Concepts and Principles of Partnership, Collaboration, and Teamwork

Development of Teamwork and Collaboration

Teamwork and collaboration develop progressively, beginning with self-awareness, then moving to dyadic relationships, groups, and finally to teams that may be part of interdisciplinary healthcare systems.

Self-Awareness

Definition: The conscious knowledge of one's character, feelings, motives, and desires.

Importance in Teamwork:

- Acts as the foundation for effective interpersonal relationships
- Encourages *emotional intelligence* — the ability to manage one's own emotions and recognize others'
- **Self-aware nurses** understand their communication style, biases, and stress responses
- Promotes accountability, which is vital for team trust

Dyad (Two-Person Relationship)

Definition: A dyad is the smallest possible group — a pair, typically formed between a nurse and another individual (e.g., patient, colleague, physician).

Importance in Collaboration:

- The nurse-patient dyad forms the basis of therapeutic relationships
- Nurse-colleague dyads (e.g., nurse-physician, nurse-technician) allow for direct, focused communication and role clarity
- **Trust, communication, empathy, and mutual respect** are key to a functional dyad

Group

Definition: A collection of individuals working together but not necessarily interdependently.

Characteristics:

- Shared interests or goals, but not always shared responsibilities
- Less cohesion than teams
- Example: Nurses attending a workshop or training session together

Challenges:

- Varying levels of participation
- Lack of shared accountability

Importance in Development of Teamwork:

- A step towards team formation
- Encourages understanding of *group dynamics* (roles, norms, leadership styles)

Team

Definition: A group of individuals with **complementary skills** who are mutually accountable and work interdependently toward a common goal.

Key Principles:

- Shared goals
- Clear roles and responsibilities
- Open and respectful communication
- Collaborative decision-making
- **Collective accountability**

Healthcare Teams

What is a Healthcare Team?

Definition: A team of health professionals providing care to a patient or population.

Members May Include: Nurses, physicians, pharmacists, therapists, dietitians, social workers, case managers.

Function:

- Each member brings unique expertise
- Collaboration ensures holistic, patient-centered care
- Regular team huddles, rounds, and interdisciplinary meetings improve coordination
- Example: Post-operative care of a surgical patient requires coordination among surgeons, nurses, physical therapists, and dietitians

Multidisciplinary Team

Definition: A group of healthcare professionals from different disciplines working independently but in parallel toward patient care. Each professional evaluates, treats, and documents separately, with minimal formal collaboration.

Key Features:

- Less integrated than an interdisciplinary team
- Each professional provides services related to their discipline with limited collaboration
- The patient may receive *fragmented care* if communication is weak

When It Works Best:

- Routine, stable patient situations where care pathways are standardized
- Settings where professionals work in different physical locations
- When patients have straightforward, single-system issues

Interdisciplinary Team

Definition: A group of healthcare professionals from different disciplines who work in an **integrated, collaborative manner** with shared goals, joint decision-making, and regular communication.

Key Features:

- Integrated Work: Professionals work together, sharing information and coordinating care
- Shared Goals: The team develops collective goals for the patient
- Frequent Communication: Regular team meetings, huddles, and collaborative documentation
- Holistic Care: The patient is viewed as a whole person, not a collection of separate problems
- Role Blurring: Some overlapping of roles occurs as team members contribute to shared outcomes

When It Works Best:

- Complex, chronic, or multi-system patient situations
- Settings where patients have multiple comorbidities
- End-of-life care, rehabilitation, and complex discharge planning
- When care coordination is critical to outcomes

Things to Remember

- Effective teamwork and collaboration require **self-understanding, trust, clear communication, and role clarity**
- Team development is a process — it grows from individual self-awareness to interdependent professional teamwork
- Nurses often function within both dyads and teams and must navigate these relationships with professionalism and empathy
- Healthcare delivery is team-based, and understanding multidisciplinary roles ensures continuity and quality of care

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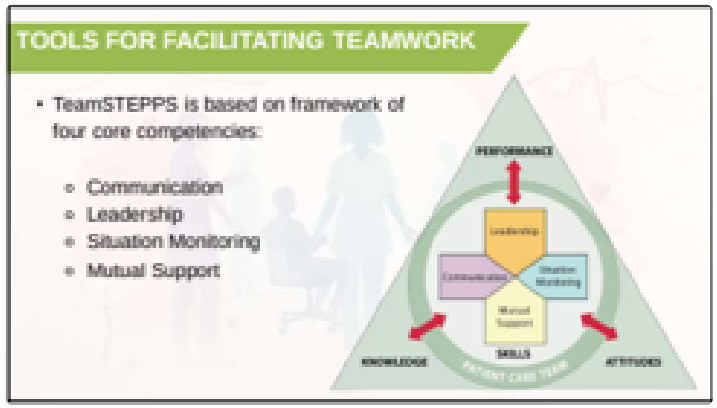
Tools for Facilitating Teamwork

Teamwork in nursing doesn't happen by accident — it is built intentionally using specific tools, structures, and behaviors. These tools enhance communication, coordination, role clarity, and decision-making, ensuring that patient care is safe, efficient, and high-quality.

TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety)

- Evidence-based teamwork system developed by the Agency for Healthcare Research and Quality (AHRQ)
- Provides training modules and tools for: **Leadership, Communication, Mutual Support, and Situation Monitoring**



Core Competencies:

- **Communication:** Effectively exchange information among team members, regardless of how it is communicated
- **Leadership:** Direct and coordinate, assign tasks, motivate team members, and facilitate optimal performance
- **Situation Monitoring:** Develop common understandings of the team environment, apply strategies to monitor team members' performance, maintain a *shared mental model*
- **Mutual Support:** Anticipate other team members' needs through accurate knowledge, shift workload to achieve balance during periods of high workload or stress

Communication Tools

SBAR — A standardized technique for communicating critical information that requires immediate attention and action concerning a patient's condition. SBAR stands for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation/Request.

Call-out — A tactic used to communicate important or critical information. It informs all team members simultaneously during emergent situations and helps team members anticipate next steps.

Check-back — A strategy for *closed-loop communication* to ensure that information conveyed by the sender is understood by the receiver as intended.

Hand-off — The transfer of information during transition in care across the continuum. It provides an opportunity to ask questions, clarify, and confirm. A specific tool for this is **'I PASS THE BATON'** , designed to enhance information exchange.

Leadership Tools

Brief — A short session prior to the start of a procedure or event to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and likely contingencies.

Huddle — Ad hoc meeting to re-establish situational awareness, reinforce plans already in place, and assess the need to adjust the plan.

Debrief — Informal information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors.

Situation Monitoring Tools

Cross-monitoring — A harm error reduction strategy that involves monitoring the actions of other team members, providing a safety net within the team, ensuring that mistakes or oversights are caught quickly and easily. "Watching each other's back."

STEP — A tool for monitoring situations in the delivery of healthcare. STEP stands for: **S**tatus of the patient, **T**eam members, **E**nvironment, **P**rogress towards a goal.

I'M SAFE Checklist — A checklist used during situation monitoring by each team member to assess his or her own safety status. I'M SAFE stands for: **I**llness, **M**edication, **S**tress, **A**lcohol and Drugs, **F**atigue, **E**ating and Elimination.

Mutual Support Tools

Two-Challenge Rule — Empowers all team members to "stop the line" if they sense or discover an essential safety breach.

CUS — An assertive statement used when a team member would like to "stop the line": **I am Concerned! I am Uncomfortable! This is a Safety Issue!**

DESC Script — An approach for managing and resolving conflict. DESC stands for: **D**escription, **E**xpress, **S**uggest, **C**onsequences.

