COURSE GUIDE

NSC 220
FOUNDATION OF PROFESSIONAL NURSING PRACTICE II

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INTRODUCTION

Welcome to NSC 220 – Foundation of Professional Nursing Practice II is a two-credit unit course for students who are pursuing BNSc. It is one of the courses meant to lay your desired foundation for choice of nursing as a course of study and profession.

The course consists of 2 Credit units (30 hours of instruction online; 24 hours of laboratory & clinical practice). This is a second-year second-semester concurrent BNSc degree programme course.

WHAT YOU WILL LEARN IN THIS COURSE

The overall aim of this course is to introduce you to the ability to assess the patient, skills of the nurse regardless of the practice setting. All settings where nurses provide care, eliciting complete history and using appropriate assessment skills as critical to identifying physical and psycho-emotional problems concern experienced by the patient. The course will provide you with a broad base understanding on Nursing care and practice.

COURSE AIMS

This course aims to provide a comprehensive understanding of philosophy, ethical, legal aspect of nursing practice and theories and models in nursing.

COURSE OBJECTIVES

To achieve the aims set out above, the course sets overall objectives. In addition, each unit also has specific objectives. The unit objectives are always given at the beginning of a unit; you should read them before you start working through the unit. You may also want to refer to them during your study of the unit so as to check on your progress. You should always look at the unit objectives after completing a unit. In this way, you can be sure that you have done what was required of you by the unit.

Below are the wider objectives of the course, as a whole. By meeting these objectives, you should have achieved the aims of the course as a whole. On successful completion of the course, you should be able to:

i. discuss the concept of philosophy in relation to nursing
ii. describe the differences between ethical and legal concerns of nursing practice

iii. discuss the impact of law on nursing practice and legal responsibilities of nurses in delivering client care
iv. describe legal aspects of professional nursing
v. define concept, theory and model
vi. discuss communication and its application in nursing practice.
vii. describe the application nursing process in the rendering individualistic care
viii. describe the concept of interpersonal relationship and its application to nursing care
ix. enumerate the chain of events that link the reservoir of infectious agents with the susceptible host
x. discuss the nature and concept of pain.

WORKING THROUGH THIS COURSE

To complete this course, you are required to read the study units, as well as other related materials. Each unit contains self-assessment exercises, and at certain points in the course, you are required to submit assignments for assessment purposes. At the end of the course, you are going to sit for a final examination. The course should take you about fifteen weeks, in total, to complete. Below you will find listed all the components of the course, what you have to do, and how you should allocate your time to studying the course.

You will be expected to read every module along with all assigned readings to prepare you to have meaningful contributions to all sessions and to complete all activities. You must attempt all the Self-Assessment Excercises (SAEs) at the end of every unit to help your understanding of the contents and to help you prepare for the in-course tests and the final examination.
You will also be expected to keep a portfolio where you keep all your completed assignments.

Specifically, each unit has activities and videos that will guide your ability to learn the health, history and physical assessment skills.

COURSE MATERIALS

STUDY UNITS

There are fifteen study units in this course as follows:

Module 1 Philosophy, Ethical and Legal Aspect of Nursing

Unit 1 Philosophical Thoughts in Nursing

Unit 2 Influence of Philosophical Schools of Thought on Nursing
Unit 3 Ethical Issues in Nursing
Unit 4 Legal Aspects of Professional Nursing I
Unit 5 Legal Aspects of Professional Nursing II

Module 2 Theories and Models in Nursing

Unit 1 Concepts, Principles, Theories and Models in Nursing
Unit 2 Theories in Nursing
Unit 3 Introduction to Nursing Process as a Framework for Nursing Practice

Module 3 Nursing and Caring

Unit 1 Communication in Nursing
Unit 2 Interpersonal Relationship in Nursing
Unit 3 Infection Control
Unit 4 Health Education

Module 4 Promoting Physiological and Psychological health

Unit 1 Pain Management
Unit 2 Stress and Adaptation
Unit 3 Sexuality and Gender Issues

TEXTBOOKS AND REFERENCES

- Berman, A., Snyder, S. J., Kozier, B., Erb, G. L., Levett-Jones, T., Dwyer, T., Hales, M., Harvey, N., Moxham, L., & Park, T. (2014). *Kozier & Erb's fundamentals of Nursing Australian edition* (Vol. 3). Pearson Higher Education AU.
- Berman, A., Snyder, S., & Frandsen, G. (2016). *Study Guide for Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, [by] Berman, Snyder*. Pearson.
- Brooker, C., & Waugh, A. (2013). *Foundations of Nursing Practice E-Book: Fundamentals of Holistic Care*. Elsevier Health Sciences.
- Cherry, B., & Jacob, S. R. (2016). *Contemporary nursing: Issues, trends, & management*. Elsevier Health Sciences.
- DeLaune, S. C., & Ladner, P. K. (2011). *Fundamentals of nursing: Standards and practice*. Cengage learning.
- Dolan, J. A., Fitzpatrick, M. L., & Herrmann, E. K. (1983). *Nursing in society: A historical perspective*. WB Saunders Company.

- Donahue, M. P. (2011). *Nursing, the finest art: An illustrated history*. Mosby.
- McCormack, B., & McCance, T. (2011). *Person-centred nursing: theory and practice*. John Wiley & Sons Mortimer, B. (2004). Introduction: the history of nursing: yesterday, today and tomorrow. In *New Directions in Nursing History* (pp. 17-37). Routledge.
- Potter, P. A., Perry, A. G. E., Hall, A. E., & Stockert, P. A. (2009). *Fundamentals of nursing*. Elsevier Mosby.

EQUIPMENT AND SOFTWARE NEEDED TO ACCESS THE COURSE

You will be expected to have the following tools:

1. A computer (laptop or desktop or tablet)
2. Internet access, preferably broadband rather than dial-up access
3. MS Office software – Word PROCESSOR, PowerPoint, Spreadsheet
4. Browser – Preferably Internet Explorer, Mozilla Firefox
5. Adobe Acrobat Reader

NUMBER AND PLACES OF MEETING (ONLINE, FACE-TO-FACE, LABORATORY PRACTICALS)

The details of these will be provided to you at the time of commencement of this course.

DISCUSSION FORUM

There will be an online discussion forum and topics for discussion will be available for your contributions. You must participate in every discussion every week. Your participation links you, your face, your ideas and views to that of every member of the class and earns you some marks.

ASSIGNMENT FILE

The assignment file will be the Tutor Marked Assignment (TMA) which will constitute part of the continuous assessment (CA) of the course. There are 20 assignments in this course with each unit having an activity/Self-Assessment exercise for you to do to facilitate your learning as an individual.

Assessment There are two aspects to the assessment of the course. These are the Tutor marked assignments and written examinations. In tackling

the assignments, you are expected to apply information, knowledge and strategies gathered during the course. The assignments must be turned in to your tutor for formal assessment following the stated presentation schedules. The works you submit to your tutor for assessment will count for 30% of your total course work. At the end of the course, you will need to sit for a final written examination of three hours duration. This examination will also count for 70% of your total course mark.

TUTOR-MARKED ASSIGNMENT (TMA*)* There are 30 tutor-marked assignments in the course. You are advised in your interest to attempt and submit the assignments at the stipulated time. You will be able to complete the assignments from the information and materials contained in your reading and study units. There are other self activities contained in the instructional material to facilitate your studies. Try to attempt it all. Feel free to consult any of the references to provide you with a broader view and a deeper understanding of the course. The assignment accounts for 30% of the total assessment pack for the course. Continuous self-assessment materials will be enclosed with the instructional materials so that you can monitor your progress through the course.

GRADING CRITERIA

Grades will be based on the following percentages

Tutor- Marked Assignments		
Computer- marked Assignment	30%	
Group assignments	5%	40%
Discussion Topic participation	5%	
Laboratory practical		
End-of-Course examination	60%	

GRADING SCALE
A = 70-100
B = 60 - 69
C= 50 - 59
F = $\leq$ 49

HOW TO GET THE MOST FROM THIS COURSE

i. Read and understand the context of this course by reading through this Course Guide paying attention to details. You must know the requirements before you will do well.
ii. Develop a study plan for yourself.
iii. Follow instructions about registration and master expectations in terms of reading, participation in the discussion forum, end of unit and module assignments, laboratory practicals and other directives given by the course coordinator, facilitators and tutors.

iv. Read your course texts and other reference textbooks.
v. Listen to audio files, watch the video clips and consult websites when given.
vi. Participate actively in online discussion forum and make sure you are in touch with your study group and your course coordinator.
vii. Submit your assignments as at when due.
viii. Work ahead of the interactive sessions.
ix. Work through your assignments when returned to you and do not wait until when the examination is approaching before resolving any challenge you have with any unit or any topic.
x. Keep in touch with your study centre and Department of Nursing Science website as information will be provided continuously on this site.
xi. Be optimistic about doing well.

MAIN COURSE

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MODULE 1 PHILOSOPHY, ETHICAL AND LEGAL ASPECT OF NURSIN

UNIT 1 PHILOSOPHICAL THOUGHTS IN NURSING

CONTENTS

1.0 INTRODUCTION

In this unit, you will be learning briefly about what philosophy is and how philosophy of nursing is derived. The need for a philosophy of nursing will be highlighted. Values which are closely related to philosophical statements will be discussed and salient words defined. Concepts that make up the philosophy of nursing will also be discussed.

Philosophy is the basis of knowledge. It is a science that cuts across all disciplines. It develops one's logical reasoning, moral and value development. History has demonstrated that philosophical thoughts have modified the basis for nursing practice from the time of Florence Nightingale to date. Also, the interest of nursing in philosophy and use of philosophical principles has grown as nursing evolved into a profession.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

- identify what philosophy means in nursing
- discuss how value is formed and role in development of philosophy
- highlight the history of philosophy
- list four factors pertinent to the philosophy of nursing
- enumerate four factors hindering the full implementation of nursing philosophy.

3.0 MAIN CONTENT

3.1 Concept of philosophy

You may wonder what a philosophy is. If it is new to you, then look into an English dictionary because it is a commonly used word and has so many meanings. Everyone has a philosophy of life. It is simply one's belief about an issue or something. For example, what is your philosophy about human beings?

First let us examine the definition according to the English dictionary. It is the search for knowledge-attitude towards life or something. In nursing it is the belief about nursing life society/environment and health. The health care in any country is usually a reflection of the philosophy of health and society.
Ask yourself these questions:

- How do you perceive it?
- Is it unique with individual response to disease and care?
- Should one take part in decision about his/her health?
- Should human dignity be protected?
- Is health a human right?

Philosophy is formed from Greek word "philus" lover and "Sophia" wisdom. It is like a guide for nursing practice. All professions have a philosophical basis for practice and all healthcare organizations should have a written philosophy. Philosophies of nursing are statements of belief upon which nursing practice in a particular health care institution is based. The current nursing philosophy holistically views the individual. The individual is a total person not in fragments within the context of the family and community.

Let us examine the word wisdom. It is the ability to think and act appropriately utilising knowledge, experience, understanding common

sense and insight. Philosophy can be the ability to analyse issues resulting in clear logical conclusions to form a basis of decision. The word (philosophy) is used in different ways.

From the previous units, you have learnt about the history of nursing. The philosophy of Florence Nightingale was that the nurse should look after the environment and nature will act on the physiological state for healing to occur. This philosophy is still relevant but it has changed due to life, events experience, etc. The various changes in society, human beings the environment, health and technological advancement among others have resulted into the contemporary philosophy of nursing. The importance of these various developments will be clear to you as you advance in the programme.

The philosophy held by each nurse is based on inferences of meaning and purpose of life, health and the profession. This constitutes a value judgement; philosophy helps to develop reasoning to make choices and it determines the professional way of life.

SELF-ASSESSMENT EXERCISE

i. What is your philosophy of life?
ii. What are your values?
iii. Are you happy to be a nurse?

Has the foregoing whetted your appetite a bit? Now let us examine why there is a need for a philosophy of nursing.

3.2 Need for a Philosophy of Nursing

Nursing started as an occupation as you are aware, from the previous units. As the profession evolved into a science-based discipline, the body of knowledge shifted from tradition and experience to include more systematic approaches. The philosophy of nursing goes beyond mere occupation. It:

- enables nurses to reflect on the meaning and purpose of their lives and lives of people they take care of.
- helps nurses to identify other factors that are influencing nursing and nurses, and
- gives an insight into societal values and helps to ascribe values to nurses' actions.

You have come across some new words like *values* and it is important to expatiate on them because they may sound abstract and difficult to relate to philosophy.

3.3 What are *values?*

You should note that *value* is a personal belief about the worth of a given idea or behaviour upon which a person acts. Values are standards that influence behavior. They vary from person to person developing and changing as a person grows and matures. Values have strong motivational components that direct conduct. Values are standards for guiding actions, developing and maintaining attitudes towards relevant objects morally judging self and others and comparing self and others (Potter & Perry, 2009).

Nurses are members of the society so they practice under personal and professional sets of values. Some of the values that nurses hold include human dignity, independence positive human relation and so on. In client! nurse relationships nurses must understand the values of the clients and must not use their personal values to judge clients.

For example, personal values about health determine the choice mode about how to promote health, and use health care promptly during illness, e.g., eating a good balanced diet exercising and seeking medical care when ill.

3.3 Formation of Values

Reflect on what you claim you value. How did you come about it? Is it through observation or experiences? Values are formed through observing others and the environment, for example a student nurse can closely observe an instructor's actions at the client's bedside and the client’s reaction. The effectiveness of the action can be copied and imbibed by the student nurse. Similarly, when the instructor praises the nurse for good performance the experience is valued by the student and is repeated. Other ways that promote value formation include modelling, moralizing and reward/punishment.

Examples are:

- *Modelling* -A nurse talking and walking like a senior nurse she admires.
- *Moralizing* -Parents always demanding that children speak the truth because it is the right way.
- *Reward and punishment* being given a prize in school for punctuality and being asked to pick litter when one is late.

