writers met in two batches at the Association of Deans of Philippine Colleges of Nursing, Inc. (ADPCN) Center for Training and Development in Quezon City to fine tune the work plan and identified competencies for which modules will be developed.

On July 1, 2013, the writers and the project team had another brainstorming session to discuss issues related to module development. The parts and formats of the modules were finalized and it was agreed that the module of Dr. Araceli O. Balabagno on the Care of the Older Person was accepted as a prototype.

The writers met again on July 25, 2013 and revised the timetable of activities and list of writers. Dr. Annabelle R. Borromeo presented the Training Framework. The discussion focused on the roles of the Master Trainers and strategies for training. It was clarified that two levels of training would be required: Master Trainers and Implementation Facilitators. The average length of modules and coverage were also resolved in the meeting.

Individual work on writing the modules took place from July to September. The drafts of the modules were submitted for printing prior to the Orientation of Coaches and Mentors. The modules were reproduced and reviewed per cluster.

Coaches and mentors were drawn from the pool of module writers and content experts. They were tasked to train nurse educators (curriculum chair or level coordinators), hospital training officers and community health nurses to have the necessary skills and abilities needed to perform the three major roles of a master trainer. Criteria for the selection of mentors and coaches were: commitment, availability, expertise on the content and ability to deliver and facilitate trainings effectively.

A three-day Orientation of Mentors and Coaches was held on October 10-12, 2013 at ADPCN. On the first day of the orientation course, many issues were raised and resolved. Mentors and coaches assessed modules, developed a list of recommended changes and peer reviewed the materials. The group also

discussed plans and preparations for the Pilot Test.

After considerable discussion and revisions, the modules were deemed ready for pilot testing. In accordance with the project plan, pilot tests were conducted in Luzon, Visayas and Mindanao in order to seed master trainers throughout the Philippines. Training modules on the 2012 National Nursing Core Competency Standards (NNCCS) were pilot tested during five-day trainings in Luzon, Visayas and Mindanao. Only twenty-four selected modules were discussed out of the total thirty-two (32) completed modules. These were likewise evaluated during the training sessions. The discussions were enlightening and the participants were generous in giving comments about the draft of the modules and the training strategies.

The pilot test of the modules in Luzon was held on November 11 - 15, 2013 at the ADPCN Center for Training and Development in Quezon City. Similar workshops were simultaneously conducted at Cebu Normal University (Visayas) and Ateneo de Davao University (Mindanao) on November 18 - 22, 2013. Coaches and mentors used the modules developed by module writers in training the master trainers. The roles of master trainers can be found in Module 1: Introduction.

The experiences derived from these workshops were collated. The evaluations from the three workshops were given as feedback to the writers and used to revise the draft of the modules. The training team likewise noted the suggestions of the participants and trainers which were considered in the revision of the modules.

The revised modules were subjected to further refinement by editing. A layout artist/designer worked on the draft for uniformity in the presentation. Other details on the drafts were completed to comply with the requirements for publication.