Phases of TeamSTEPPS Implementation

Phase One: Assessment

- Determine the organization's readiness by conducting a training needs analysis
- Establish a multidisciplinary change team at the organizational level
- Identify challenges and opportunities for improvement
- Develop goals for the intervention

Phase Two: Planning, Training, and Implementation

- Define the TeamSTEPPS intervention and develop a plan for its effectiveness
- Draft an implementation plan and communication plan to prepare the organization
- Systematically implement the TeamSTEPPS intervention through training

Phase Three: Sustainment

- Establish a sustainment plan to practice TeamSTEPPS principles
- Engage leadership to emphasize new skills and practices with regular feedback
- Celebrate wins to bolster engagement in teamwork
- Measure the intervention's effectiveness
- Update the plan

Other Facilitating Tools

Interdisciplinary Rounds — Regular meetings involving multiple disciplines (nurses, physicians, pharmacists, therapists, etc.) to review and plan patient care. Enhances collaborative decision-making.

Delegation Tools — Help nurse leaders assign tasks based on team members' competencies and scopes of practice. Example: **5 Rights of Delegation** (Right task, right circumstances, right person, right direction/communication, right supervision/evaluation).

Clinical Pathways / Care Plans — Structured, evidence-based plans that outline coordinated care activities for specific diagnoses. Ensures all team members follow a unified care approach.

Electronic Health Records (EHR/EMR) — Shared digital platform for real-time patient information. Facilitates information access and updates by all team members. Reduces duplication and errors.

Simulation and Role-Playing — Used in training to practice teamwork in realistic clinical scenarios. Builds skills in communication, leadership, decision-making, and crisis management.

Conflict Resolution Tools / Guidelines — Policies and communication frameworks for addressing misunderstandings or team conflict. Example: Using the **DESC Script** for constructive conversations.

Feedback and Evaluation Tools — Peer reviews, 360-degree feedback, and performance appraisals help monitor team effectiveness and individual contributions.

Roles of the Nurse in the Healthcare Team

Care Provider

- The primary role of the nurse
- Involves holistic care — physical, emotional, psychological, spiritual
- Includes assessment, planning, implementation, and evaluation of nursing care
- Promotes continuity of care, which strengthens teamwork and trust

Communicator

- Nurses are communication hubs between patients, doctors, allied health, and families
- Uses **SBAR** as a tool for concise and structured communication
- Clear communication prevents errors and enhances team function

Collaborator

- Participates in interdisciplinary planning and rounds
- Coordinates with other healthcare providers for integrated patient care (e.g., discharge planning with social workers)
- Builds therapeutic relationships with colleagues through mutual respect and shared goals

Leader/Manager

- Delegates tasks effectively based on staff competencies
- Uses time management, prioritization, and supervision to ensure quality care delivery
- Supports staff through guidance, coaching, and conflict resolution

Researcher/Innovator

- Engages in *evidence-based practice* (EBP)
- Encourages quality improvement projects and new approaches in nursing practice
- Shares findings with the team to improve patient outcomes

Advocate

- Represents and protects patients' rights and needs within the team

- Speaks up during ethical dilemmas, unsafe practices, or treatment plans not in the patient's best interest

Educator

- Provides patient teaching and supports other staff with knowledge-sharing
- Promotes lifelong learning within the team by participating in training and mentoring

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Leadership Versus Management

- **Leadership:** Influence, inspiration, change, vision — about people and direction
  - Example: Motivating your team during a stressful code blue debrief
- **Management:** Planning, organizing, structure, control — about processes and systems
  - Example: Creating the monthly staff schedule and ensuring adequate coverage

> ***Leaders "do the right thing," focusing on vision and challenging the status quo, while managers "do things right," concentrating on systems and structure. Ideally, effective individuals can function as both.***

Why This Matters Now:

- NCLEX Focus: **Leadership and Management** is a core category on the NCLEX
- Clinical Preceptorship: Nurses will soon be expected to "take charge" of a patient group, delegating tasks and making independent judgments

Leadership Styles and Theories

Trait Theories — Explore specific qualities leaders possess. Effective leaders are often described as having integrity, courage, a positive attitude, initiative, energy, optimism, perseverance, balance, the ability to handle stress, and self-awareness.

Motivating Theories — Link leadership to inspiring and engaging followers.

Emotional Intelligence — Recognized as a key competency for leaders, involving self-awareness, self-regulation, motivation, empathy, and social skills.

Situational Theories — Emphasize that leadership effectiveness depends on adapting one's style to the specific situation and follower readiness.

Transformational Leadership — Involves inspiring and motivating followers to achieve extraordinary outcomes and develop their own leadership potential. These leaders challenge the status quo, inspire a shared vision, enable others to act, are role models, and encourage the heart.

Moral Leadership — Underscores the importance of ethical conduct and integrity in leadership.

The "Great Man" Leadership Theory — Posits that leaders are born with specific traits. However, contemporary understanding recognizes that leadership can be learned and developed.

Nursing Management Functions

Henri Fayol's Classic Management Tasks (1916):

- Planning: Defining goals and how to achieve them
- Organizing: Establishing structures, allocating resources, and assigning tasks
- Commanding (Directing): Guiding and motivating employees
- Coordinating: Harmonizing activities among different parts of the organization
- Controlling: Monitoring performance, evaluating outcomes, and taking corrective action

Evolution of Management Theories:

- **Scientific Management (Frederick Taylor):** Focused on efficiency, standardization, and incentives to optimize worker output
- **Human Relations-Based Management (Mayo, McGregor):** Emphasized human needs, social factors, and motivation. McGregor's **Theory X** (workers dislike work, need control) and **Theory Y** (workers can achieve personal goals by aligning with organizational goals) illustrate contrasting views on motivation
- **Servant Leadership (Greenleaf):** Prioritizes serving others and fostering their growth
- **Complexity Science:** A more recent view emphasizing self-organization, emergent relationships, and recognizing uncertainty in complex systems like healthcare

Roles of Nurse Managers

- **Team Builder:** Fostering strong interdisciplinary teams for effective healthcare delivery
- **Decision Maker:** Making decisions at various levels, from patient care to resource allocation
- **Communicator:** Ensuring clear and effective information flow within the organization
- **Negotiator:** Mediating conflicts and gaining support for plans
- **Mentor:** Providing guidance and support for professional growth to new nurses

Positive Practice Environment (PPE)

A **Positive Practice Environment** is a setting that supports nurses' professional, emotional, and physical well-being, enhancing patient care outcomes, teamwork, and job satisfaction.

Foundations for Nurse Well-Being and Excellence

Safe and Healthy Work Conditions:

- Adequate staffing levels
- Protection from violence/hazards
- Safe patient-nurse ratios
- Ergonomic, clean workspaces

Supportive Leadership and Management:

- Recognition and reward programs
- Fair and transparent decision-making
- Open, two-way communication

Professional Development Opportunities:

- Continuing education and training
- Access to mentorship programs
- Career progression pathways

Autonomy and Empowerment:

- Involvement in decision-making
- Freedom to act on best practices
- Respect for clinical judgment

Fair Compensation and Benefits:

- Overtime pay and leave policies
- Competitive salaries
- Wellness programs

Effective Teamwork and Respect:

- Interdisciplinary collaboration
- Respect for all team members
- Zero tolerance for bullying

Ethical and Values-Based Practice:

- Upholding dignity and justice
- Safe whistleblowing and reporting
- Patient-centered care

Characteristics of a Positive Practice Environment

- **Respectful:** Everyone's contributions are valued and acknowledged
- **Empowering:** Nurses are given opportunities to lead, innovate, and make decisions
- **Supportive:** Physical and emotional well-being are prioritized
- **Transparent:** Decision-making processes are clear and just
- **Inclusive:** Diversity is embraced; no discrimination or marginalization
- **Collaborative:** Open communication, shared goals, team spirit
- **Growth-Oriented:** Learning is encouraged and rewarded
- **Flexible:** Accommodates nurses' needs while ensuring patient care quality

Benefits of a Positive Practice Environment

- Lower turnover and absenteeism
- Higher job satisfaction and morale
- Better patient outcomes

- Enhanced teamwork and trust
- Increased efficiency and productivity

Continuing Professional Development (CPD)

Continuing Professional Development (CPD) refers to the ongoing, systematic, and self-directed learning process that nurses undertake to maintain and enhance their knowledge, skills, competence, and professional performance. CPD is not only a regulatory requirement but a professional and ethical responsibility.