The next area you need to focus on is the essential nursing values and behavior. Below is a table that shows the essential values, the attitudes

and personal qualities of the nurse and the professional behavior expected of the nurse.

Table 1: Essential Nursing Values and Behaviours

Essential Values	Attitudes and Personal Qualities	Professional Behaviours
Altruism: Concern for the welfare of others	Caring, commitment, compassion, generosity and perseverance	Giving full attention to the patient/client when giving care. Assisting other personnel in giving care when they are unable to do so. Express concerns about social trends and issues that have implications for health care
Equality: Having the same rights, privileges or status	Acceptance, assertiveness, fairness, self-esteem and tolerance	Provide nursing care based on the individual's need irrespective of personal characteristics. Interacts with other providers with nondiscriminatory manner. Express idea about the improvement of access to nursing and health care
Aesthetic: Quality of object, events and persons that provides satisfaction.	Appreciation, creativity, imagination, sensitivity	Adapt the environment so that it is pleasing to the patients/clients. Create a pleasant work environment for self and others. Presents self in a manner that promotes a positive image of nursing
Freedom: Capacity to Self-Assessment Exercise choice	Confidence, hope independence, openness, self-direction, self-discipline	Honours individual's right to refuse treatment. Supports the right of other provider to suggest alternative to the plan of care. Encourage open discussion of controversial issues in the profession
Human dignity: Inherent worth and uniqueness of an individual	Consideration, empathy, humaneness, kindness, respectfulness, trust	Safeguards the individual's right to privacy. Addresses individuals as they prefer to be addressed. Maintains confidentiality of patients/clients and staff. Treat others with respect regardless of background

Justice: Upholding moral and legal principles	Courage, integrity, morality, objectivity	Acts as a health care advocate. Allocate resources fairly. Reports incompetent, ethical and illegal practice objectively and factually.
Truth: Faithfulness to fact or reality	Accountability, authenticity, honesty, inquisitiveness, rationality, reflectiveness	Documents nursing care accurately and honestly. Obtains sufficient data to make sound judgement before reporting infractions of organizational policies. Participates in professional efforts to protect the public from misinformation about nursing

Source: Potter *et al.,* (2009)

Study the table above and compare it with your values. Are your values similar? Discuss those you don't think are essential with your facilitator. Bear in mind that they may be clearer later in the course.

At this stage, a brief history of philosophy will be discussed and common schools of Thoughts highlighted.

3.5 Brief History of Philosophy

Here you will examine a brief history of philosophy as a background to the discussion. The history can be divided into ancient e.g., nationalism, medieval e.g. (idealism) modem and contemporary. We will only focus on modem and contemporary because they are more relevant to nursing than the two earlier periods. You can read about the earlier two periods in your reading text.

During ancient and medieval philosophy, the deliberations of philosopher were mainly concerned with explaining and understanding God (Naturalism) but they also strayed into science or nature which started weakening the religious position. In modem philosophy science and scientific methods dominate with less focus on speculative thoughts. In essence, some of the philosophers were working on the empirical world while other were on metaphysical terms. They debated on the source of knowledge and what is possible for a man to know. While Descartes argued that the source of knowledge was the mind, there was also debate about ethics and moral conduct between deontological philosophers like Kant and teleological philosophers like Mill. The utilitarian groups have just started contributing to ethical debate while the church was losing its unquestioned authority.

3.5.1 Contemporary philosophy

This can be discussed under existentialism and pragmatism. The existentialist thoughts can be traced to disregard for subjective human experience of life as it is lived rather than as it is thought about. Another development in philosophy in the late 19th and early 20th century is the school of pragmatism with forms on knowledge and learning. They were interested in practical course queued of ideas and totally in contrast with the existentialism. Nursing has developed unique research, approaches called phenomenology and feminist approach from the contemporary knowledge in existentialism. These will be discussed in great detail with areas of influence in nursing in the next unit.

3.6 Factors pertinent to the philosophy of nursing

You need to reflect again on the history of nursing and the position of religion in its early development. Nurse leaders worldwide claim that nurses across the globe have their roots in the two major religions irrespective of their religious belief. The influence of theism (the belief in one God as the creator and ruler of the universe) seems to be the universal component common to nursing philosophies which serve as guidelines for social factors, interpersonal relationships and therapeutic use of self.

3.6.1 Relationships with a supreme being

This means that all people have a relationship with God and the nurse must respect this. Compassionate empathic nursing requires that the nurse should help clients to the best of his/her ability to maintain relationship with God.

3.6.2 Human rights

All persons regardless of name, nationality colour, political status, occupation culture social position or personal achievements have fundamental right which include an inalienable right to be respected as human beings and have responsibilities, rights and privileges in terms of their humanity. United Nations since 1948 has declared the fundamental human rights. The issue of health care as a right and quality nursing care for all people is a care principle.

3.6.3 Humanity as a focal point

The individual within the context of family and society is the bedrock of nursing. Humanism centres on interest in the welfare of people. Health is a major aspect of welfare.

3.6.4 Ethical and moral principles

All people have moral values and principles. It is the responsibility of the nurse to uphold the moral values of the society he/she functions in. Conflict between value systems and judgement must be avoided as much as possible. All professions have codes of practice that guide their actions. The ethical code is also based on value, on health humanity caring and respect for the rights of people.

Please note that some of these issues will be learnt in greater detail as you progress in the course. They will continue to recur and unfold with greater understanding and applicability in other nursing courses.
Please find below a philosophy of nursing which are statements about human beings, nurses and nursing. It could. also include Health and environment depending on the institution.

The following statement by Steele and Harmon (1983:54-55) no doubt reflects some of your statements on the philosophy of nursing.

- "The human being is a holistic being, has intrinsic value and should be treated with dignity. The human being has the right to decide his or her own future if that future does not infringe the rights of others".

- "Nurses are morally and legally responsible for providing safe and quality care. Nurses are caring citizens with the knowledge and skill to influence the social settings in which they work. Nurses are part of democratic society and help patients who cannot speak for themselves to reap the benefits of democratic ideals. Nurses have a responsibility to work in collaboration with other health professionals to guarantee that the highest quality of health services are given to a patient".

- "Nursing is an art and a science and is a humanistic service provided in a variety of settings. Nursing is a systematic process and is delivered to people from all sectors of society without regard to age, colour, creed or political opinions."

3.7 Factors hindering effective implementation

Before ending this unit there is need to look at factors that pose as challenges and limit the implementation of a sound philosophy of nursing. We have mentioned some in our earlier discussion and these include rapid changing medical technology, cultural and social environment which create difficulties in defining the role of the nurse. Demographic variables with population explosion in developing countries including Nigeria is a serious factor. The declining economy with lack of basic resources to meet health needs of the population. Shortage of nurses, either artificial or real, from brain drain or economic reforms, has resulted into excessive workload and sub-standard care. The workplace conditions and confusions hindered the full application of the philosophy of nursing in each institution, especially in developing countries.

SELF-ASSESSMENT EXERCISE

List one example or your experience in life for modelling, moralizing, reward and punishment.
Following your value statements in the previous activity write down your philosophy of nursing.

4.0 CONCLUSION

We have been discussing the concept of philosophy, the need for a philosophy of nursing, the role of values and value-formation in philosophy. A brief history of philosophy and factors commonly used in developing or writing philosophy of nursing were highlighted. Finally, the factors hindering the full implementation of the beliefs about nursing and nursing practice were enumerated.

5.0 SUMMARY

The need for philosophy statement by professions and organization cannot be over-emphasized. It guides practices and practitioners; it can be used to negotiate minimum standards that professionals will tolerate. As values of society change the philosophy is modified. The needs of each group of clients are different so unit philosophy to reflect the clients can be stated e.g., adolescents, adults, children, men, etc. The influence of the various philosophical thoughts on nursing will be discussed in the next unit.

6.0 TUTOR- MARKED ASSIGNMENT

1. Discuss what you understand by philosophy.
2. Explain the factors that must be considered when formulating statement for the nursing philosophy.
3. Explain the factors that hinder on **full** use of nursing philosophy.
4. Discuss how values can affect your philosophy.

7.0 REFERENCES/FURTHER READING

Berman, A., Snyder, S., & Frandsen, G. (2016). *Study Guide for Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, [by] Berman, Snyder*. Pearson.

Brooker, C., & Waugh, A. (2013). *Foundations of Nursing Practice E-Book: Fundamentals of Holistic Care*. Elsevier Health Sciences.

Potter, P. A., Perry, A. G. E., Hall, A. E., & Stockert, P. A. (2009). *Fundamentals of nursing*. Elsevier Mosby.

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UNIT 2 INFLUENCE OF PHILOSOPHICAL SCHOOLS OF THOUGHT ON NURSING

CONTENTS

1.0 INTRODUCTION

In the previous study unit, we looked at the philosophical thoughts in nursing. We noted that our values are based on our philosophy, which enables us to assess the value in the meaning of our actions as nurses. Our role models to nurse evolves with appropriate nursing value by means of their actions so that the continuation of these values is assured from one generation of nurses to the next.

Nursing should be distinguishable by its philosophy of care-particularly its approach to the wellbeing of clients is ultimately the end purpose of nursing. This moral end involves seeking a good, which not only designs but also shapes the science learned and technological skills developed in nursing. Decision-making specific to nursing practice has evolved from philosophical schools of thought to meet the needs of the profession. In this unit we shall examine the influence of a few major philosophical schools of thought to help you examine personal and thoughts develop a framework from which responsible professional nursing practice can begin.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

- identify four philosophical schools of thought
- describe each philosophical position
- describe how each influence nursing till contemporary thoughts.

3.0 Main content

3.1 Ancient Philosophy-Naturalism

This philosophy is the oldest known in the Western world and can be traced back to the fourth century BC. Naturalists maintain that there is a defensible and consistent order in nature, that reality and nature are identical, and that there is no reality beyond nature.

This philosophy has universal appeal because of its simplicity, which is both its strength and its weakness. Its strength lies in the fact that it offers individual freedom from presumption and decreases the influence of confusion in society. Human beings, for example, are successful because they consider nature when exploring the moon, planting crops, and constructing building or sailing ships. This oversimplification of life and existence is also a primary weakness because deep insights and adequate explanations cannot be found. Nature is not always harmonious.

The law of nature is an old concept that is often applied to moral law and ethics. Natural law has several different meanings and can be theistic (belief in God) or non-theistic. Those who believe in God see nature as God's creation. Others see nature, rather than God, as the ultimate. It has been argued that just as there are natural laws governing the universe, such as the law of gravity, so there are natural moral laws. If there is natural moral law, which determine what is morally right in any given situation it is binding on everyone. The strongest argument against natural law theories is that acceptance of a universal being the rule removes the element of choice. Since we can research and decide what is right or wrong, not using that reasoning ability would in itself be contrary to natural law.

3.1.1 The influence of naturalism in Nursing

Now let us discuss how natural law affects health care and nursing. Naturalism forms the basis for moral principles. Natural law is based on some assumptions. One of them is that an action is good if it is in accord with human nature and bad if it is contrary to that nature. It is also assumed that nature of things can be discovered by reason. Naturalism

also posits that an individual can get the highest value out of life by living as close to nature as possible. You will remember the position of Florence Nightingale about the role of the nurse "what nursing has to do is to put the patient in the best condition for nature to act upon him".

The Naturalist School of Thought considers the scientific approach to be the only reliable method of acquiring knowledge. This may have influenced a fundamental principle in nursing science, which is the understanding and correctly applying the scientific method.

3.2 Idealism

This is the name given to a group of philosophical theories that have in common the view that what would normally be called "the external world" is somehow created in the mind. Subjective experiences ideas and thoughts are viewed as the centre of every reality. To the idealist, reality is that which is observed, whether it be through experience, thoughts, emotions or one's free will, as it relates to a particular individual. For this reason, the idealist considers the *self* as the fundamental reality since the personal experience of an individual or a community is definitive.

The philosophy of idealism is probably a form of perfectionism having as its aim the development of a balanced individual in a balanced and harmonious society. In terms of idealism individuals ought to live in harmony with one another. Mutual respect and consideration are essential. No one person is more important than any other and everyone has an inborn need to do good. The good life is to be found in progressing towards this and other ideals.

3.2.1 The influence of idealism in Nursing

The philosophy stresses the human elements in life, education and work. Idealism insists that the human and persons are more important than scientific advancement. However, it does not deny the benefits of the increase sophistication of scientific progress. Of particular relevance to the field of nursing is the philosophy of Immanuel Kant, whose writings were to influence philosophy throughout the 19th century. At the heart of his thinking was the freedom of the individual. He believed that a person's inner reasoning dictates her or his moral actions. These actions, motivated by the mind's reasoning, are free actions and it is this freedom that nurses must accord to his/her clients regardless of status, color or creed.

Idealism has many variations including the idea that perception is the primary reality. Kant expressed principles common among the idealist school. C individual can morally engage in Some act if it is seen that an

act cannot universally practiced by all. Euthanasia (mercy killing) for example, might be justified but it cannot be applied to everyone.

Relations between individuals must be harmonious because people are seen as ends rather than means. One individual is just as important as another. every person there is an innate need to do good. Obedience to universal moral laws constitutes ethical values that are essential in relationship because individuals are persons and as persons, they can act only in ways they feel to be for the ultimate good of all human beings.

All these principles have a great impact on nursing practice as the application of a nursing philosophy that takes into account the religious, moral, emotional, physical, intellectual and social attitudes that form the basis of high-quality nursing care. Such nursing care is given to people regardless of nationality, race, color, creed, socio-economic and political status or social standing. It is provided within the boundaries of the practitioner's professional registration and *love* of his or her *fellow* human beings and an inborn desire to do good.