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19. MA. ISABELITA C. ROGADO, RN, MAN is known for her expertise in clinical nursing education primarily in critical care nursing, leadership development, operational turn-around efforts, physician partnership and strategic development plans geared toward quality and safety enhancement procedures particularly in the field of informed nursing practice. She has risen from the ranks of the Nursing Service of the Philippine Heart Center and took an early retirement from government position to pursue experience in the private sector such as being the Vice President of the Division of Nursing of St. Luke's Medical Center - Quezon City (2005 – 2008). She is presently the Chairperson of the Philippine Nurses Association Committee on Continuing Education and a member of the Stroke Society of the Philippines. In pursuit of her passion in the field of critical care nursing, she is the President of the Critical Care Nurses Association of the Philippines, Inc (CCNAPI) and Secretary of the World federation of Critical Care Nurses (WFCCN). Currently, she taking a course for a doctoral degree in nursing.
20. ELIZABETH R. ROXAS, RN, MSN is currently the National President of the Association of Deans of Philippine Colleges of Nursing Inc. (ADPCN Inc.). She is also the Dean of Baliuag University College of Nursing.
21. MARCO ANTONIO C. STO. TOMAS, RN, MAEd, MAN is a charismatic Catholic-Christian Lay Leader and Prayer Warrior. He served as Dean of Nursing for twenty-two and a half (22 ½) years and was a former Auditor, Public Relations Officer (P.R.O) and Vice President of the Association of Deans of Philippine Colleges of Nursing (ADPCN) before his appointment to the Professional Regulation Commission Board of Nursing in 2006. His strength is in mentoring and sharing his heart to people.
22. LOURDES MARIE S. TEJERO, RN, Ph.D. and JOYCE ANN D. MARTIJA, RN. Dr. Tejero is presently the Dean of the University of the Philippines College of Nursing (UPCN). She was the Director of the UP National Graduate Office for the Health Sciences. She worked in the pediatric wards and neonatal intensive care unit of the Philippine Children's Medical Center (PCMC) in 1995 and resigned as Nurse V from the Training Division of PCMC Nursing Services in 2001. Ms. Martija is currently a neurosciences nurse at London's King's College Hospital NHS Foundation Trust. She worked at St. Jude Hospital and Medical Center as Critical Care Nurse and Nurse Manager. She obtained her B.S. Nursing degree from University of Santo Tomas and her coursework for M.A. Nursing at the University of the Philippines.
23. MA. LUISA T. UAYAN, RN, MSN, DHSc finished her Bachelor of Science in Nursing from the University of the East Ramon Magsaysay Memorial Medical Center (UERMMMC) College of Nursing. She took her Master of Science in Nursing from St. Paul University Philippines in Tuguegarao City, Cagayan Valley where she honed her competencies in Community Organizing Participatory Action Research (COPAR). She graduated from the University of Tokyo, Tokyo, Japan with a degree on Doctor of Health Science & Nursing (DHSc). She dedicate most of her time on researches related to Women's Health & Migration,

Community Health Nursing, Perinatal Nursing, Geriatrics and Nursing Informatics. Currently she is a Professor and the College Secretary of the UERMMMCI College of Nursing.

24. DEOGRACIA MERCADO VALDERRAMA, RN, MAN, MHA, DPA is the current Dean of the School of Health Sciences Mapua Institute of Technology. She worked with the University of the Philippines - Philippine General Hospital Medical Center for forty-three (43) years, ten (10) years of which she served as Director II for Nursing in the same institution. In 1996, she was deputized by the Professional Regulation Commission – Board of Nursing (PRC-BON) to chair the Task Force to develop specialty programs for nursing in the Philippines. When PRC-BON created the Nursing Specialty Certification Council, she was subsequently appointed as the Vice Chair of the council until the present BON created the CNARS. She is also the ongoing Chair of the Philippine Nursing Education Academy, the educational arm of the Association of Deans Philippine Colleges of Nursing.

National Nursing Core Competency Standards Training Modules for the Philippines

These training modules represent the nursing core competency standards of the Philippines developed by the *Nursing Core Competencies Training for Master Trainers in Nursing Education and Practice project*. This initiative is part of a three-year project funded by the European Union (EU) and implemented by the International Labour Organization (ILO) under the *Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers*.

The overall objective of this intervention is to improve nursing education and practice through the enhancement of the core competencies of nursing practitioners and students.

The project partners include the Commission on Higher Education (CHED) and its Technical Committee for Nursing Education, the Professional Regulation Commission (PRC) and its Board of Nursing, and excellent and dedicated nursing educators, administrators and practitioners.

This initiative promotes the practice of standard nursing core competencies among nurses. Nursing schools, health facilities, the Commission on Higher Education (CHED) and the Professional Regulation Commission (PRC) will benefit from the consistent and uniform implementation of the nursing core competencies. This effort supports the enhancement of the quality of nursing education and practice in the Philippines.



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