Lifelong Learning in Nursing

Lifelong learning is the continuous, voluntary, and self-motivated pursuit of knowledge for personal or professional development throughout a nurse's career.

Importance:

- Keeps nurses updated with evidence-based practices and technology
- Enhances confidence, job satisfaction, and adaptability
- Builds clinical competence and improves decision-making
- Strengthens patient safety and quality of care

Methods of Lifelong Learning:

- Attending seminars/workshops
- Graduate degrees/certifications
- Webinars and online courses
- Mentoring and being mentored
- Reading nursing journals
- Clinical simulations

Philippine Context: RA 10912

Under **RA 10912**, also known as the CPD Act of 2016, all registered professionals are required to earn CPD units as a prerequisite for license renewal. Nurses must:

- Engage in learning activities accredited by the CPD Council for Nursing (PRC)
- Earn a specified number of CPD units per renewal period

Career Path Development Map

A career development map outlines a nurse's potential journey from novice to expert, including educational milestones, job roles, and leadership pathways.

Purposes:

- Helps in setting realistic goals and achieving them step-by-step
- Clarifies roles, competencies, and expectations at each level
- Promotes career planning and motivation
- Encourages alignment with institutional goals and personal aspirations

Tools for Career Planning in Nursing

Individual Development Plan (IDP): A structured, written document that outlines a nurse's short-term and long-term career goals, along with the specific actions, resources, and timelines needed to achieve them.

- Self-assessment of strengths and areas for growth
- Action steps with timelines and resource identification
- Specific, measurable goals aligned with role requirements
- Regular review and updates with supervisors

Competency Frameworks: A structured system that defines the specific knowledge, skills, abilities, and behaviors required for different nursing roles and levels of practice.

- Objective criteria for performance evaluation
- Clear benchmarks from novice to expert practice
- Identifies gaps for targeted development
- Aligns individual growth with organizational standards

Career Coaching or Mentorship Programs: Structured relationships where experienced professionals provide guidance, feedback, support, and networking opportunities to help nurses navigate their career paths.

- Goal-setting support and accountability
- Personalized guidance from experienced professionals
- Exposure to new opportunities and networks
- Emotional support and confidence building

Quality Assurance (QA) in Nursing

Quality Assurance in Nursing is a system of activities and processes designed to ensure that nursing care meets established standards of practice and improves patient outcomes.

Objectives of QA

- Ensure safe, effective, and efficient nursing care
- Promote accountability and continuous improvement
- Identify and correct deficiencies in care delivery
- Build public trust in the healthcare system

Components of a QA Program

- **Standards Setting:** Define measurable nursing care standards (e.g., patient-to-nurse ratios, infection control). Based on laws, guidelines, or evidence-based practices.
- **Performance Monitoring:** Evaluate nursing processes (e.g., documentation, medication administration). Use audits, peer reviews, and patient satisfaction surveys.
- **Feedback Mechanisms:** Identify gaps in practice. Encourage open communication between staff, patients, and management.
- **Corrective Action:** Address issues through training, policy changes, or staff reassignment.
- **Continuous Quality Improvement (CQI):** Uses tools like the **PDCA Cycle** (Plan-Do-Check-Act) to drive ongoing improvements.

Tools Used in QA

- Nursing Audit
- Key Performance Indicators (KPIs)
- Clinical Outcomes
- Root Cause Analysis (RCA)
- Patient Satisfaction Surveys
- Incident Reporting System

Role of the Nurse in QA

- Adheres to practice standards and policies
- Participates in quality audits and accreditation processes
- Identifies areas for improvement and implements change
- Engages in continuing education programs to improve competence

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Filipino Culture, Values, and Practices Concerning Health Care

Filipino Cultural Values Affecting Healthcare

Hiya (Shame)

- Patients may avoid disclosing health concerns due to embarrassment, especially concerning reproductive or mental health
- **What to Do:** Nurses must practice sensitivity and nonjudgmental listening

Pakikisama (Smooth Interpersonal Relationship)

- Patients may agree with health advice to maintain harmony but not follow through
- **What to Do:** Nurses should verify understanding through return demonstrations or clarification questions

Utang na Loob (Debt of Gratitude)

- Some may rely on traditional healers due to familial obligation
- **What to Do:** Nurses should respect this while offering complementary medical care

Family-Centered Decision Making

- Filipinos often consult the whole family before making health decisions
- **What to Do:** Nurses must consider the role of family in planning care

Faith and Spirituality

- Prayer and religious rituals are important coping mechanisms
- **What to Do:** Nurses should support spiritual needs (e.g., allow rosaries, prayer items)

Ethico-Moral and Legal Considerations in the Practice of Nursing

The Philippine Nursing Law of 2012 (RA 9173)

RA 9173, or the Philippine Nursing Act of 2002 (amended 2012), is a national law that:

- Regulates nursing practice in the Philippines
- Defines the qualifications, scope, licensure, education, rights, and responsibilities of nurses
- Enacted to protect the public and uphold professional nursing standards

Article VI, Section 28: Scope of Nursing Practice

This section clearly outlines what registered nurses are legally authorized to perform. It defines safe, competent, and autonomous practice and recognizes the professional role of nurses in various healthcare settings.

Detailed Scope of Practice: What Can Nurses Do?

1. Provide independent nursing care:

- Nurses can assess clients, make nursing diagnoses, and implement nursing care plans without direct orders, based on the nursing process
- This includes care to sick, injured, or disabled individuals across all settings

2. Promote health and prevent illness:

- Health teaching
- Immunization campaigns
- Nutritional counseling
- Family planning support
- Wellness programs

3. Perform nursing procedures and techniques:

- IV therapy (with appropriate certification)
- Wound care
- Medication administration
- Catheter insertion
- NGT (insertion and feeding)
- Oxygen therapy
- Vital signs monitoring and interpretation

4. Collaborate with physicians and other healthcare providers:

- Carry out doctor's orders and provide feedback on patient progress
- Act as a liaison between the patient and the medical team
- Participate in interdisciplinary rounds and case conferences

5. Supervise and train subordinate personnel:

- Responsible for guiding nursing aides, nursing attendants, and student nurses
- Delegation must be appropriate to their level of training and competence

6. Participate in health research and policy-making:

- Contribute to research-based practice
- Participate in data collection, analysis, and policy development
- Advocate for community health reforms

7. Engage in nursing education and training:

- Qualified nurses may serve as clinical instructors, preceptors, or trainers to help grow the profession

Legal Boundaries: What Nurses CANNOT Do

1. Diagnose medical conditions or prescribe treatments/medications (unless authorized under special laws like the Universal Health Care Act for advanced practice)
2. Perform surgeries or medical procedures outside their scope
3. Issue medical certificates or sign prescriptions
4. Act beyond training or without physician supervision, when required by law

Implications

- Nurses must always know and stay within their legal scope
- Performing tasks beyond one's scope or without competency can lead to:
  - Administrative cases (e.g., license suspension)
  - Civil liability (e.g., patient harm)
  - Criminal charges (e.g., negligence or malpractice)

Case Scenarios

- **Is it legal to administer CPR without consent during an emergency?** YES — implied consent applies in emergency situations where the patient cannot give direct permission
- **A student nurse administers IV meds without supervision. Is this legal?** NO — student nurses must practice under supervision

Reflection Questions

- How does Section 28 empower nurses to be autonomous professionals?
- Can a nurse be held legally liable for tasks delegated to others?
- How can nurses ensure they stay within their scope of practice in the clinical area?

National Nursing Core Competency Standards (NNCCSS)

The **NNCCSS** emphasizes competencies such as holistic, evidence-based, and compassionate care; legal and ethical practice; and research utilization and continuous learning.