You may be saying to yourself what does this boil down to at the end of the day? You need to note that nursing is not just a series of technical actions that can be performed by anyone. Nursing means concern for people and *that* caring is based on knowledge of the client's (sick or *well)* culture. This is not based on race, colour or creed but goes far deeper into nurse/client relationship. Caring signifies a degree of involvement between the nurse and client. The views of the client and nurse about the role of the client in the relationship have a great influence on the outcome of the nurse/client relationship.

Nursing requires understanding so that one may provide support, although this is considerably complicated by the uniqueness of each client and the complexity of cultural attitudes and conceptions. Nevertheless, the nurse must try and understand the patient as far as Possible-and this is no easy task when there are, for example, ethnic differences between the nurse and the patient. This is the reason why nursing often degenerates into being is no more than the provision of a technical service.

2. Contemporary Philosophy-Pragmatism

This philosophical movement developed in the last hundred years through nee, the writings of Charles Saunders Pierce on the pragmatic theory of meaning and William James's pragmatic theory of truth. A philosophical movement holding that practical consequences are the criteria of knowledge, meaning and value.

Pragmatism is a method for looking directly at a question to determine its use, its function and whether or not it serves a purpose. The word is derived from the Greek pragma (action) Pragmatism holds that no idea has meaning unless there is some direct or indirect application of it to something real. Value, is often practical use and consequences. In decision-making or debates, for example, the following question may be asked: "What practical difference does it make?" If no practical difference is made, the idea is not regarded as either significant or useful. Pragmatism, therefore, equates practical consequences with worth and truth.

3.3.1 The influence of pragmatism in Nursing

In a practical health science such as nursing, pragmatism offers (and offered) quite several feasible approaches to the teaching and practice of this discipline, both today and in the past. Philosophic interpretation of this era is very useful, as it was during this period that auxiliary nurses came to prominence. These "nurse aides" and "Practical" nurses performed much of the actual nursing care.

The tremendous shortage of trained nursing staff during and after World War II compelled the nursing profession to seek extremely pragmatic solutions to this problem in nursing care. Coaching auxiliary nurses or nurse aides through informal in-service training and other short courses to meet the immediate need-hence found a pragmatic solution their entry to the profession as sub-professional nurses. Not only nursing assistants, but many other specialized technical groups of experts emerged to provide for immediate needs within the ambit of nursing care in general. This gave rise to a situation in which the trained nursing staff were concentrating on supervision and training while the actual care of patients was taken over by auxiliary staff -a situation that is not being encouraged in the contemporary context of the profession.

Another influence of pragmatism that may be observed in the case of patients is the fragmentation of health care for the sake of its practical value. Fragmentation and the consequent fact that both doctors and nursing staff are specializing in clinical fields such as cardiology, psychiatry and geriatrics-to mention but a few-have many important advantages for the execution of health care. Despite this, this trend raises the question of the consequent lack of a holistic view of people among health professionals. It is also worth noting that health care delivery and nursing curricula were organized by disease and that "the focus was on the problem, and the disability, the disease and the diagnosis, not on the person, his family, his needs, his wholeness or his humanity", Nurses generally referred to patients according to their diagnosis of the body part,

which was affected for example, “Are the Appendectomy and Amputee in bed”?

Discussion on ethical schools of thought, also maintains that because nursing is grounded in the physical and biological sciences, it uses the same approach to the integration of knowledge as the pragmatic ethicist. Pragmatists believe that facts must be assessed as they are, and this requires recognition of problem, formulating a hypothesis, collecting and observing data, and testing hypotheses. This allowed the nurse to determine the correct way to respond to a particular situation and given value of any given action. Towards the end of this era, however, practical realities in nursing care began to dominate. The need for intensive care units, rehabilitation and ambulatory units in the 1950s forced nurses to turn their focus back to care of the patient or the human need. This transition period was the precursor of the later era of humanism in nursing.

3.4 Humanism and existentialism

Let us discuss it in two parts first. By humanism we mean the philosophical view that accepts human beings as the primary source of meaning and value. This school of thought believes in human effort and ingenuity rather than religion. It emphasizes the value, beauty and importance of being human and a concerted action geared to human ideals, human existence and the quality of life. Bevis (1984:1) maintains moreover that humanism is characterized by a value system that places a great importance and high priority on caring about people.

Existentialism is a philosophical trend or attitude that influenced Europe in the beginning of the 20th century. This modem philosophical view accepts that reality exists in the mind of the person, and is unique to each person who is a holistic being. The sum of a person is greater than what the scientific study of his individual parts can reveal. Underlying this philosophy are choices for personal destiny and accountability. Existentialism stresses personal experience and responsibility and their demand on the individual, who is seen as a free agent in a deterministic and seemingly meaningless universe. The major weakness in existentialism for nurses may be that it denies reference to codes of ethics and codes of behavior in general. Ethical decision-making is solely the responsibility of the individual. Now, what do the two concepts mean?

3.4.1 Humanistic existentialism

This is a label that Bevis (1989-24) uses to reflect the influence of humanism and existentialism on nursing and which provides a strategy for understanding nursing today. She believes that humanistic

existentialism is a natural maturational philosophy for nursing as it implies that people are the central and basic priority of all nursing activity. The patient/client as a human being is an organic whole, complete and unified, who cannot be treated as component parts. Parts cannot explain the whole, the mystery of the whole, how it works and its ultimate unpredictability. This, however, does not prevent nursing from trying to predict responses and from basing nursing care on scientific principles that provide a way of predicting consequences.

3.4.2 The influence of humanistic existentialism in Nursing

You will recall that in our discussion on pragmatism we outline the way the shortage of nursing staff after World War II caused patient care to be taken over by sub-professional nursing staff. We went on to explain why specialization and the consequent fragmentation of patient care seemed, from a practical point of view, to be the best approach to the rendering of health care. In the context of this discussion, it is interesting to note that it was precisely this fragmentation and consequent lack of recognition of the patient's need for holistic nursing care that motivated the nursing profession to change its view or philosophy. "In other words, pragmatic values moved nursing toward humanism and holism". Humanistic existentialism with human beings as its main theme and as the central and basic priority of all health care therefore provides several natural philosophical guidelines for nursing. The influence and implementation for nursing are as follows:

Acknowledging the uniqueness of each patient/client

Existential experience basically means a person's awareness of the self and the other. This means every person is unique and should be regarded as such by a nurse who is likewise a unique person. Existentialism sees the individual as a unique, irreplaceable person who can never be supplicated. Although someone's biological status can be explained scientifically that person is a person, and as such he or she can never be fully explained.

Rejecting stereotypes

Following from the previous point is the notion that the existentialist school of thought rejects stereotyping so common in health services. This philosophy emphasizes that a person should be treated as a total entity. One should not concentrate simply on a patient's pneumonia or amputated limb-the patient must be treated as an individual. Every person's biological and psycho-social make-up is just as unique as her or his genetic structure. One should not only anticipate how a certain individual

will react to scientific treatment, but one should also be alert to the fact that two individuals may react quite differently to the same treatment.

Acknowledging freedom of choice

Existentialism is highly individualistic, and an individual can never separate from his or her "place" in the world. The individual is part of the social matrix of the society in which he or she lives, and it is the individual who can ultimately determine how he or she fits into this matrix, because the individual makes his or her own decisions. The philosophy emphasizes the fact that decisions regarding one's action or how one reacts to others, cannot be forced on one by someone else. It, therefore, allows for the possibility that individual patients/clients can make personal choices regarding their nursing care, alternative methods of healing, medical care, or ways in which they may achieve their own aims-even to the extent of accepting or rejecting nursing and medical advice.

Accepting accountability

According to existentialism, there is a great deal of subjectivity about the choices that individuals are called upon to make since they are not linked to laws and traditions. Human beings are thinking beings who can choose freely, and are therefore unpredictable. Freedom of choice is regarded as the most fundamental of all freedoms, even if it is freedom coupled with accountability. This ideal is of fundamental importance to professionalism. Accountability is regarded as the yardstick for determining whether or not nursing profession. Nurses can no longer evade the responsibility of their professional actions or negligence by saying that "the doctor prescribed this action". Personal responsibility of a registered professional person entails not only taking responsibility for one's action, but also accountability towards the patient, the law and the registration authority.

Personalizing the idea of death

One of the fundamental concepts of existentialism is that people must personalize death for themselves. Living and dying are a part of human existence. Human beings know that their being is going to end sometime in future. Death is inevitable and an inherent part of life. Continually seeking attain one's goals and living out their values should therefore vitalize existence. This concept implies that people should be made aware of themselves and of what they wish to become to make life as meaningful as possible for themselves.

Recognizing comprehensive patient care

A very important consequence of humanistic thinking in nursing science is ideal of comprehensive patient care-this includes physical, psychological, spiritual and social care. Allied to this concept is the belief that the patient the center and must always be respected as a unique person requiring care. The particular caring nature of the nursing profession forms the core of nursing philosophy. This philosophy has a universal significance for people in all cultures and communities. One of the main tasks of the nursing profession is to equip the nurse by means of the process of socialization to provide humanistic care. Caring is vital in the therapeutic interpersonal relationship between nurse and patient. Nursing care is a special phenomenon that occurs in all societies and cultures. "The caring process helps the person attain (or maintain) health or die a peaceful death".

Acknowledging self-extension

A humanistic existentialist approach to nursing requires a nurse to recognize the individual's complexity, nature, humanity, searches, experience and becoming. Human beings are never complete-they are becoming.

Nursing is concerned with how this particular person, with his or her particular history, experiences being labeled with this general diagnosis, with being admitted, discharged and living our lives with a condition as she/he views it in her/his world. To promote the ability to act in a manner that is orientated to one's fellow human beings and thus to recognize the needs of others and help them to develop themselves, the interaction between patient and nurse should be one of self-extension. Self-extension is the hallmark of both personal and professional maturity. The health care approach that it requires self-extension of both practitioner and client is based on the concept that people, as responsible beings should themselves endeavor to look after their own health and that of their families. Considering how little most patients/clients know about health care, all they can usually do is manage their health within the guidelines laid down by concerned, caring health experts. The experts should help them acquire the necessary knowledge for this purpose, support them in their endeavor and in situations they cannot deal with themselves, and impress upon them the belief that faith and hope also play a part in the healing process. Self-development and the cultivation of values, sound judgement and sensitivity human relationships are based on the nursing philosophy itself. This philosophy is of fundamental importance in the development of empathy and sympathy, and personal and professional integrity. A nurse's every action and communication (oral and otherwise) influence the

choices made by his or her patients, including the means they choose to achieve self-actualization.

SELF-ASSESSMENT EXERCISE

i. List four basic concept nursing practice
ii. Outline the position of idealism and influence on nursing.
iii. Trace the thought of the *pragmatists* and the implication on nursing.
iv. Compile a list of the principles (or characteristics) of each philosophy and indicate its influence in nursing.

4.0 CONCLUSION

We have discussed four schools of thought in philosophy and their implication on nursing. We have demonstrated that as the philosophized thought changed over ancient to contemporary periods the philosophy of nursing changed. Contemporary nursing views man as a biopsychosocial being within the context of a family and community.

5.0 SUMMARY

As earlier mentioned in the previous unit the need for philosophy in nursing is paramount. The philosophy will as in the past modify the philosophy of nursing in the future. In this unit we had looked at the influences of some philosophical thoughts on Nursing, we identified naturalism, idealism, pragmatism. The various areas of influence were highlighted and conclusively one can say that philosophy had guided the theoretical and approaches to care from Florence Nightingale theory of environment and nature with the nurse doing everything for the patient, Orem's self-care theory and individualized care.

6.0 TUTOR-MARKED ASSIGNMENT

1. a) List four philosophical schools of thought. b) Discuss each of them.
   c) Highlight the influence from ancient to contemporary times.

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UNIT 3 ETHICAL ISSUES IN NURSING

CONTENTS

1.0 INTRODUCTION

In the last unit, we examined sexuality and gender about nursing practice. Two major factor that influences sexual attitudes are biological and personality which are determinants of individual sex roles. These are ethics in nursing practice which provides for confidentiality of care of patient. Ethics is a science of morals. It stipulates the standard of behaviour and values relating to human conduct. It starts from childhood experiences, taught and learned from home, religious beliefs and standard of conduct. One is governed by an individual ethical code, professional code and the affirmation duties imposed by the Law. Nursing profession is guided by both ethical and legal concerns as it is the tool for professional discipline which gives the nurse a broad idea of what is expected of her as she moves from the protective atmosphere of school into the society. Ethics of any profession imposes some responsibilities on its members and consequently, the recipient of a professional service has his/her rights to be protected.

This unit will examine the ethical issues in nursing practice considering the history of nursing ethic, development of nursing codes of conduct, ethical concepts applied to nursing, the Patients' Bill of Rights, and the interrelationship of ethics and law.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

- enumerate the elements in Patients' Bill of Rights that have ethical concerns
- identify the differences between ethical and legal concerns of nursing practice
- describe clients' expectation which has implications in the face of professional negligence.

3.0 MAIN CONTENT

3.1 History of Nursing Ethics

Many books on nursing ethics in the past have in larger part restricted their content to professional etiquette. In 1900, Robb one of the early nursing leaders wrote on a breach of etiquette, but her comments reflect the sociology of the situation, including difference in role, function and status. She remarked that occasionally we find a nurse who, through ignorance or from an increase of her self–conceit and an exaggerated idea of her importance, may overstep the boundary in her relationship with the doctor and commit some breach of etiquette. The implication of this does not rest with the nurse alone, but also her school and the profession come under share of criticism and blame. Aikens (1937) observed the nursing ethics as old-fashioned virtues and this includes truth in nursing reports, discreetness of speech, obedience being teachable, and respect for authority, discipline and loyalty. The master and servant relationship between Physician and Nurses also expresses another angle of nursing ethics in 1943. Nurses were subservient to the hospital which employed them and the hospital becomes responsible for her actions. With this arrangement, any disobedience to the physician's order is not only a matter of professional etiquette but a violation of the employee contract. During such times, even when the physician is mishandling the patient's treatment, the nurse must either continue to carry out his orders or give up the case. This was more private duty nursing practice.

Many of the early ethics books delved into the private life and morality of nurses, reflecting the status of nursing students in an apprenticeship system and the stereotype of the intellectually and morally weak women. Such concerns focused on the individual's morality, and the nurses' duties, obligations, and loyalties referred to a situation in which nurses were on the one hand, expected to exhibit a dedication of almost a religious nature while on the other hand, their morality was opened to suspicion.

3.2 Development of Nursing Codes of Conduct

The code of conduct for nursing practice has spanned from decade to decade with specific moderations. To provide one means of professional self-regulation, the America Nurses Association (ANA) revised its code of ethics, which had originally been adopted in 950. The Code of Nurses (1976) indicated the nursing professions acceptance of the responsibility and trust with which it has been invested by society. The requirement of the Code may often exceed, but are not less than, those of the law. While violation of the law subjects the nurse to criminal or civil liability, the Association many reprimand, censure, suspends or expels members from the Association for violation of the code. The interpretive statements that accompany the ANA code outline the ethical principles that underpin each section of the code.

Code of conduct for Nurses

- The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes or the nature of health problems.
- The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
- The nurse acts to safeguard the clients and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
- The nurse assumes responsibility and accountability for individual nursing judgments and actions.
- The nurse maintains competence in nursing.
- The nurse exercises informed judgments and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities and delegating nursing activities to others.
- The nurse participates in activities that contribute to the ongoing development of the professions' body of knowledge.
- The nurse participates in the professions efforts to implement and improve standards of nursing.
- The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high–quality nursing care.
- The nurse participates in the professions' efforts to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

- The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

3.3 Ethical Concepts Applied to Nursing

The fundamental responsibility of the nurse is fourfold: to promote health, prevent illness; restore health and alleviate sufferings. The need for nursing is universal. Inherent in nursing is respect for life, dignity, and rights of man. It is unrestricted by considerations of nationality, race, creed, age, politics, or social status. Nurses render health services to the individual, the family, and the community and co-ordinate their services with those of related groups. The International Council of Nurses in Geneva updated its code of ethics in 1977 and it includes:

- **Nurses and People**

The nurse's primary responsibility is to those people who require nursing care, the beliefs, values, and customs of the individual.
The nurse holds in confidence personal information and uses judgement sharing this information.

- **Nurses and Practice**

The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning.
The nurse maintains the highest standards of nursing care possible within the reality of a specific situation.

The nurse uses judgement concerning individual competence when accepting and delegating responsibilities.

The nurse when acting in a professional capacity should at all times maintain standards of personal conduct that would reflect credit upon the profession.

- **Nurses and Society**

The nurse shares with other citizens the responsibility with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person.

- **Nurses and the Profession**

The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education.
The nurse is active in developing a care of professional knowledge.
The nurse, acting through the professional organization, participates in establishes and maintaining equitable social and economic working conditions in nursing.

3.5 Patients' Bill of Rights

2 Bill of Rights developed include:

- A patient's bill of right developed by the American Hospital Association in 1973.
- A Consumer Rights in health care published in Canada by the National Consumers Association.
  Patient's Bill of Rights states the following:
- The patient has the right to considerate and respectful care. He has the right to an explanation to what is happening.
- The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis. When consider not appropriate tell his/her relation. (see the box below).
- Patient has the right to receive from his physician information necessary to give informed consent before the treatment of everything to be done on them except in emergencies.
- Patient has the right to refuse treatment to the extent permitted by law and be informed of the medical consequences of his action. He should not be forced but the authority must be informed.
- Patient has the right to every consideration of his privacy concerning his own medical programmes.
- Patient has the right to expect that all communications and records about his care should be treated as confidential.
- Patient has the right to expect that within its capacity a hospital must take reasonable response to the request of a patient for service.
- The patient has the right to be advised if the hospital propose to engage in or perform human experimentation affecting his care or treatment.
- Patient has the right to expect reasonable continuity of care.
- Patient has the right to examine and receive an explanation of his bill regardless of source of payment.
- Patient has right to be informed of hospital rules and regulations applied to his conduct as a patient.
- A disabled person has the right to treatments.

- A disabled person has the right to economic and social security and to a decent level of living.
- A disabled person has the right to live with their families and participate in all activities.
- A disabled person shall be protected against all exploitations.
- A pregnant woman has the right to explanation on any care to be carried out on her and the risks involve affecting her and the baby in the womb.
- The pregnant patient has the right to be accompanied during the stress of labour for and who cares for her.
- The obstetric patient has the right to be informed in writing of the name of the person who delivered her baby.

In giving out information to the patient as stipulated in the rights consideration should be given to:

1. Who gives what information?
2. To whom is the information given?
3. When is it appropriate to give it?

Activity 1

Quickly recap eight (8) of the Bill of Rights off hand. Of what use is information to the nurse and patient?

3.7 Interrelationships of Ethics and Law

Ethics and Law interface in any nursing practice and administration. Smith and Davis (1980) identified four (4) situations in which ethics and law interface.

1. That which is ethical is legal e.g. informed consent.
2. That which is ethical is illegal e.g. euthanasia (see unit 14).
3. That which is unethical is legal e.g. abortion.
4. That which is unethical is illegal e.g. involuntary medical treatment in non-emergency situations.

Two of the situations are congruent and two are conflict.
N.B. *If you are in doubt, check for the meaning of Congruent and Conflict in the Advanced Learners Dictionary (ALD) before attempting the exercise.*

The following statement serves to put the four situations in proper perspectives:

- The conflict between ethical and illegal and unethical and legal will probably always be with us. Ethical cannot be bound by the law when ethical considerations override legal ones. Law cannot be held hostage to ethics in the sense that a law cannot be enhanced to control every immoral act. Therefore, the nurse as patient care administrator must expect this tension between ethics and law.
- The role of the institutional lawyer and that of the nurse as patient care administrator may conflict. A nurse care administrator can recommend that a health care institution hire additional lawyers as advocates for patients. This option provides a balanced perspective.
- Lawyers use basic tenets in formulating laws, and ethicists use laws or court decisions as part of their database in arriving at morally justified decisions. Ethics is not the final determinant of law, and the law is not the final determinant of ethics.
- A reasonable compromise or acquiescence to a majority decision by the nurse and lawyer may be in the overall best interest of all.

The standards of care and professional performance help nurses as patient care administrators ensure that they are creating and maintaining a professional nursing system within their health care settings. Standards of professional performance are not static; they reflect changes in society, technology and the professions. Nursing's reflection of these changes, however, must always be a responsible one that ultimately is accountable to ethics, law and the society contract between nursing and society.

SELF-ASSESSMENT EXERCISE

i. Differentiate between ethics and etiquette.
   a. The mother of an AIDS patient knows that her son is seriously ill but does not know the diagnosis. One day, she asks the nurse if he is dying saying she's afraid he has Leukemia. What should the nurse do?
   b. Discuss your opinion with others and check it in line with the code of conduct for nurse number 2.

ii. Mention 2 congruent situations:……..….

iii Mention 2 conflict situations:……...

4.0 CONCLUSION

Both nursing and ethics are in state of profound transition. Regarding nursing, the scope of nursing practice and how nurses are reimbursed for their care are changing with ethics. During the past several decades, classical ethical theories and associated principles dominated. Today, feminist ethics and the ethics of care are coming into their own. Both are transformative ethics which are best articulated and developed from the outset with a keen awareness of multicultural and global perspectives in a search for and an understanding of common humanity. A detailed lecture on Nurse and the Law in this course will further shed light on the legal implications of nursing practice and the consequences of neglect or negligence since the code of nursing practice maintains that the primary ethical obligation is to the patient.

5.0 SUMMARY

This unit has examined extensively the ethical issues in nursing with clear definition of nursing codes of conducts, ethical concepts applied to nursing, Patients' Bill of Rights, and the interrelationships of ethics and the Law to guide the nurse in the discharge of her nursing roles to the clients.

6.0 TUTOR-MARKED ASSIGNMENT

List the fourfold fundamental responsibility of ethical concepts for nurses. Briefly state the International Council of nurses' code of ethics.

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UNIT 4 LEGAL ASPECTS OF PROFESSIONAL NURSING I

CONTENTS

I.0 INTRODUCTION

We live in a changing world and nothing is really static. Indeed, the only thing that is permanent in life is change. It is therefore an open truth that the wind of change is blowing over every aspect of life including nursing professional practice. There are changes in orientation and standards of practice. The present unit, therefore, aims at introducing learners to the legal framework of nursing to broaden the learner's horizon on legal intricacies in nursing practice.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

- discuss the impact of law on nursing practice
- enumerate legal responsibilities of nurses in delivering client care
- explain legal concepts that apply to nurses.

3.0 MAIN CONTENT

3.1 Nature of Law

Right from creation, every society, primitive or civilized, is governed by a body of rules which members of the society regard as standards of behaviour. It is when such rules involve the idea of obligation that they become law. As such laws can be defined as those standards of human

conducts established and reinforced by the authority of an organized society through its government. Bernzweig (1996) defined it as 'those rules made by human, which regulate social conduct in a formally prescribed and legally binding manner'.

3.2 The Sources of Nigerian Law

Nigeria laws has its origin primarily from two sources namely:

a) Nigerian Legislation, which consist of:

- **Customary Laws –** This consist of customs accepted by members of the community as binding among them. Can be broadly classified into **Ethnic** (i.e. Non-Moslem) customary law and Moslem or **Sharia** law.
- **The Constitution** – This is an embodiment of principles upon which any state (i.e. nation) is governed. A document written or unwritten containing a body of rules that specifies the functions of different organs of government and their interrelationship with each other for good governance. All other laws take their validity from the constitution. As such the constitution is believed to be supreme to all other laws.
- **Judgments of Courts (Judicial Precedents)** – Decisions of the court of law. Judgments passed by courts of law usually serve as precedent for deciding similar cases in future (Decisional Laws). This principle of following precedent in settling legal tussles is known as the doctrine of '*Stare Decisis'* meaning to stand as decided or previous decision stands.
- **Statutes (Statutory Law)** – Decisions made by legal democratic institutions whether at National, State or Local level. They are laws enacted by the legislative arm of government and are usually politically inclined. Nigerian statutes include: (i) Ordinances (ii) Acts (iii) Law (iv) Decrees (v) Edicts.
- **Rules and Legislation (Administrative Law)** – These are promulgated by groups who are appointed to governmental administrative agencies, and who are entrusted with enforcing the statutory laws passed by the legislature.

(b) Received English Law, which encompasses:

- **Common Law –** Historically, these are laws made common to the whole of England and Wales after the Norman Conquest of 1066 and which following its full establishment was imported to all British colonial territories, Nigeria inclusive. With time the common law became so stringent, harsh and crafty so much that justice could not be done in all cases. This inability of the common

law to render fair decisions in all cases provoked the emergence of Equity.

- **The Doctrine of Equity –** Body of rules or principles laid down in the court of Chancery before 1873 that are intended to supplement the common law by providing new rights and new remedies and by ameliorating the common law where this was too rigid, harsh and inflexible. Its emergence tremendously contributed to the fairness of court decisions in England and her colonial territories.

- **Statutes of General Application in force in England on January 1, 1960**.
- **Statutes and subsidiary legislation on specified matters**.

Types of Nigerian Laws/Classification of Nigerian Laws

Nigerian laws can be broadly classified into three main categories viz:
Public Law – Public law refers to the body of law that deals with relationships between individuals and the government and governmental agencies. The different types of public law are outlined below:

(a) **Constitutional Law –** The laws of the federal republic of Nigeria is set forth in the Nigerian constitution.

(b) **Administrative Law –** The Nurse Practice Act, The Pharmacy Law, Food and Drug Administration and Control Act etc., are all examples of administrative laws.

(c) **Criminal Law –** These are sets of rules or statutes, which deals with how a society as a whole should behave. Criminal law addresses acts against the safety and welfare of the public. That is criminal offence is against the state. Prosecution is therefore by the state represented by the Commissioner of Police or Director of Public Prosecutions or Attorney General. Note that an individual can occasionally institute a criminal action in the court. The objective is to convict by the way of fine, imprisonment or both or death. The prosecutor however has to prove the guilt of the accused beyond all reasonable doubt. Perhaps it should be added that an accused cannot agree with the state to withdraw a criminal case already in court but the Attorney General can enter '*Nolle Prosequi*' and thereby withdraw the case from court (Babajide, 2001).

(d) **Civil Law –** The phrase 'civil' has several meanings. It may be taken to mean a branch of the law of a country that governs the relations that exist between citizens themselves i.e., concerned with the protection of individual rights of members of society. It may even be viewed as laws made to direct the affairs of workers

and government functionaries i.e., Government Order. Call it civilian law and one may not be wrong as the word civil to those in the armed forces denotes anything that is not peculiar to the military. Civil laws therefore encompass all laws that deals with crimes against a person or persons in such legal matters as contracts, torts, mercantile law, and protective/reporting law. Most cases of malpractice fall within the civil law of torts. Civil wrong is a breach of individual's right (Martin, 1998; Flight, 1993).

The individual who brings a civil action in court is called a plaintiff while the person for whom action is brought against is known as the defendant. The whole essence of civil suit is to compensate the victim of the civil wrong complained about. The standard of proof in civil cases is based on balance of probabilities. And unlike the criminal case, civil suit can be withdrawn from the court by the parties and be settled out-of-court.

(e) Customary Law – As earlier mentioned these are customs (written or unwritten) that are accepted by members of the community as binding among them. Can be broadly classified into **Ethnic** (i.e. Non-Moslem) customary law and Moslem or **Sharia** law. The ethnic customary law is indigenous and applies to members of a particular ethnic group. The Sharia law on the other hand is a religious law. It is based on Islamic injunction or Islamic doctrine and has its own principles which are Islamic oriented. It is basically applicable to members of the Islamic faith.