Three Domains of NNCCSS

Domain 1: Patient Care Competencies

- Focuses on the nurse's ability to deliver safe, quality, and holistic care to clients across the lifespan and various settings

Key Competencies:

1. Applies the nursing process in providing safe, humanistic, and evidence-based care
2. Promotes health and prevents illness in individuals, families, and communities
3. Demonstrates clinical judgment and decision-making based on assessment and client needs
4. Provides culturally sensitive, gender-responsive, and ethical care
5. Performs nursing procedures according to professional standards
6. Ensures continuity of care through collaboration and appropriate referrals

Domain 2: Empowering (Professional and Legal) Competencies

- Focuses on professional and legal accountability

Key Competencies:

1. Practices in accordance with ethical, legal, and professional standards (RA 9173 and Code of Ethics)
2. Advocates for client rights, including access to care and informed decision-making
3. Engages in lifelong learning and personal development
4. Demonstrates professional accountability and commitment to the profession
5. Maintains accurate documentation and record keeping
6. Reports and addresses unsafe, unethical, or illegal practices in healthcare

Domain 3: Enabling (Management and Leadership) Competencies

- Covers the ability to coordinate, lead, and manage nursing care effectively in collaboration with the health team

Key Competencies:

1. Manages resources and environment to provide safe and effective care
2. Collaborates with interprofessional teams for quality health outcomes
3. Leads and supervises nursing care teams effectively
4. Participates in quality improvement programs in the workplace

5. Utilizes technology and informatics to enhance nursing practice
6. Engages in disaster preparedness and emergency response

Uses of NNCCSS

- Curriculum development for BSN programs
- Clinical evaluation tool for student nurses and RNs
- Licensure exam content framework (PNLE)
- Benchmarking for continuing professional development (CPD)
- Quality assurance in nursing education and practice

Patient's Bill of Rights

Highlights:

- Right to respectful and safe care regardless of socioeconomic status
- Right to informed consent and refusal of treatment
- Right to confidentiality, privacy, and access to information
- Right to make decisions about care plans and receive second opinions

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Informed Consent

Definition: A legal and ethical process ensuring the patient understands the nature, purpose, risks, and benefits of a procedure before agreeing.

Key Points:

- Nurses serve as witnesses to the consent and ensure the patient is competent, voluntary, and informed
- For minors or unconscious patients, legal guardians provide consent
- **Informed consent is not a one-time form — it is a communication process**

Code of Ethics for Nurses (PNA)

The **Philippine Nurses Association (PNA)** outlines moral obligations and professional conduct.

Responsibilities to:

- **Patients:** Respect, compassion, and confidentiality
- **Self:** Personal and professional growth
- **Co-workers:** Collaboration and respect
- **Society:** Promoting health and human rights

Philippine Professional Nursing Roadmap

- A strategic plan for strengthening the nursing profession from **2021-2030**
- **Goals include:**
  - Elevating the image and value of nursing
  - Enhancing nurse education and competency
  - Retaining nurses in the country through supportive policies
  - Highlighting the importance of lifelong learning, leadership development, and global competitiveness

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Evidence-Based Practice (EBP)

Overview and Purpose

Evidence-Based Practice (EBP) is the conscientious use of current best evidence in making decisions about patient care. It integrates:

- Best research evidence
- Clinical expertise
- Patient preferences and values

Purpose of EBP in Nursing:

- Improve quality of care

- Enhance patient outcomes
- Promote cost-effective interventions
- Foster professional accountability and lifelong learning

The Three Components of EBP

Best Research Evidence

Sources of Best Evidence:

- Systematic reviews and meta-analyses
- Randomized controlled trials (RCTs)
- Cohort or case-control studies
- Clinical guidelines based on research
- Expert consensus (when high-level studies are unavailable)

Characteristics of "Best" Evidence:

- **Reliable:** Comes from well-designed and peer-reviewed studies
- **Current:** Reflects the most up-to-date findings
- **Relevant:** Applies directly to the clinical question
- **Valid:** Free from bias, with sound methodology

Clinical Expertise

Definition: Clinical expertise is the knowledge, skills, and past experience that a nurse or healthcare provider brings to patient care.

Sources of Clinical Expertise:

- Academic preparation
- Hands-on clinical experience
- Ongoing education and training
- Reflective practice and critical thinking

It includes the ability to:

- Assess patient conditions accurately
- Recognize early warning signs
- Apply individualized care strategies
- Make real-time decisions in dynamic situations
- Interpret evidence in context

Why It's Important: Even with strong evidence, not all research is applicable to every patient or situation. Nurses must adapt interventions to the clinical context using sound judgment.

Example: While evidence shows that IV antibiotics can be administered in a certain time frame, a nurse with years of experience recognizes a specific patient is exhibiting signs of an allergic reaction and delays administration to reassess and notify the physician.

Patient Preferences and Values

Definition: This refers to the individual experiences, goals, beliefs, cultural traditions, and expressed needs of the patient that must be respected and considered when making care decisions. EBP must be patient-centered.

Why It's Essential: Even the best research and most experienced nurse cannot ensure quality care without aligning decisions with the patient's values and informed choices.

Key Aspects:

- Cultural and religious beliefs
- Past experiences with healthcare
- Financial or family concerns
- Personal goals (e.g., quality of life vs. longevity)
- Health literacy and understanding of options

Nurse's Role:

- Engage in shared decision-making
- Provide clear, unbiased information about options
- Support autonomy and informed consent

Example: Evidence supports chemotherapy for a specific cancer type, but the patient values natural healing methods and refuses aggressive treatment. The nurse respects this decision and helps coordinate supportive palliative care instead.

The EBP Triad

> ***EBP is not just about "doing what the research says" but about balancing scientific evidence, nursing judgment, and the patient's voice to deliver safe, respectful, and effective care.***

Research-Related Roles and Responsibilities of Nurses

As Consumers of Research

Role: All nurses must read, critique, and apply research findings in practice.

Responsibilities:

- Stay updated with current literature (e.g., reading peer-reviewed journals)
- Identify practice issues that need improvement
- Use clinical guidelines and protocols based on evidence
- Participate in journal clubs or EBP committees

Example: A staff nurse reads a recent study about turning immobile patients every 2 hours vs. every 3 hours and applies the findings to reduce pressure ulcers.

As Evidence Implementers

Role: Nurses translate research into bedside practice.

Responsibilities:

- Collaborate with interdisciplinary teams to apply EBP interventions
- Help revise care protocols based on evidence
- Educate peers on newly implemented practices
- Monitor patient outcomes to assess effectiveness

Example: A nurse helps implement a hand hygiene protocol based on WHO guidelines and tracks infection rates.

As Clinical Problem Solvers (Using the EBP Process)

Role: Evidence-Based Practice transforms research into actionable patient care. The 5-step cyclical process ensures rigor, relevance, and continuous improvement.

The 5-Step EBP Process

Step 1: ASK — Formulate a Clinical Question (PICOT Format)

Purpose: Convert clinical uncertainty into a focused, searchable question.

PICOT Components:

- **P**opulation (e.g., older adults with diabetes)
- **I**ntervention (e.g., telehealth monitoring)
- **C**omparison (e.g., in-person visits)
- **O**utcome (e.g., HbA1c reduction)
- **T**ime (e.g., over 6 months)

Example: "In older adults with diabetes (P), does telehealth monitoring (I) compared to in-person visits (C) reduce HbA1c levels (O) within 6 months (T)?"

Key Tools: PICOT templates, clinical question generators.

Step 2: ACQUIRE — Search for the Best Evidence

Purpose: Locate high-quality, relevant research.

Strategies:

- **Databases:** PubMed, CINAHL, Cochrane Library
- **Keywords:** Combine PICOT terms (e.g., "telehealth" + "diabetes" + "HbA1c")
- **Filters:** Limit to systematic reviews, RCTs, clinical guidelines (last 5 years)

Example: Search: ("telemedicine" OR "remote monitoring") AND ("diabetes mellitus") AND ("HbA1c" OR "glycated hemoglobin")

Avoid: Predatory journals; prioritize peer-reviewed sources.

Step 3: APPRAISE — Critically Evaluate the Evidence

Purpose: Assess validity, reliability, and applicability.

Critical Appraisal Checklist:

- **Validity:** Was the study design rigorous? (e.g., blinding, randomization)
- **Impact:** Are results statistically significant? (check p-values, confidence intervals)
- **Applicability:** Can findings be applied to your patient population?