3.3 Functions of Law in Nursing and Legal Responsibilities of Professional Nurses

Functions of the Law in Nursing

Berman, etal. (2016) declared the following as the functions of law in nursing:

i. It provides a framework for establishing which nursing actions in the care of clients are legal.
ii. It differentiates the nurse's responsibilities from those of other health professionals.
iii. It helps establish the boundaries of independent nursing action.
iv. It assists in maintaining a standard of nursing practice by making nurses accountable under the law.
v. It serves as a professional update of client's/patient's legal rights.

Legal Roles of Professional Nurses

Nurses have three separate, interdependent legal roles, each with associated rights and responsibilities as provider of service, employee or contractor for service, and citizen (Berman, et. al. 2016)

Provider of Service – The nurse is legally responsible to ensure that the client receives competent, safe, and holistic care. To ensure this and to avert possible liability nurses are expected to:

- Render care based on their education, experience and circumstances. The standard of care by which a nurse acts or fails to act are legally defined by the nurse practice acts and by the rule of reasonable and prudent action i.e., what a reasonable and prudent professional with similar preparation and experience would do in similar circumstances.
- Discuss with the client the associated risks and outcomes inherent in the plan of care as well as alternate treatment modalities.
- Maintain clinical competence and refuse to carry out orders that would be injurious to the client.
- Document the care the client receives and other significant events affecting the client. (Berman, et al. 2016).

Employee or Contractor for Service – In all nurse-patient relationships, the nurse holds the patient/client a duty of care. Personal inconvenience and personal problems are not legitimate reasons for failing to fulfill this contract whether as an independent practitioner or as an employee. The nurse employed by a hospital functions within the policies of the employing agency. According to Berman, et. al. (2016) this type of legal relationship creates the ancient legal doctrine known as **respondent superior** ('let the master answer'). In other words, the master assumes responsibility for the conduct of the servant (employee) and can also be held responsible for malpractice by the employee. This doctrine does not however imply that the nurse cannot be held liable as an individual nor does it exonerate her in cases where her actions are extra-ordinarily inappropriate, that is beyond those expected or foreseen by the employer. In a nutshell, the nurse has obligation to her employer, the client, and other personnel.

Citizen – The rights and responsibilities of the nurse in the role of citizen are the same as those of any individual under the legal system. Rights are privileges or fundamental power to which an individual is entitled unless they are revoked by law or given up voluntarily; responsibilities are obligations associated with these rights. An understanding of these rights and responsibilities associated with them will therefore promote legally responsible conduct and practice by nurses (Berman, et. al. 2016).

3.4 Regulation of Nursing Practice in Nigeria

The Nursing and Midwifery Council of Nigeria established by decree 89 of 1979 and variously amended by decree 54 of 1988, decree 18 of 1989 and decree 83 of 1992, is saddled with the responsibility of regulating nursing practice in Nigeria. This specifies the functions and administration of the nursing and midwifery council of Nigeria. The major functions include Registration, regulation of professional standard, training and discipline.

3.5 Contractual Arrangements in Nursing

Nature of a Contract: A contract may simply be defined as a legally binding agreement (oral or written) between two or more competent persons, on sufficient consideration (remuneration), to do or not to do some lawful act. Implicit in this definition is that an agreement between two or more parties is of the essence of a contract. Consequently, the general principle is that no party can derive any benefit from a contract or have any obligation imposed on him by it unless he is a party to the contract. A contract then is the basis of the relationship between a nurse and an employer. Contract may be implied or expressed. A contract is considered to be expressed when the two parties discuss and agree orally or in writing to its terms, for example, that a nurse will work at a hospital for a stated length of time and under stated conditions. An implied contract on the other hand, has not been explicitly agreed to by the parties but that the law nevertheless considers existing. For instance, in the contractual relationship between the nurse and the patients, the patients have the right to expect that the nurse caring for them have the competence to meet their needs. The nurse also has the associated right to expect the patient to provide accurate information as required (Berman, et. al. 2016). It is important to mention at this juncture that it is not all agreement that one enters into that is legally binding.

The following are a few examples:

- A gentle man's agreement.
- Agreement between family and friends relating to purely social or domestic matters.
- An agreement to marry commonly known as engagement.
- Agreement made under duress.

Essentials of a Contract: A valid contract requires the following five elements

- Offer
- Acceptance – the assent of the parties/persons involved.

- There must be a valid consideration or something of value, in most cases financial compensation for fulfilling the terms of the contract.
- The parties to the contract must have contractual capacity i.e. must be of legal age and must possess mental capacity to understand the requirement of the contract.
- Intention to enter into a legal relationship which in most cases are presumed by the parties' conduct, must be manifestly seen.

SELF-ASSESSMENT EXERCISE

i. List Nigerian laws and their classifications.
ii. What are the legal roles of professional nurses.

4.0 CONCLUSION

In conclusion, law in nursing provides a framework for establishing which nursing actions in the care of clients are legal, establishes the boundaries of independent nursing action, and helps in maintaining a standard of nursing practice by making nurses accountable under the law.

5.0 SUMMARY

The unit opens with a succinct background on the need for nurses to become conversant with legal concepts affecting the practice of nursing. It portrays laws as rules made by human, which regulate social conduct in a formally prescribed and legally binding manner. That is law defines and limit relationships among individuals and the government. The unit contends that Nigerian laws are from two major sources: Nigerian legislation and Received English laws, and they can be classified into three broad groups namely: Public law, Civil law and Customary law.

6.0 TUTOR-MARKED ASSIGNMENT

Outline the need for Law in professional practice today and the legal responsibilities of a professional nurse. Discuss the concept of contractual agreement in nursing.

7.0 REFERENCES/FURTHER READING

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UNIT 5 LEGAL ASPECTS OF PROFESSIONAL NURSING II

CONTENTS

1.0 INTRODUCTION

One of the direct consequences of the changes in life patterns talked about in the preceding unit is that, the employers and clientele now expect a level of excellence of practice from the professional. The public also becomes better informed than ever about their rights. This in addition to the subtle but complex legal relationship that is in existence in many countries of the world, therefore, demands that a nurse has an understanding of basic legal concepts as they affect the practice of her profession.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

- explain legal concepts that apply to nursing
- identify areas of potential liability in nursing practice and actions nurses can implement to avoid these problems
- differentiate between unprofessional conduct and negligence
- distinguish between tort and crime
- explain the role of the nurse in the informed consent process.
- discuss how privileged communication applies to the nurse-client relationship
- discuss advance directives and differentiate between living will, directive to physicians, and durable power of attorney.

3.0 MAIN CONTENT

3.1 Selected Legal Aspects of Nursing Practice

(a) Confidential Communication

Medical and nursing practice is built on a relationship of trust and confidence in which the patient might disclose many things of confidential nature, which this undertakes to regard as a professional secret. It is not uncommon to find such privileged information to be given to a professional nurse who is forbidden by law not to divulge without the consent of the patient who provided it This relationship is imperative if the patient is not going to be afraid to seek advice from the nurse and if nurses are to be free to ask any question that they consider to be germane to the management of the patient. This rule is also entrenched in the nurses' code of ethics, which states that – *The nurse safeguards the individuals' right to privacy by judiciously protecting information of a confidential nature, sharing only that information relevant to his care.*

There are however exceptions to this rule. And that takes us to the question – when can we divulge such information?

(i) When compelled by the law: – Courts
- Notifiable diseases
- Vital statistics such as births and deaths

(ii) With the consent of the patient.

(iii) Where there is a public duty of disclosure, for example armed robbery cases or in a forensic case; an epileptic patient who may be a driver; or in a case of child or elder abuse.

(iv) Where the interest of the health personnel requires it, for instance patients' refusal to pay bill.

(b) Informed Consent

The law has long recognized that individuals have the right to be free from bodily intrusions. This perhaps informs the inculcation of informed consent into medical practice. The doctrine of informed consent not only requires that a person be given all relevant information required to reach a decision regarding treatment but also that the person be capable of understanding the relevant information regarding various treatment modalities so that the consent can be truly an informed process. Therefore, informed consent can be described as an agreement by a client to allow a course of treatment or a procedure to be carried out on him after complete information, has been provided to him by a health care provider, including the risks of such treatment and facts relating to it.

There are basically two types of consent: *express* and *implied* **Express consent** may either be oral or verbal. **Implied consent** is an assumed consent and it exist when the individual's non-verbal behavior indicates agreement. Examples of implied consent include:

- Tubal ligation in a grand multiparous woman whose attitude suggest acceptance of procedure.
- During surgery when additional procedures are needed that are consistent with the procedure already consented to.
- When clients continue to participate in therapy without removing previous consent.

Obtaining an informed consent for a medical or surgical procedure is the responsibility of a physician although this responsibility is delegated to nurses in some agencies. The nurses' responsibility is to witness the giving of informed consent for medical procedure. This involves the following:

- Witnessing the exchange between the client and the physician
- Establishing that the client really understands i.e. was really informed.
- Witnessing the signature.

In addition, nurses may play a role in decision-making through teaching, counselling, and clarifying issues with the patient but should not be made to provide medical information. This said, there are instances where the nurses themselves have to assume the responsibility of obtaining informed consent, especially when the procedure to be performed is purely nursing like passing a nasogastric tube, medication administration, and so on.

There is a common misconception that only written consent is legal or valid. On the contrary, oral consent is equally binding. Furthermore, the fact that consent is written is not the proof that the consent is informed or valid, but it can be useful evidence that a discussion between the nurse/doctor and the patient/client took place. In fact, written consent can give a false sense of reassurance especially when the wordings of such consent are vague and meaningless. Therefore, the legal issue in litigation is precisely what the client was told and not the procedural aspects of signing the form. What then are the essential elements of an informed consent?

- The consent must be given voluntarily, not coerced.
- The client must be of the age of maturity and must be mentally competent.

- The client must be given enough information to be ultimate decision maker.

Sometimes, the amount and type of information required for a client to make an informed decision can be challenging. Kozier et.al. (2000) gave the following as general guidelines:

- The purposes of treatment
- What the client can expect to feel or experience
- The intended benefits of treatment
- Possible risks or negative outcomes of the treatment
- Advantages and disadvantages of possible alternatives to the treatment (including no treatment).

It should also be noted that it is not in all cases that consent is required. Outlined below are instances when consent may not be required:

- **Prisoners –** No legal right in court
- **On a court order –** If the court orders that certain procedures be carried out on a client.
- **Immigrants –** Screening procedure to ensure safety of citizens.
- Milk and Food Handlers- Screen procedures for the health of the generality of people.

(c) Controlled Substances

In Nigeria like any part of the world, the law of the nation regulates the distribution and use of controlled substances such as narcotics, stimulants, etc. Misuse of controlled substances therefore attracts criminal penalties. The law also requires that record be kept on dispensing narcotics. Hence the wisdom behind keeping these substances in double locked cupboards in most hospitals with special logbook for documenting their administration?

(d) Advance Directives

Lowe (1995) expressed that to preserve a patient's rights, all healthcare workers need to be aware of the patient's wishes regarding continuing, withholding, or withdrawing treatment in the event the patient cannot make these decisions for himself or herself. Caulfield (1995) quoting the Omnibus Reconciliation Act of 1990 tagged Patient Self Determination Act defines an advanced directive as a written instruction such as living will or durable power of attorney for health care, that is recognized under state law and is related to the provision of such care when individual is incapacitated. Consequently, there are three types of advance directives viz:

A living Will – This is a written and legally witnessed document prepared by a competent adult instructing a health worker to withhold or withdraw life-sustaining procedures in a person in event of the person's incapacitation or becoming unable to make decisions personally.

Durable Power of Attorney (Health Care Proxy) – This is an authorization that enables a competent individual to name someone to make medical decisions for him/her in the event the individual is unable to make those decisions. This designated person does not necessarily be a relative.

Advance Care Medical Directive – This is also a document made by the client in consultation with the physician and other advisors that authorizes the physician to be the decision-maker in matters concerning his/her medical care. The physician must also agree in writing, to accept to be the client's agent.

What are the nurses' responsibilities in advanced directives?

- Understand the different types of advanced directives.
- Know the laws relating to the Patient Self-Determination Act.
- Obtain assistance if the patient wishes to change an advanced directive, as the person's health or desires change.
- Teach patient so informed decisions can be made.
- Inform patients that they have the right to refuse treatment or can refuse life-prolonging treatment but still receive palliative care and pain control. (Caulfield, 1995).

3.2 Liability in Nursing Practice

The term liability connotes a sense of obligation or legal responsibility one incurs for one's acts (or inaction) including financial restitution for harms resulting from negligent acts, deliberate commission of a forbidden act or omission of an act required by law. We live in an information age and the public are not only better informed now than ever before about their rights but do seek redress/damages (legal claims) where such rights are infringed upon. As such tort liability (intentional and unintentional torts) has become the subject of most litigations against nurses and other health care providers. A tort is a civil wrong committed against a person or a person's property. Legally, it connotes wrongful doings by one citizen against another, serious enough to merit the award of compensation to the person affected (the victim). Intentional torts include malicious prosecution, invasion of privacy, defamation, assault and battery, and false imprisonment. Unintentional torts include Negligence and Malpractice.

Negligence – This is one of the most common lawsuits instigated by patients. Because the society attaches great weight to a determination that conduct is or is not negligent, an objective and fair a standard as possible must be established for measurement of such conduct. A search for the above culminated in the emergence of "the reasonably prudent man concept", whose hypothetical conduct is the standard against which all other conduct is judged. Negligence therefore is defined as 'the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do'.