Example: An RCT shows telehealth reduces HbA1c by 1.2% ($p<0.01$), but your patients lack tech literacy → Applicability limited.

Step 4: APPLY — Integrate Evidence into Practice

Purpose: Combine research with clinical expertise and patient values.

Steps:

1. **Synthesize:** Merge findings with patient preferences (e.g., patient fears technology → simplify tools)
2. **Customize:** Adapt protocols (e.g., teach family members to assist with telehealth)
3. **Implement:** Pilot changes; train staff

Barriers and Solutions:

- **Time Efficiency:** Use rapid appraisal tools (e.g., JBI Critical Appraisal Checklist)
- **Interprofessional Collaboration:** Involve librarians (searching), statisticians (data analysis)
- **Technology:** Leverage EHR alerts for evidence updates
- **Ethics:** Prioritize patient autonomy (e.g., opt-out options)

Step 5: ASSESS — Evaluate Outcomes

Purpose: Measure impact and refine practice.

Metrics:

- **Clinical Outcomes:** HbA1c levels, hospital readmissions
- **Process Indicators:** Adherence rates, patient satisfaction (e.g., surveys)
- **Balanced Measures:** Cost, staff efficiency

Example: After 6 months: Avg. HbA1c decreased 0.8% (goal: 1.2%) → Adjust intervention; 92% patient satisfaction → Sustain patient education

Cycle Restart: Findings → New PICOT questions (e.g., "How to improve tech literacy?")

Ethical Responsibilities in Nursing Research and EBP

All nurses involved in research or EBP must adhere to ethical standards:

- **Respect autonomy** and obtain informed consent
- **Beneficence** — maximize benefits and minimize harm
- **Justice** — ensure fair and equitable selection of participants
- **Confidentiality** — protect personal data

Nursing Interventions to Promote Healthy Psychosocial Response

Self-Concept

Definition

Self-concept is how individuals perceive themselves physically, emotionally, and mentally. It is the composite of beliefs and knowledge one holds about oneself. It is dynamic and evolves.

Components of Self-Concept

Identity — Refers to the internal sense of individuality, wholeness, and consistency over time. Includes personal characteristics such as name, gender, ethnicity, values, beliefs, and personality. Disruption can occur during major life changes (e.g., adolescence, retirement, illness). Nursing relevance: Identity crises may emerge in patients undergoing transitions or facing chronic conditions (e.g., amputation, mastectomy).

Self-Esteem — One's overall sense of self-worth or personal value. High self-esteem promotes resilience, while low self-esteem can increase vulnerability to stress and depression. Influenced by feedback from others, personal accomplishments, failures, or social comparisons.

Body Image — How one views and feels about their physical appearance and bodily functions. Influenced by culture, media, peer opinion, and experiences (e.g., illness, aging). Disturbances can lead to depression, anxiety, eating disorders. Examples: Burn victims, individuals post-surgery, or undergoing chemotherapy may have altered body image.

Role Performance — How individuals perceive their ability to carry out expected roles (e.g., parent, nurse, student). Changes in role performance may occur due to illness, disability, job loss, or life transitions. Role conflict or role strain can significantly affect self-concept.

Social Feedback — Refers to the verbal and non-verbal responses (e.g., praise, criticism, body language) individuals receive from others in social interactions. It shapes self-perception by providing external validation or disapproval.

- Positive feedback and self-enhancement: Encouragement and approval boost self-esteem, reinforcing a positive self-concept
- Negative feedback and self-doubt: Criticism or rejection can damage self-concept, leading to insecurity or low self-esteem
- Internalization and self-concept formation: Over time, repeated social feedback is internalized, shaping one's beliefs about their abilities, personality, and worth. The opinions of significant others (family, peers) have the strongest influence.

Developmental Influences on Self-Concept (Erikson's 8 Stages)

Trust vs. Mistrust (Infancy, 0-1.5 years)

- Conflict: Can I depend on my caregivers?
- Nursing Insight: Bonding with parents shapes future relationships. Trust and consistent caregiving promote a foundation of positive self-image.
- Nursing Role: Promote secure attachment (e.g., skin-to-skin contact for newborns).

Autonomy vs. Shame/Doubt (Toddler, 1.5-3 years)

- Conflict: Can I control my own actions?
- Nursing Insight: Toilet training and choices build self-confidence.
- Nursing Role: Encourage safe independence (e.g., letting toddlers choose a bandage color).

Initiative vs. Guilt (Preschool, 3-5 years)

- Conflict: Can I explore and lead?
- Nursing Insight: Play fosters creativity. Beginning of self-identity, imaginative play, and gender role formation.
- Nursing Role: Use medical play (e.g., toy stethoscopes) to reduce procedure fears. Reinforce positive behaviors.

Industry vs. Inferiority (School Age, 5-12 years)

- Conflict: Am I competent compared to peers?
- Nursing Insight: School/sports achievements matter. Feedback from peers, teachers, and performance influence self-worth.
- Nursing Role: Praise effort (e.g., "You're so brave during shots!"). Recognize achievements, manage bullying concerns.

Identity vs. Role Confusion (Adolescence, 12-18 years)

- Conflict: Who am I, and where do I fit?
- Nursing Insight: Peer approval and body image are critical. Exploration of values, sexuality.
- Nursing Role: Address self-esteem (e.g., discussing acne or chronic illness impacts).

Intimacy vs. Isolation (Young Adult, 18-40 years)

- Conflict: Can I form loving relationships?
- Nursing Insight: Romantic bonds, intimacy, and career define identity. Role establishment affects self-concept.
- Nursing Role: Support pregnancy or illness adjustments (e.g., fertility treatments). Support transition to adult roles and relationships.

Generativity vs. Stagnation (Middle Age, 40-65 years)

- Conflict: Am I contributing to the world?
- Nursing Insight: Parenting and mentoring bring purpose. Re-evaluation of life goals and career.
- Nursing Role: Encourage patient education (e.g., diabetes management for families). Address role strain or burnout.

Ego Integrity vs. Despair (Elderly, 65+ years)

- Conflict: Did my life have meaning?
- Nursing Insight: Life review reduces end-of-life anxiety. Physical decline, retirement, and loss of loved ones may affect self-esteem and identity.
- Nursing Role: Facilitate legacy-building (e.g., recording life stories).

Factors Affecting Self-Concept

- **Illness and Injury:** Acute or chronic conditions can alter body image, independence, and role performance. Example: A stroke patient may feel loss of self-worth due to dependency.
- **Trauma:** Physical or emotional trauma (e.g., abuse, accidents) can significantly damage self-esteem and body image. PTSD and other psychological effects often accompany trauma.
- **Cultural Background:** Cultural norms shape body image ideals, gender roles, and personal values. Cultural dissonance can occur when a person's beliefs conflict with dominant societal values.
- **Family Dynamics:** Supportive families contribute positively to self-concept. Dysfunctional families or critical parenting may impair self-worth and identity formation.

- **Developmental Stage:** The ability to form a stable self-concept depends on age-related tasks. Failure to resolve key developmental tasks can result in confusion or low self-esteem.

Nursing Assessment of Self-Concept

Verbal Cues: Listen for expressions of hopelessness, worthlessness, or confusion about roles. Statements like "I'm useless now" or "I don't recognize myself anymore" may indicate distress.

Behavioral and Role Changes: Sudden changes in participation in family roles, work, or hobbies. Noncompliance with treatment or refusal of care may reflect self-worth issues.

Self-Report Tools:

- **Rosenberg Self-Esteem Scale:** A 10-item scale designed to measure self-esteem. Originally designed for high school students but has been used with a variety of groups including adults.
- **Body Image Assessment Tools:** Psychological instruments designed to measure individuals' perceptions, attitudes, and feelings about their physical appearance. Types include self-report questionnaires, figure rating scales, implicit measures, and clinical interviews.
- **Beck Depression Inventory (BDI):** A widely used self-report questionnaire that assesses the severity of depression, including symptoms related to mood, self-esteem, and negative self-perception. 21 items rated on a 0-3 scale. Domains assessed include cognitive symptoms (self-blame, worthlessness), affective symptoms (guilt, sadness), and somatic symptoms (fatigue, appetite changes).