A more lucid definition is – 'the failure of a professional person to act following the prevalent professional standards or failure to foresee possibilities and consequences that a professional person having the necessary skills and training would note in her area of knowledge and practice. Potential areas of negligence include performing nursing procedures that you have not been taught; failing to meet established standards for the safe care of the patient; failing to prevent injury to patients, hospital employees and visitors; to mention a few.

Parameters for Negligence: For negligence to be established there are four things otherwise called element of negligence that must be critically looked at. They are:

- Owe a duty of care (contractual engagement)
- Breach of the duty of care
- The client suffers an injury or loss
- The breach is the proximate cause of harm/loss

The general rule is that the plaintiff must be able to establish the aforementioned points before negligence can be ascertained. The ultimate goal of law in negligence is to compensate the person who was injured by the wrongful conduct of the other person. It is not to penalize or punish the other person even though that is what is indirectly done.

Malpractice The term malpractice refers to behaviour of a professional person's wrongful conduct, improper discharge of professional duties or failure to meet the standards of acceptable care, which result in harm to another person (Zerwekh & Claborn, 1994). Stated differently, malpractice constitutes any professional misconduct, unreasonable lack of skill or fidelity in professional duties, evil practice, or illegal or immoral conduct which results in injury or death to the patient. To hold a nurse responsible for damages, it must be proved that the defendant failed to Self-Assessment Exercise the degree of skill and care required by the law.

Liability of Hospitals for Negligence of Nurses (Vicarious Liability)

Although a patient can sue a nurse directly in action for negligence, in practice this is often not the case. Generally, the patient/client will sue the hospital or employing institution where the nurse works under the principle of vicarious liability/respondent superior literarily translated as 'let the master answer'. This is because it is assumed that an employer should ensure the competency of its staff. As such the employing institution is held liable for negligent actions of its staff. This however does not totally exonerate the nurse from litigation as she can be added as a second defendant.

Exemptions to this rule are:

- Where the nurse commits clear-cut professional mistakes.
- In the case of a private hospital, where the hospital obtains the services of competent hands (nurses and physicians) and provides proper apparatus for treatment of clients.
- In cases of visiting nurses who have been selected with due care but are not servants of the hospital governor.
- Where the nurse is operating independently; not an employee of a hospital probably engaged and paid by the patient.

Defamation – This is the act of discrediting the reputation of someone else i.e., an act of creating wrong or false impression of somebody – negative connotation or giving wrong picture of another individual. Defamatory statements, whether oral or written, pictured or otherwise communicated therefore are those which tend to expose a person to hatred, contempt, aversion, disrespect and the likes. The most common examples of this tort are giving out inaccurate or inappropriate information from the medical record; discussing clients, families or visitors in public places or speaking negatively about co-workers (Zerwekh & Claborn, 1994; Caulfield, 1995).

Defamation can occur in two ways namely: *Slander* and *libel. Slander* is the term given to malicious verbal statements or defamatory statements made in a non-permanent form e.g. during a conversation, a gesture, sign language. *Libel* on the other hand is defamation by means of prints, writing, pictures, cartoons, broadcast, or telecast from a prepared print that are more permanent. Since libel can be broader in its application, it is generally actionable without the plaintiff's need to show special damages. There to avoid incessant litigations secondary to defamation, every member of the health team should refrain from idle conversations, gossip and inaccurate reports.

Assault and Battery – These two terms are often used together but each has a separate meaning. Assault is described as an intentional and unlawful offer or threat to touch a person in an offensive, insulting, or physically intimidating manner. For instance, a nurse who threatens a client with an injection after the client has refused oral medication may be committing assault. The battery is the willful touching or intentional harmful or offensive contact with another person without consent or with consent exceeded or fraudulently obtained. The term embraces such things as striking and beating another person but excludes accidental bumping of persons. In nursing care, giving an injection against the patient's will; forcing a patient out of bed; and wanton use of physical restraints, all constitute battery.

The legal issues arising from assault and battery are usually based on consent, in terms of whether the client agreed to the touching that occurred. In order not to be held liable for assault and battery, the nurse must respect the client's/patient's cultural values, beliefs, and practices and ethnic orientation. In the U.S, as a safeguard against assault and battery, adults are asked to sign a general permission for care and treatment on admission while additional written consent are obtained for special procedures.

False Imprisonment – Illegal detention as it is sometimes called means unlawful detention or intentional confinement without authorization. It occurs when clients are made to wrongfully believe they cannot leave a place. The most common example is telling a client not to leave the hospital until the bill is paid. Other examples are the use of physical or chemical restraints and threats of physical or emotional harm without legal justification. Note that restraints are legal only if they are necessary to protect the client or others from harm. The law mandates that the use of restraints or seclusion must have a physician order. False imprisonment must however not be confused with statutory authority which permits hospitals to quarantine for a limited time patients suffering from contagious diseases.

Of course, occasions may arise in health care relationships that necessitate the extension of period of admission. In such situations, nurses should only counsel with the patient on the need to stay rather than detaining patients against their will. The point to be made is that patient has the right to insist on leaving even though it may be detrimental to their health. The only rational and lawful thing that could be done is to make the patient to sign an absence without authority form (AWA) or discharge against medical advice (DAMA) form.

Invasion of Privacy – The right to privacy is the right of individuals to withhold themselves and their live from public scrutiny. Encroachment

upon this right without a person's consent constitutes an invasion of privacy and it is actionable. Medical instances where privacy laws may be violated include photographing a patient without consent, revealing a patient's name in a public report, allowing an unauthorized person to observe the patient's care. To this end, nurses must always obtain patient's permission before disclosing any information regarding the patient, going through patient's personal belongings, performing procedures, and photographing the patient.

3.4 The Nurse and the Criminal Law

As earlier stated, a crime is an act committed in violation of public law and is punishable by fine and/or imprisonment in a state or federal penitentiary. Crimes are mainly of two types: a **felony** (a crime of serious nature, such as murder and manslaughter, arson and armed robbery, usually punishable by imprisonment) and **misdemeanors** (crime of less serious nature punishable by imposition of fines or imprisonment for less than a year).

Murder is defined as direct and deliberate killing of an innocent person (a person who has not forfeited his right to life); death is intended as end or means. It is an unjust killing, done without legitimate authority. It excludes killing criminals on authority of the state; the soldier killing the enemy in war; and killing in self-defense (excusable homicide). Because murder is morally wrong, the practice of *Euthanasia* (mercy killing) whether active or passive euthanasia, has come under great criticism over the years and the moral argument is that it violates the right of God who has exclusive full ownership over human life.

Manslaughter is an unintentional killing (accidental killing). Manslaughter in the first degree include cases where the victim is killed while the defendant was engaged in the commission or attempt to commit a misdemeanor affecting the person or property of the killed person or another. This embraces cases where there is willful killing of a viable fetus by injury inflicted on the mother, as in abortion deaths. Manslaughter in the second degree involves culpable negligence of a drunken doctor or nurse.

SELF-ASSESSMENT EXERCISE

Discuss three legal concepts that apply to nursing practice.

4.0 CONCLUSION

The significance of law in professional nursing practice cannot be overemphasized. The fact that ignorance is not a defense in law has therefore makes it mandatory for nurses to acquaint themselves with legal concepts and issues relating to their practice. In pursuance of this lofty objective, this unit has provided a compendium of legal issues emanating from nurse-patient and nurse employers relationship. It is believed that if attention is given to these seemingly trivial but delicate issues, nurses will be able to wade off a lot of potential litigations.

5.0 SUMMARY

It contends that all nurses must know the law that applies to their area of practice.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is negligence and how does it differ from malpractices? Identify and explain the key legal issues in professional negligence that will assist the court to award damages.
2. It is no exaggeration that nurse is the closest set of health practitioners to the patients and indeed the group that stay longest with the patients. However, this in itself tends to open them to liabilities. As a nurse clinician, give a succinct discussion of legal safeguards in nursing.

7.0 REFERENCES/FURTHER READING

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MODULE 2 THEORIES AND MODELS IN NURSING

UNIT 1 CONCEPTS, PRINCIPLES, THEORIES AND MODELS IN NURSING

CONTENT

1.0 INTRODUCTION

In this unit, you will be learning about the definition of *concept, principle, theory, framework* and *model* in nursing. It is important to note that as the profession emerged over the years, nursing continues to identify its own unique body of knowledge. In identifying this body of knowledge various concepts, models and theories specific to nursing were developed.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- define concept, theory and model
- identify the characteristics of each
- identify the relationship between concept, theory and model
- describe a model in health
- list at list five goals of nursing model.

3.0 MAIN CONTENT

Many nurses use these terms without much understanding so it is important to discuss them. Are you familiar with these words? These words would have been used in earlier units too. The words will be defined and examples in nursing given. Let us examine each one:

3.1 Definition of concept

The first definition is that *concepts* are vehicles of thought that involve images: abstract, notions similar to the definition of ideas. The second definition says, it is a complex mental formulation of an object, property or even that is derived from individual perception and experience.
Is the use of the word new to you? Concepts are also used in chemistry, physics and even in other subject matters.

SELF-ASSESSMENT EXERCISE

Think of other subject areas you are familiar with. Write two examples of concept that you know.

Since the discussion in the unit includes theory let us add a third definition that links concepts and theory, third definition is that concepts are words that describe objects' properties, or events and are the basic components of theory. Note that the use of the word concept is not new in nursing and that it has been part of the historical background of nursing. It has been in use for over fifty years. Concepts can be classified for better understanding.

3.1.1 Categories of concepts

Empirical: These are the concepts that can be easily observed in the real world. Examples of empirical concepts are boat, cups, drinking glasses table, male, female, etc.

Inferential concepts: These are indirectly observable concepts. Examples are pain, blood pressure.

Abstract concepts: These are the concepts that are not observable such as health stress, man to represent all humans, needs, empathy adaptation, and stimuli. It may be difficult to classify some, what you should note is that the more abstract the concept the more difficult it is to understand its meaning.

The next thing to learn is for you to list some of the characteristics of concepts.

3.1.2 Characteristics of concepts

Concepts create images abstract in nature. They can have different meanings and interpretations. Individual perception, previous learning and experience, especially the abstract ones, affect the concepts.

- Concepts must be sufficiently described to ensure that the image one attempts to project is clear.
- A concept can be in association or related with another to increase clarity.

3.1.3 Nursing concepts that determine practice

In our discussion on philosophy some concepts were mentioned for writing good philosophy. Nursing philosophy, as you remember influences nursing practice. The following concepts are significant in nursing and nurses must understand them.

- The human or individual
- Society/environment
- Health
- Nursing

These have been discussed in other units. Amongst these concepts the core of the practice of nursing is the individual, it is from the client that the other nursing concepts arise. Without any of these concepts nursing cannot evolve either as a science or professional practice. Below is a figure on interrelation- ship among the concepts, Study the figure, note the double direction of the arrows, which show the interrelationships.

3.2 Theory

The next aspect of the discussion is on theories. Theories are also not new in Nursing. They have been provided and used since the period of Florence Nightingale. The theories in Nursing are either borrowed, adopted or theories by nurse theorists. Within nursing and many disciplines, the meaning of theory varies and this is due to the search for truth and clarity. Before defining the word, it is important to examine the evolution of the word.

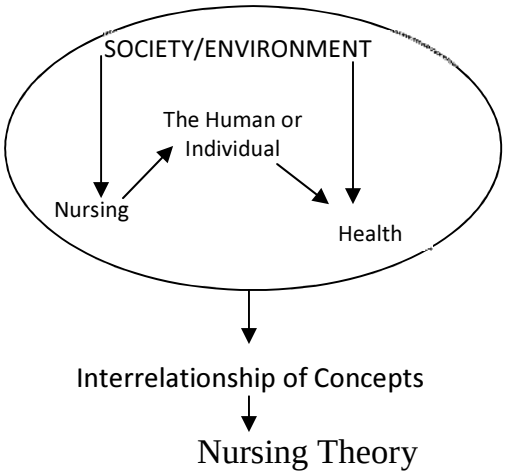


Fig. 1: Concepts essential to practice

Theory is derived from the Greek word 'theoria' signifying a "vision". You will be familiar with theories in other science disciplines like mathematics, physics and chemistry.

3.2.1 Definition

Within the context of nursing Kerlinger views theories as a set of interrelated concepts that give a systematic view of phenomena (an observable fact even), that is explanatory and predictive. It can also be defined as a systematic way of looking at the world to describe explain, predict or control it.

What are the common elements in these definitions?

3.2.2 Elements

Theories are comprised of concepts (see Fig. 1).

- They can describe, explain, predict.
- They are testable
- They are needed by all disciplines
- They are needed for research
- They are needed for practice

As mentioned earlier use of theories had been since the inception of Nursing as a profession. It is worth noting that the first group of theories used in nursing were theories from other disciplines like physical science e.g., gas laws, developmental theories from social science Maslow's theory from motivational theory in management, and so on.

What does this mean? It means that in nursing you will find some borrowed theories, some adopted and as the nursing discipline matured nursing theories by nurse theorists emerged. Examples are Orem (1971) *Self-Care Theory*, Henderson (1955) *Theory*, Peplau (1951).
NOTE: Theories are not laws or facts.

Having done the above self-assessment exercise let us discuss why we need to know about theories in nursing.

3.2.3 Purpose/function of theories

Theories serve the following purposes:

- To develop the body of knowledge in nursing
- To describe, explain, predict and control events
- To analyse client care situations
- To communicate in coherent and meaningful ways.

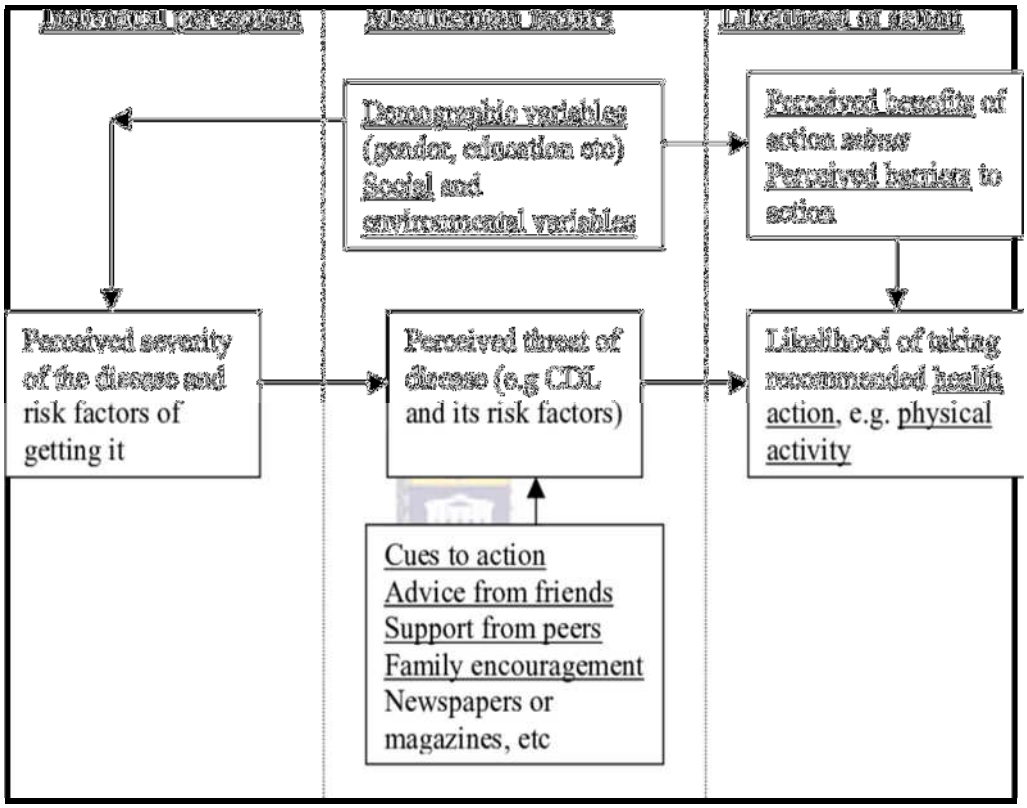
Nursing theories do describe and explain the human condition in terms of environment and illness but are limited in their ability to predict or control a nursing situation. This is also true for sociological and psychological ones. More detailed discussions on theories in nursing will be provided in the next unit. Let us look at what models are and their uses in nursing.

3.3 Models

As a child you probably played with models of cars, teddies, dolls and so on. Also, in your science classes in school, you used models of various body parts and other models.

3.3.1 Definitions of models

Models can be referred to as representations of the interaction among and between concepts showing patterns of these interactions. A miniature representation of a real object but it also has all parts and the way the parts interrelate is the same. A model can also be viewed as a theoretical way of understanding a concept or idea, Health and illness are complex abstract concepts as already highlighted to you in the earlier discussion in other units. Model of a health illness continuum can be drawn to facilitate the understanding and the relationship. between these concepts. For example, health belief model, health promotion model, below demonstrates the relationship between these" various complex concepts.



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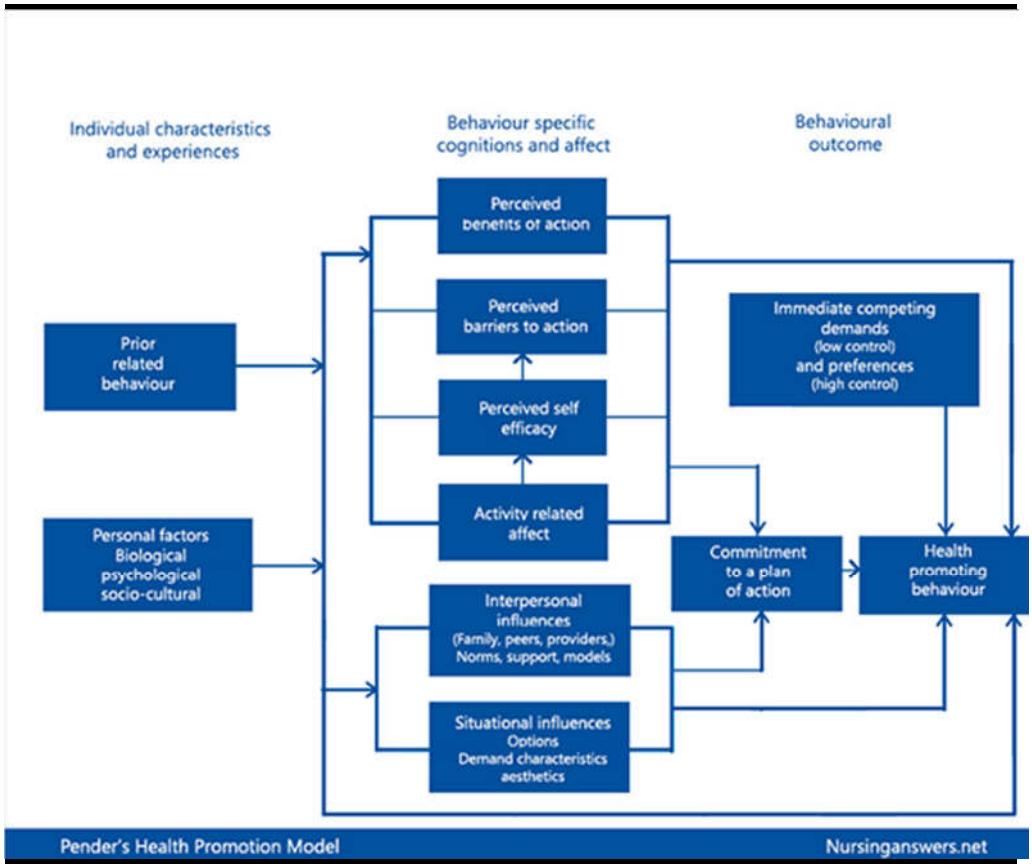

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3.3.2 Purpose of models

- To understand the relationship between concepts and client attitude and reaction.
- To understand client health behaviour.
- To allow nurses to understand and predict client health behavior including how they use health services and comply with therapy
- Used to provide knowledge to improve practice.
- Guide research and curricula and identify domain of nursing.

This unit will not be complete without talking about conceptual and theoretical models in nursing practice. One of these models will be used in discussion on nursing process in the next unit.

3.3.3 Conceptual and theoretical models

Models have been explained, theories and concepts discussed so you probably will agree that conceptual and theoretical nursing models are used to provide knowledge to improve practice, guide research and curricula and identify the domains and goals of nursing practice. Concepts make up theories so in essence theoretical models will consist of concepts. Below are the goals of theoretical model as highlighted in Potter and Perry (1993).

Goals of theoretical nursing model

- Guide research to establish empirical knowledge base for nursing. Identify area to be studied.
- Identify research techniques and tools that will be used to validate nursing interventions
- Identify nature of the contribution that research will make to the advancement of knowledge.
- Formulate legislation governing nursing practice. Research and education.
- Formulate regulations interpreting nurse practice acts so that nurses and others better understand laws.
- Develop curriculum plans for nursing education.
- Establish criteria for measuring quality of nursing care education and research.
- Prepare job descriptions used by employers and nurses.
- Guide development of nursing care delivery system.
- Provide knowledge to improve nursing administration, practice education and research.
- Provide systematic structure and rationale for nursing activities.
- Identify the domain and goals of nursing.

At your level, conceptual framework cannot be explained in great detail but references will be made to this discussion in other units.

SELF-ASSESSMENT EXERCISE

i. In your own words define concept and give two examples of each category.
ii. In your own words define theory and give two examples of theory that you have used in the past.
iii. Define theory within the context of nursing. List 4 elements of theory list two nursing theories and two from other disciplines, but used in nursing.
iv. Define models in your own words and list four examples of models that you had used in the past.

4.0 CONCLUSION

It is worth noting that nursing knowledge is interrelated and interdependent that no knowledge should be compartmentalized or forgotten after completion. References will always be made to theories at all points of nursing practice and research.

5.0 SUMMARY

We have been discussing concepts, theories, and models in Nursing. They have all been defined, their purposes and examples given. Conceptual or theoretical models and their goals in nursing are highlighted.

6.0 TUTOR-MARKED ASSIGNMENT

1. What do you understand by:
- Concepts
- Theories
- Models
2. Describe five elements of a theory.
3. Highlight 5 purposes of model.
4. List 5 goals of theoretical nursing model.

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UNIT 2 THEORIES IN NURSING

CONTENT

1.0 INTRODUCTION

Theory and Nursing have been defined and discussed in the earlier Unit. The focus of this Unit will be on historical development of theories in Nursing. Nursing theorists and their theories and some other theories from other disciplines are commonly used in Nursing. As you are aware that nursing is a relatively young profession and the body of knowledge continues to be developed through theory building, research to test it and through utilization in practice to improve care. The process of theory development is complex for this level but simply it starts with identification of the concepts which should be clearly defined and related concepts put together to form propositions. The detailed process will be discussed in other courses. It is important to note that theory development is the backbone of the nursing profession.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- identify the historical development of theories in nursing
- identify at least five nursing theories
- discuss briefly five nursing theories, and one other theory used in nursing
- list at least four characteristics of a theory
- discuss the role of theory in nursing.

3.0 Main Content

3.1 Historical Development

The development of theories in nursing and some of the theorist would have been briefly mentioned in the Unit on Historical Development of Nursing. You would have come across same theorist with Florence Nightingale being in the forefront.

A review of the last 120 years according to Potter and Perry (1993) has witnessed a demonstration of the development of a growing body of knowledge in Nursing. The genesis and need for theory in nursing can be traced to the mother of nursing Nightingale (1860) who advocated for professional knowledge. Her practice was based on taking care of the environment while nature is allowed to look after the physiological processes in clients. After her demise nursing lost the tempo and drive instilled by Nightingale until the mid-1950s. This was due to the 2nd World War and economic recession.

Information from the history of nursing and nursing education claimed that nursing education in higher institutions started in 1912 in Columbia University in the United States. These scholars were equipped with knowledge of research and theory development. They started to promote nursing research in nursing education and practice. These scholars from the Columbia University Teachers' college launched the nursing research journal in 1952. Among these scholars were Peplau, Henderson, Hall, Abdellah King, Roger, etc.

The drive for theory development was emphasized in the 1960 to 70s. Nursing was further defined as a process rather than an end, an interaction, rather than content and a relationship between two human beings rather than an interaction between unrelated nurse and patient. In 1965 also American Nurses Association (ANA) position paper emphasized that the goal of nursing was theory development. In the USA, federal support was given for degrees in Nursing. Series of symposia were also organized for theory development by National League for Nurses between 1960 and 1970.

3.2 Nursing theories in perspective

Below is a table of the summary of Nursing theories in chronological order and applicability in nursing practice. It is totally beyond this Unit to discuss each of the theories in great detail but each will be briefly discussed. The theory will be further discussed and used in major nursing

courses like medical/surgical nursing, nursing research, community health nursing, etc.

Theorist	Goal of Nursing	Framework for Practice
Nightingale (1960)	To facilitate "the body reparative processes" by manipulating client environment (Torres, 1986)	Client's environment is manipulated to include appropriate noise, nutrition, hygiene, light, comfort, socialization and hope
Peplau (1952)	To develop interaction between nurse and client (Peplau, 1952)	Nursing is significant, therapeutic, interpersonal process (Stockmann, 2005). Nursing participate in structuring health care systems to facilitate natural ongoing tendency of humans to develop interpersonal relationship (Hancock, 2000)
Henderson (1955)	To work interdependently with other health care workers (Hancock, 2000), assisting clients to gain independence as quickly as possible (Henderson, 1964). To help clients gain lacking strength (Stockmann, 2005)	Nurses helps client to perform Henderson's 14 basic needs (Henderson, 1966)
Abdella (1960)	To provide service to individual, families, and society. To be kind and caring but also intelligent, competent, and technically well prepared to provide this service (Hancock, 2000)	This Theory involves Abdella's 21 Nursing problems (Abdella et al, 1960)
Orlando (1961)	To respond not client's behaviour in terms of immediate needs by identifying client's behaviour, reaction of nurse, and nursing	Three elements including client behaviour, nurse reaction, and nurse action, compose nursing situation (Orlando, 1961)

	action to be taken (Torres, 1986; Chinn & Jacob, 1987)	
Hall (1962)	To provide care and comfort to client during disease process (Torres, 1986	The client is composed of the following overlapping parts: person (core), pathology state and treatment (cure), and body (care). Nurse is a care givers (Chinn & Jacob, 1987; Hancock, 2000)
Wiedenback (1964)	To assist individuals in overcoming obstacles that interfere with the ability to meet demands or needs brought about by condition, environment, situation or time (Torres, 1986)	Nursing as practice is related to individuals who need helps because of a behavioural stimulus. Clinical nursing has the following components: Philosophy, Purpose, practice and art (Chinn & Jacob, 1987)
Levine (1966)	To use conservation activities aimed at optimal use of client's resources	This adaptation model of human as integral whole is based on "four conservation principles of nursing" (Levine, 1973)
Johnson (1968)	To reduce stress so that client can move more easily through recovery process	This basic need framework focuses on seven categories of behaviour. Individual's goals is to achieve behavioural balance and steady by adjustment and adaptation to certain forces (Johnson, 1980)
Theorist	**Goal of Nursing**	**Framework for Practice**
Rogers (1970)	To maintain and promote health, prevent illness, and care for the rehabilitate ill and disable client through "humanistic science of nursing" (Rogers, 1970)	"Unitary man" evolves along life process. Client continuously changes and coexists with environment
Orem (1971)	To care for and help the client attain total self-care	This is the self-care deficit theory. Nursing care becomes necessary when client is unable to fulfill

		biological, psychological, developmental, or social need (Orem, 1985)
King (1971)	To use communication to help client re-establish positive adaptation to environment	Nursing process is defined as a dynamic interpersonal process between nurse, client, and health care system
Travelbee (1971)	To assist individual or family to prevent or cope with illness, regain health, find meaning in illness, or mainatain maximal degree of health (Marriner-Tomey, 1989)	Interpersonal process is viewed as human-to-human relationship formed during illness and "experience of suffering"
Neuman (1972)	To assist individuals, families and groups to attain and maintain maximal degree of health (Marriner-Tomey, 1989)	Stress reduction is goal of systems model of nursing practice (Torres, 1986). Nursing actions are in primary, secondary, or tertiary level of prevention.
Roy (1979)	To identify types of demands placed on client, assess adaptation to demands, and help client adapt.	This adaptation model is based on the physiological, psychological, sociological, dependence and independence adaptive modes (Roy, 1980)
Patterson and Zderad (1976)	To respond to human needs and build humanistic nursing science (Patterson & Zderad, 1976; Chinn & Jacob, 1987)	Humanistic nursing requires participants to be aware of their uniqueness and commonality with others (Chinn & Jacob, 1987)
Leininger (1978)	To provide care consistent with nursing emerging science and knowledge with caring as central focus (Chinn & Jacob, 1987)	With this trans-cultural care theory, caring is central and unifying domain for nursing knowledge and practice (Leininger, 1980)
Watson (1979)	To promote health, restore client to health, and prevent illness	This theory involves philosophy and science of caring, caring is