Holistic Data Collection: Include spiritual beliefs, coping mechanisms, support systems. Cultural sensitivity in assessing personal identity and body image.

Nursing Interventions Relating to Self-Concept

- Active listening and therapeutic communication
- Encourage self-expression and decision-making
- Promote body image acceptance after surgeries or disabilities
- Support role transition (e.g., adolescence, retirement, chronic illness)

Stress and Adaptation

Definition

Stress is a physical, emotional, or psychological response to demands. **Adaptation** is how the body responds to maintain balance.

Types of Stress

Eustress (Positive Stress):

- Beneficial stress that can motivate, focus energy, and improve performance
- Examples: Preparing for an exam or a job interview, competing in sports, getting married or having a baby
- Physiological effect: Triggers the body to be alert but returns to baseline after the event

Distress (Negative Stress):

- Harmful stress that overwhelms a person's ability to cope, leading to physical and emotional problems
- Examples: Death of a loved one, financial crisis, chronic illness
- Consequences: Anxiety, fatigue, sleep disturbance, weakened immune system

Acute Stress:

- Brief, short-term stress in response to a perceived threat or demand
- Signs: Increased heart rate, muscle tension, headache
- Effects: Sudden argument, job insecurity

Chronic Stress:

- Prolonged, long-term stress resulting from persistent stressors
- Examples: Long-term illness, relationship problems, unemployment
- Impacts: Can lead to hypertension, depression, gastrointestinal issues, or burnout

General Adaptation Syndrome (Selye's Model)

Alarm Stage:

- "Fight or flight" response triggered
- Hormones involved: Adrenaline, Cortisol
- Symptoms: Increased heart rate, elevated BP, alertness, muscle tension
- Nursing point: This stage prepares the body to respond to danger, but prolonged activation can be harmful

Resistance Stage:

- The body attempts to adapt to the stressor
- Hormonal levels stabilize, and vital signs return to normal

- Symptoms: Coping mechanisms are in use; outward signs of stress may be less visible
- Nursing point: If successful, the body recovers; if not, it moves to exhaustion

Exhaustion Stage:

- Body resources are depleted
- Inability to maintain normal function
- Symptoms: Fatigue, burnout, depression, illness
- Nursing point: Prolonged stress here may lead to serious physical and psychological illness

Coping Mechanisms

Adaptive Coping:

- Healthy and constructive ways to manage stress
- Promotes growth, balance, and resolution of stress
- Examples: Talking to a trusted friend, regular exercise or meditation, time management, setting realistic goals, seeking professional help

Maladaptive Coping:

- Unhealthy or destructive responses to stress
- Temporarily relieves stress but worsens the situation long-term
- Examples: Substance abuse (alcohol, drugs), overeating or starvation, aggression, withdrawal, denial, self-harm

Nursing Assessment of Stress

Identify Stressors: Ask open-ended questions: "What is currently bothering you most?" Consider internal (self-doubt, illness) and external (family conflict, work demands) stressors.

Coping Styles:

- Emotion-focused coping: Managing emotional response
- Problem-focused coping: Addressing the problem directly (e.g., making a plan)
- Determine if the patient's coping is adaptive or maladaptive

Physical Signs: Headache, fatigue, GI issues, sleep disturbances, muscle tension. Increased BP, HR, shallow breathing.

Emotional and Behavioral Signs: Irritability, anxiety, mood swings, isolation, difficulty concentrating. Changes in appetite, substance use, poor hygiene.

Assessment Tools: Perceived Stress Scale (PSS), Coping Strategy Inventory (CSI), observation, and therapeutic communication.

Nursing Interventions Relating to Stress and Adaptation

Therapeutic Communication:

- Encourage verbal expression of feelings
- Use active listening and empathy
- Avoid judgment; validate emotions

Stress Management Techniques:

- Teach relaxation techniques: deep breathing, progressive muscle relaxation
- Introduce mindfulness or guided imagery
- Encourage regular physical activity and healthy diet

Time and Priority Management:

- Help patients break down overwhelming tasks into manageable steps
- Promote scheduling and goal setting

Health Teaching:

- Educate patients about the physiological effects of stress
- Guide patients in recognizing early warning signs of stress and burnout

Support Systems:

- Promote involvement of family and friends
- Refer to support groups, pastoral care, or counselors when needed

Environmental Modifications:

- Create a calm, safe space (e.g., reduce noise, control stimulation)
- Respect patient routines and preferences

Loss, Grief, and Dying

Definition

Grief is an emotional reaction to loss; **dying** is a process involving physical and psychosocial preparation for death.

Types of Loss

Actual Loss: Recognized by the individual and others. Tangible and observable. Examples: Death of a loved one, loss of a limb, loss of a job or home, divorce.

Perceived Loss: Internal and uniquely felt by the individual; not always recognized by others. Often related to psychological or emotional experiences. Examples: Loss of self-esteem, loss of youth or independence, feeling rejected or unloved.

Anticipatory Loss: Experienced before the actual loss occurs. Can affect both the patient and their family/caregivers. Examples: A family grieving before a terminally ill loved one dies, a patient diagnosed with a progressive, incurable disease.

Types of Grief

Normal (Uncomplicated) Grief:

- Natural and expected response to loss
- Includes emotional, physical, cognitive, and behavioral responses
- Gradually resolves with time, although the loss is never forgotten

Anticipatory Grief:

- Occurs before the actual loss, especially in terminal illness
- May help with emotional preparation and reduce shock when loss occurs
- May coexist with hope for recovery

Complicated Grief:

- Prolonged, intense, or disabling grief
- Interferes with daily functioning
- Subtypes: chronic, delayed, exaggerated, masked
- May need referral for psychiatric or psychological support

Disenfranchised Grief:

- Grief that is not acknowledged or supported by society
- Examples: Loss of an ex-spouse or secret partner, miscarriage or abortion, death from suicide or overdose

Kubler-Ross's Five Stages of Grief (DABDA)

Denial: "This isn't happening." Protective mechanism to buffer initial shock. Nursing Tip: Support gently without forcing reality.

Anger: "Why me?" Directed toward self, healthcare team, or others. Nursing Tip: Don't take it personally; allow expression without judgment.

Bargaining: "If only I can live to see my daughter graduate..." Negotiating with a higher power in hopes of postponing death. Nursing Tip: Listen empathetically and support spiritual needs.

Depression: Quiet sadness, withdrawal, sleep disturbance, crying. May be preparatory (coming to terms) or reactive (to losses already experienced). Nursing Tip: Be present; avoid trying to "cheer up" too quickly.

Acceptance: "I am at peace with this." Acknowledgment of the reality of death and readiness to face it. Nursing Tip: Offer comfort, maintain dignity, ensure holistic care.

> ***Note: These stages are not linear and may not apply to every individual.***

Nursing Interventions at the End of Life

Emotional Support:

- Listening to fears, regrets, or spiritual concerns
- Being present and emotionally available
- Offering reassurance and validation

Pain and Symptom Control:

- Administering medications for pain, dyspnea, or anxiety
- Monitoring for non-verbal cues of distress
- Using palliative care protocols to improve comfort

Presence:

- Sitting silently with the patient
- Offering physical touch (holding a hand) if appropriate
- Providing a calm and respectful environment
- Role of the nurse: Advocate for a "good death" — free from pain, with dignity, and surrounded by love/support if possible

Spiritual and Cultural Considerations:

- Respect individual beliefs about death, afterlife, rituals, and forgiveness
- Be aware of cultural norms around touching the body, praying, or the presence of certain people
- Avoid assumptions — always ask the patient/family what they need
- Examples: Some cultures require a family elder to lead prayers; in others, only men may be allowed to touch the deceased; offer to call a chaplain, spiritual leader, imam, priest, or rabbi if requested

Respecting Cultural and Religious Practices

- Ask: "Are there any traditions or rituals you would like us to honor?"
- Support dietary needs, prayer times, or modesty requirements
- Ensure spiritual leaders are contacted if desired

Use of Therapeutic Presence and Silence

- Just being present can be more powerful than words
- Silence allows space for the patient or family to reflect, cry, or speak

Facilitating Goodbyes and Family Rituals

- Encourage open communication, forgiveness, or closure
- Allow religious ceremonies or bedside prayers
- Provide a quiet, private space for families

Supporting the Family Through the Grieving Process

- Offer grief education and reassurance that emotions are normal
- Refer to bereavement support groups or counselors
- Provide follow-up calls or sympathy notes if part of policy

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Sensory Functioning

Definition

Sensory functioning refers to the reception and processing of sensory input (sight, hearing, taste, touch, smell, proprioception).

Common Sensory Deficits

Hearing Loss:

- Can be **conductive** (problems with ear canal or eardrum) or **sensorineural** (damage to inner ear or nerve)
- Common in older adults (presbycusis)
- Signs: Difficulty hearing high-pitched sounds, withdrawal from conversations, frequently asking others to repeat themselves
- Nursing Implications: Risk for isolation, depression, falls due to missed alarms or warnings

Vision Impairment:

- Includes cataracts, glaucoma, macular degeneration, and diabetic retinopathy
- Can cause blurry vision, poor night vision, and light sensitivity
- Impact: Difficulty reading, walking safely, or recognizing faces
- Nursing Implications: High risk for falls, medication errors, and decreased independence

Peripheral Neuropathy (Sensory Loss):

- Common in patients with diabetes, chemotherapy, or spinal cord injury
- Involves loss of sensation, tingling, or burning in hands and feet
- Nursing Implications: Increased risk for skin breakdown, burns, or injuries due to lack of pain detection

Sensory Deprivation

Definition: Inadequate sensory input or stimulation.

Causes: Isolation (e.g., in ICU or quarantine), blindness or deafness, bed rest or immobilization.

Signs: Daydreaming, drowsiness, depression, disorientation, hallucinations in severe cases.

At-Risk Patients: ICU patients, prisoners, elderly in long-term care.

Sensory Overload

Definition: Excessive sensory stimulation, making it hard to focus or respond.

Causes: Noisy environments (alarms, lights, conversations), pain, anxiety, or multiple caregivers interacting at once.

Signs: Agitation, confusion, restlessness, anxiety.

At-Risk Patients: ICU patients, patients with dementia or autism.

Assessment Tools

Mini-Cog Test:

- Quick screening for cognitive impairment, often used in older adults
- Developed by Dr. Soo Borson in 2000
- Components: 3-word recall (memory) and clock drawing (executive function)
- Administration Time: Approximately 2-3 minutes

Glasgow Coma Scale (GCS):

- A neurological assessment tool used to evaluate a patient's level of consciousness, particularly after head injuries, strokes, or other brain-related conditions
- Developed in 1974 by Graham Teasdale and Bryan Jennett
- Scores eye opening, verbal response, and motor response
- Total score ranges from 3 (deep coma) to 15 (fully alert)
- Interpretation: 13-15 mild brain injury, 9-12 moderate, ≤8 severe

GCS Components:

- Eye Opening: 4=spontaneous, 3=to voice, 2=to pain, 1=none
- Verbal Response: 5=oriented, 4=confused, 3=inappropriate words, 2=incomprehensible sounds, 1=none
- Motor Response: 6=obeys commands, 5=localizes pain, 4=withdraws from pain, 3=abnormal flexion, 2=abnormal extension, 1=none

Impact of Sensory Deficits on Psychosocial Health

- **Isolation:** Hearing or vision loss may limit social interaction. Patients may avoid group activities or stop engaging with others.
- **Depression:** Loss of independence, frustration, or loneliness can lead to sadness, apathy, or suicidal thoughts. Patients with combined sensory and cognitive impairments are at higher risk.
- **Confusion:** Sensory input errors (e.g., mishearing, misseeing) can lead to misinterpretation of surroundings. This may result in disorientation or paranoia, especially in older adults.

Nursing Interventions for Patients with Sensory Deficits

Orienting Patients to Environment:

- Introduce yourself each time you enter
- Explain procedures clearly and slowly
- Describe the room layout and location of objects for visually impaired patients
- Provide clocks and calendars for orientation

Ensuring a Safe Environment:

- Keep call bell and personal items within easy reach
- Use non-slip rugs, good lighting, and clear walkways
- Label items clearly or use color contrasts for visually impaired patients
- Avoid sudden loud noises or fast movements that may startle

Providing Appropriate Sensory Stimulation:

- Offer soothing music, pleasant aromas, gentle conversation, or hand massage
- Encourage reading, puzzles, conversation, and family interaction
- Rotate sensory activities to prevent boredom or overstimulation

Use of Assistive Devices:

- Encourage use of hearing aids, eyeglasses, walkers, canes
- Ensure devices are clean, functioning, and within reach
- Educate patient and family on proper use and care

Human Sexuality

Definition

Sexuality is a broad concept that includes gender identity, sexual orientation, intimacy, and sexual health. It is a multidimensional aspect of human identity that encompasses biological, psychological, social, cultural, and emotional dimensions.

Components of Sexuality:

- **Sexual Orientation:** Romantic/emotional attraction (e.g., heterosexual, homosexual, bisexual)
- **Gender Identity:** Personal sense of being male, female, non-binary, etc.
- **Biological Sex:** Physical traits (chromosomes, hormones, genitals)
- **Sexual Behavior:** Actions related to sexual expression
- **Intimacy and Relationships:** Emotional and physical connections

Factors Affecting Sexuality

Illness:

- Chronic or terminal illnesses (e.g., cancer, diabetes, cardiovascular disease) can affect libido, arousal, and physical capability
- Conditions like spinal cord injuries, stroke, or arthritis may cause physical limitations in sexual activity
- Illness may also cause emotional distress, body image concerns, or fear of hurting a partner

Medications:

- Many medications can impair sexual desire or function
- Antidepressants, antihypertensives, diuretics, opioids, and chemotherapy are common culprits
- Side effects may include erectile dysfunction, vaginal dryness, decreased libido
- Patients may not disclose issues unless asked sensitively

Aging:

- Physical changes: Men may experience delayed erection or reduced testosterone; women may have vaginal dryness or menopause-related changes
- However, sexual interest may remain intact, and intimacy can still be fulfilling
- Stereotype alert: Older adults are often wrongly assumed to be asexual

Body Image:

- Surgical procedures (e.g., mastectomy, colostomy) or disfigurement can affect self-esteem and sexual confidence
- Patients with visible scars, amputations, or obesity may avoid intimacy due to shame or embarrassment
- Psychological support is crucial for restoring healthy sexual identity

Sexual Development Across the Lifespan

Infancy to Toddlerhood:

- Biological: Genital exploration (self-touch), erections/lubrication (reflexive)
- Psychological: Attachment bonds (foundation for intimacy), curiosity about body differences
- Social: Parental reactions shape early attitudes
- Key Milestone: Recognizing gender labels ("boy/girl")

Preschool to School Age:

- Biological: Delayed sexual hormones (low activity)
- Psychological: Gender identity solidifies; "playing doctor" (natural curiosity about bodies)
- Social: Peers reinforce gender roles; first crushes (non-sexual attachments)
- Key Milestone: Understanding reproduction basics

Adolescence:

- Biological: Puberty — secondary sex characteristics (breasts, facial hair); menarche/spermarche
- Psychological: Sexual orientation awareness (attractions emerge); body image struggles
- Social: Dating exploration; risk-taking (early sexual activity, STI/pregnancy risks)
- Key Milestone: Integrating sexuality into identity (LGBTQ+ self-discovery)

Young Adulthood:

- Biological: Peak fertility/reproductive capacity; sexual response patterns stabilize
- Psychological: Intimacy vs. isolation (Erikson's stage); navigating consent/healthy relationships
- Social: Committed partnerships (marriage/cohabitation); career/family balance
- Key Milestone: Establishing sexual values

Middle Adulthood:

- Biological: Menopause/andropause (hormonal shifts); slower arousal/orgasm; erectile changes
- Psychological: Generativity vs. stagnation; body acceptance/sexual confidence

- Social: "Empty nest" reinvention; divorce/remarriage dynamics
- Key Milestone: Redefining pleasure beyond reproduction

Older Adulthood:

- Biological: Reduced hormone production (vaginal dryness, slower arousal); chronic illnesses impacting sexuality
- Psychological: Ego integrity vs. despair; prioritizing emotional intimacy over performance
- Social: Widowhood/new partnerships; stigma ("Too old for sex")
- Key Milestone: Legacy-sharing (transmitting values about love/relationships)

Cultural and Religious Influences on Sexuality

Culture:

- Defines acceptable expressions of sexuality, gender roles, and sexual orientation
- May shape perceptions about modesty, virginity, contraception, or sexual education
- Example: In some cultures, open discussion about sex is taboo, affecting willingness to disclose concerns

Religion:

- Influences beliefs about marriage, contraception, abortion, LGBTQ+ issues, and premarital sex
- Some patients may experience guilt, shame, or conflict between beliefs and behavior
- Nursing role: Respect beliefs while promoting safe and informed sexual health choices

Nursing Assessment of Sexuality

Establishing Trust:

- Approach with respect, sensitivity, and privacy
- Use inclusive and non-assumptive language (e.g., "partner" instead of "husband/wife")
- Ask about preferred pronouns and how to address the patient properly

Sample Questions:

- "Do you have any concerns about your sexual health?"
- "How has your illness affected your intimate relationships?"
- "Are you currently sexually active?"
- "What questions do you have about contraception or STIs?"

PLISSIT Model

The **PLISSIT model** is a structured framework used by healthcare professionals to address patients' sexual health concerns in a progressive, non-judgmental manner. Developed by Jack Annon in 1976.

P — Permission:

- Normalize discussions about sexuality; create a safe space
- Reduce patient anxiety; signal openness
- Example: "Many people experience changes in sexual health after surgery. It's okay to discuss this with me."

LI — Limited Information:

- Provide factual education related to the patient's concern
- Address myths; clarify biological/psychological factors
- Example: "Diabetes can affect nerve function, which may delay arousal. This is common and manageable."

SS — Specific Suggestions:

- Offer tailored strategies for sexual challenges
- Empower practical problem-solving
- Example: "Try using water-based lubricants if vaginal dryness causes discomfort during sex."

IT — Intensive Therapy:

- Refer to specialists (e.g., sex therapists, urologists)
- Address complex psychological/trauma-related issues
- Example: "I'll connect you with a therapist who specializes in intimacy after cancer."

Nursing Interventions for Sexuality

Provide Privacy and Confidentiality:

- Ensure a private setting for discussion
- Assure patients that their concerns will be kept confidential
- Use curtains/screens and minimize interruptions during physical exams

Educate About Sexual Health, STIs, and Contraception:

- Offer information tailored to age, culture, and literacy level

- Discuss safe sex practices, STI symptoms and treatment, contraceptive options (barrier methods, hormonal, IUDs, etc.)
- Address myths and misconceptions about sex

Address Sexual Concerns in Chronic Illness:

- Discuss physical and emotional effects of illness on sexual health
- Post-MI: fear of triggering another cardiac event during intercourse
- Mastectomy or prostate surgery: changes in body image and function
- Suggest adaptive strategies: alternative positions, use of lubricants, pelvic therapy
- Encourage open communication with partners

Referral to Counseling or Therapy:

- For persistent concerns or psychological distress: refer to a sex therapist, psychologist, or counselor
- Consider multidisciplinary approach for patients with complex needs (oncology, cardiology, psych)

Spirituality

Distinction Between Spirituality and Religion

Spirituality:

- A broad, personal concept of meaning, purpose, and connection
- May or may not involve belief in a deity
- Often includes values, inner peace, hope, love, and a sense of meaning in life
- Can be expressed through art, nature, meditation, relationships, or reflection

Religion:

- A structured, organized system of beliefs, practices, and worship
- Often centered on a higher power
- Typically involves rituals, sacred texts, community gatherings, and moral codes
- Examples: Christianity, Islam, Buddhism, Judaism, Hinduism

> ***Key Point for Nursing Students: All religious people are spiritual, but not all spiritual people are religious. Nurses must assess and support both spiritual and religious needs with equal respect.***

Spiritual Needs of Patients

During illness or crisis, spiritual needs often become more pronounced. Addressing these can enhance coping, comfort, and quality of life.

a. Hope:

- Gives patients the strength to endure suffering or uncertainty
- Even in terminal illness, hope may shift from "cure" to "peace" or "comfort"

b. Forgiveness:

- Some patients feel guilt or regret and seek reconciliation with others or a higher power
- May be essential for achieving emotional and spiritual peace

c. Peace:

- Inner calm and acceptance, even in the face of death or suffering
- Can be nurtured through prayer, meditation, music, or reflection

d. Purpose:

- Patients may reflect on the meaning of their lives or illness
- Providing space for these reflections can reduce anxiety and existential distress

FICA Spiritual Assessment Tool

FICA is a structured framework for assessing patients' spiritual needs in healthcare settings. It helps nurses integrate spirituality into holistic care, aligning with guidelines from the National Consensus Project for Quality Palliative Care and the World Health Organization.

F — Faith, Belief, or Meaning:

- Purpose: Identify sources of meaning (e.g., religion, nature, relationships)
- Nursing Questions: "What beliefs give your life meaning?" "Do you identify as spiritual or religious?"
- Clinical Example: A cancer patient finds purpose in art; nurses incorporate creative therapy into care

I — Importance and Influence:

- Purpose: Assess how spirituality affects health decisions and coping
- Nursing Questions: "How do your beliefs influence your healthcare choices?" "Do your beliefs help you manage stress?"
- Clinical Example: A diabetic patient declines insulin due to faith in healing prayer; nurses negotiate a balanced plan

C — Community:

- Purpose: Explore support systems (e.g., religious groups, family)
- Nursing Questions: "Are you part of a community that supports you?"
- Clinical Example: An isolated elder reconnects with a church group, reducing depression

A — Address in Care:

- Purpose: Develop actionable spiritual care plans
- Nursing Actions: Referrals to chaplains; integrate rituals (e.g., prayer before surgery); document preferences in electronic health records

Nursing Interventions for Spiritual Care

A. Encourage Expressions of Beliefs:

- Invite patients to share their thoughts, feelings, or spiritual concerns
- Use active listening without giving advice or imposing beliefs
- Avoid correcting or debating beliefs

B. Facilitate Spiritual Rituals:

- Support patients' rituals, sacraments, or religious practices
- Prayer, meditation, scripture reading, communion, fasting
- Arrange visits from clergy or spiritual leaders
- Ensure rituals are conducted respectfully and without disruption

C. Collaborate with Chaplains or Spiritual Care Providers:

- Chaplains are trained to support patients of all faiths or no faith
- Refer when patients express spiritual distress, existential questions (e.g., "Why me?"), or desire for reconciliation, forgiveness, or religious rites

D. Provide Presence and Support:

- Sometimes, simply being present is the most powerful spiritual care
- Holding a hand, maintaining silence, and offering empathy can help patients feel safe and valued
- Especially important during crises like terminal illness, death, or life-changing diagnoses

Ethical Considerations in Spiritual Care

A. Respect for Beliefs:

- Nurses must provide nonjudgmental care, even if the patient's beliefs differ from their own
- Do not impose personal values or evangelize
- Avoid dismissing spiritual needs as unimportant or "not medical"

B. Cultural Sensitivity:

- Be aware that different cultures have unique spiritual expressions
- Ask: "Are there any spiritual or cultural practices we should honor during your care?"
- Respect practices regarding prayer times, modesty, touch, or end-of-life rituals

C. Confidentiality:

- Discussions about spiritual matters should be kept private and documented with sensitivity, only when appropriate