	(Marriner-Tomey, 1989)	interpersonal process comprising interventions that results in meeting human needs (Torres, 1986)
Parse (1981)	To focus on man as living unity and man's qualitative participation with health experience (Parse, 1981); Nursing as science and art (Marriner-Tomey, 1989)	Man continually interact with the environment and participates in maintenance of health (Marriner-Tomey, 1989). Health is continual, open process rather than state of well-being or absence of disease (Parse, 1981; Marriner-Tomey, 1989; Chinn & Jacobs, 1987)

Source: Potter and Perry, (2009)

3.3 Highlight of some theories

Hear we will examine some of the nursing theories briefly for this level of the course. Note the basic contribution of each. The discussion will be in the following order as highlighted by Potter & Perry (1993).

- Nightingale theory
- Peplau' s theory
- Henderson's theory
- Abdellah' s theory
- Orlando's theory
- Lenine's theory
- Johnson's theory
- Roger's theory
- Orem' s theory
- King's theory
- Newman's theory
- Roy's
- Watson's

Nightingale's theory

Contemporary authors are beginning to explore Florence Nightingale's work as a potential theoretical and conceptual model for nursing. Nightingale's concept of environment as the focus of nursing care and her view that nurses need not know all about the disease process are early attempts to differentiate between nursing and medicine.

Nightingale did not view nursing as limited merely to the administration of medication and treatments but rather as oriented towards providing fresh air, light, warmth, cleanliness, quit e and adequate nutrition. Through observation and data collection, she linked the client's health status with environmental factors and, as a result, initiated improved hygiene and sanitary conditions during the Crimean war.

Torres (1986) notes that Nightingale provided basic concepts and propositions that could be validated and used for practice in nursing. Nightingale's "descriptive theory" provides nurses with a way to think about nursing or a frame of reference that focuses on patients and environment. Nightingale's letters and writings direct the nurse to act on the behalf of the client. Her principles encompass the areas of practice, research, and education. Most importantly, her concepts and principles shaped and delineated nursing practice. Nightingale taught and used the nursing process, noting that "vital observation (assessment) ...is not for the sake of piling up miscellaneous information of curious facts, but for the sake of saving lives and increasing health and comfort".

Peplau's theory

Hildegard Peplau's theory (1952) focused on the individual nurse, and interactive process. The result is the nurse-client relationship. According to this theory the client is an individual with a felt need, and nursing is an interpersonal and therapeutic process. Nursing goal is to educate the client and family and to help the client reach mature personality development. Therefore, the nurse strives to develop a nurse-client relationship in which the nurse serves as a resource person, counselor, and surrogate.

When the client seeks help, the nurse first discusses the nature of the problem and explains the services available. As the nurse-client relationship develops, the nurse and client mutually define the problems and potential solutions. The client gains from this relationship by using available services to meet, needs, and nurses assist the client in reducing anxiety related to the health care problem. Peplau' s theory is unique in that the collaborative nurse-client relationship creates a "maturing force" through which interpersonal effectiveness assists in meeting the client's needs. When the original needs have been resolved, new needs may emerge. The nurse-client interpersonal relationship is characterized by the following overlapping phases: orientation identification, explanation, and resolution.

Peplau's theory and ideas were developed to provide a design for the practice of psychiatric nursing but it is used in nursing generally. Nursing research on anxiety, empathy, behavioral tools, and tools to evaluate verbal response resulted from Peplau's conceptual model.

Henderson's theory

Virginia Henderson's nursing theory (1955) involves basic needs of the whole person. Henderson (1964) defines nursing as assisting the individual sick or well in the performance of those activities contributing to health or its recovery...that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.

The following needs, often called Henderson's 14 basic needs, provide a framework for nursing care and during this period are still applicable today.

- Breathe normally.
- Eat and drink adequately.
- Eliminate by all avenues of elimination
- Move and maintain a desirable position.
- Sleep and rest.
- Select suitable clothing; dress and undress.
- Maintain body temperature within normal range.
- Keep the body clean and well-groomed.
- Avoid dangers in the environment.
- Communicate with others.
- Worship according to faith
- Work at something that provides a sense of accomplishment.
- Play or participate in various forms of recreation.
- Learn, discover, or satisfy the curiosity that leads to normal development and health.

Abdellah's theory

The nursing theory developed by Faye Abdellah et al (1960) emphasizes delivering nursing care for the whole person to meet the physical, emotional, intellectual, social, and spiritual needs of the client and family. When using this approach, the nurse needs knowledge and skills in interpersonal relations, psychology, growth and development, communication, and sociology, as well as knowledge of the basic sciences and specific nursing skills. The nurse is a problem solver and decision-maker. The nurse formulates an individualized view of the client's needs, which may occur in following areas.

- Comfort. Hygiene, and safety
- Physiological balance
- Psychological and social factors
- Sociological and community factors

In these four areas, Abdellah *etal* (1960) identified the following specific client needs, which are often referred to as Abdellah's 21 nursing problems.

- To maintain good hygiene and physical comfort
- To achieve optimal activity, exercise, rest, and sleep
- To prevent accident, injury, or other trauma and prevent the spread of infection
- To maintain good body mechanics and prevent and correct deformities
- To facilitate the supply of oxygen to all body cells
- To facilitate the maintenance of nutrition to all body cells
- To facilitate the maintenance of elimination
- To facilitate the maintenance of fluid and electrolyte balance.
- To recognize the physiological responses of the body to disease conditions-pathological, physiological, and compensatory
- To facilitate the maintenance of regulatory mechanisms and functions
- To facilitate the maintenance of sensory function
- To identify and accept positive and negative expressions, feelings, and reactions.
- To facilitate the maintenance of effective verbal and nonverbal communication.
- To facilitate the development of productive interpersonal relationship
- To facilitate progress toward achievement of personal spiritual goals
- To create and/or maintain a therapeutic environment of personal spiritual goals
- To create and/or maintain a therapeutic environment
- To facilitate awareness of the self as an individual with varying physical, emotional, and developmental needs.
- To accept the optimum possible goals in light of limitations physical and emotional
- To use community resources as an aid in resolving problems arising from illness
- To understand the role of social problems as influencing factors in the cause illness

Orlando's theory

Idea Orlando (1961) viewed the client is an individual with a need that, when met, diminished distress increased adequacy, or enhanced wellbeing. Orlando's theory focused on nurses' reactions to client behaviour in term of the client's immediate needs. Orlando's theory contains three concepts for professional action, and nurse actions-

compose the nursing situation. After nurses thoroughly assess the client's needs, they recognize the impact of that need on the client's level of health and then act automatically or deliberately to meet the need, which ultimately reduces the client distress.

Levine's theory

Myra Levine's nursing theory, formulated in 1966 and published in 1973, views the client as an integrated being who interacts with and adapts to the i environment. Levine believes that nursing intervention is a conservation activity, with conservation of energy as a primary concern. Health is viewed in terms of the conservation of energy in the following areas, which Levine calls the four conservation principles of nursing.

- Conservation of client energy
- Conservation of structural integrity
- Conservation of personal integrity
- Conservation of social integrity

With this approach, nursing care involves conservation activities aimed at the optimal use of the client's resources. Each principle will be discussed in medical surgical Nursing.

Johnson's theory

Dorothy Johnson's theory of nursing (1968) focuses on how the client adapts to illness and how actual or potential stress can affect the ability to adapt. The goal of nursing is to reduce stress so that the client can move more easily through recovery. Johnson's theory focuses on basic needs in terms of the following categories of behavior:

- Security-seeking behavior
- Nurturance-seeking behavior
- Master of oneself and one's environment according to internalized standards of excellence
- Taking in nourishment in societally and culturally acceptable ways
- Ridding the body of waste in socially and culturally acceptable ways Sexual and role-identity behaviour
- Self-protective behavior

According to Johnson, the nurse assesses the client's needs in these categories of behavior, called behavioral subsystems. Under normal conditions the client functions effectively in the environment. When stress disrupts normal adaptation, however, behavior becomes erratic and less purposeful. The nurse identifies this inability to adapt and provides nursing care to resolve problems in meeting the client's needs.

Rogers' theory

In her theory, Martha Rogers (1979) considers man (unitary human being) as an energy field coexisting within the universe. Man is in continuous interaction with the environment. In addition, man is a unified whole, possessing personal integrity and manifesting characteristics that are more than the sum of the parts. Unitary man is a "four-dimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from the knowledge of parts" The four dimensions used in Rogers' theory-energy fields, openness, pattern and organization, are used to derive principles about how human beings develop. Roger's views nursing primarily as a science and is committed to nursing research. Nursing therefore incorporates knowledge of the basic science and physiology, as well as nursing knowledge:

The science of nursing aims to provide a body of abstract knowledge growing out of scientific research and logical analysis capable of being translated into nursing practice. Nursing body of scientific knowledge is a new product specific to nursing …. Nursing is a humanistic science. Reflect on knowledge from basic sciences.

Orem's theory

Dorothea Orem (1971) developed a definition of nursing that emphasizes the client's self-care needs. Orem describes her philosophy of nursing in the following way:

Nursing has as a special concern man's needs for self-care action and the provision and management of it continuously to sustain life and health, recover from disease or injury, and cope with their effects. Self-care is a requirement of every person-man, woman, and child. When self-care is not maintained, illness, disease, or death will occur. Nurses sometimes manage and maintain required self-care continually for persons who are totally incapacitated. In other instances, nurses help persons to maintain required self-care by performing some but not all care measures, by supervising others who assist patients, and by instructing and guiding individuals as they gradually move toward self-care.

Thus, the goal of Orem' s theory is helping the client perform self-care. According to Orem, nursing care is necessary when the client is unable to fulfill biological, psychological, developmental, or social needs. The nurse determines why a client is unable to meet these needs, what must be done to enable the client to meet them, and how much self-care the client is able to perform.

King's theory

Imogene King's theory (1971) focused on the interpersonal relationship between client and nurse. The nurse-client relationship is the vehicle for the nursing process, which is a dynamic interpersonal process in which the nurse and client are affected by each other's behavior, as well as by the health care system (King, 1971). The nurse's goal is to use communication to assist the client in reestablishing or maintaining a positive adaptation to the environment.

Neuman's theory

Betty Neuman (1972) defined a total-person model incorporating the holistic concept and an open-systems approach. To Neuman, the person is a dynamic composite of physiological, socio-cultural, and developmental variables that function as an open system. As an open system, the person interacts with, adjusts to, and is adjusted by the environment, which is viewed as a stressor. Stressors disrupt the system. Neuman's model included intra-personal, inter-personal, and extra personal stressors. Intra-personal stressors are forces occurring within the person; interpersonal stressors such as role expectations occur between persons, and extra-personal stressors such as financial circum- stances occur outside the person.

Neuman believes that nursing is concerned with the whole person. The goal of nursing is to assist individuals, families, and groups in attaining and maintaining a maximal level of total wellness (Neuman, Young, 1977). The nurse assesses, manages, and evaluates client symptoms. Nursing focuses on the variables affecting the client's response to the stressor. Nursing actions are in the primary, secondary, and tertiary levels of prevention. Primary prevention focuses on strengthening a line of defense through the identification of actual or potential risk factors associated with stressors. Secondary prevention strengthens internal defenses and resources by establishing priorities and treatment plans for identified symptoms, and tertiary prevention focuses on re-adaptation. The principal goal in tertiary prevention is to strengthen resistance to stressors through client education and to assist in preventing a recurrence of the stress response.

Roy's theory

Sister Callista Roy's adaptation theory (Roy, 1979; Roy, 1980) viewed the client as an adaptive system. According to Roy's model, the goal of nursing is to help the person adapt to changes in physiological needs, self-concept, role function, and interdependent relations during health and illness. The need for nursing care arises when the client cannot adapt to

internal and external environmental demands. All individuals must adapt to the following demands:

- Meeting basic physiological needs
- Developing a positive self-concept
- Performing social roles
- Achieving a balance between dependence and independence.

The nurse determines what demands are causing problems for a client and assesses how well the client is adapting to them. Nursing care is then directed at helping the client adapt.

Watson's theory

Watson's philosophy of caring (1979) attempts to define the outcome of nursing activity regarding the humanistic aspects of life. The action of nursing is directed at understanding the interrelationship between health, illness, and human behavior. Nursing is concerned with promoting and restoring health and preventing illness.

Watson's model is designed around the caring process, which she defines as 10 "curative" factors. Each factor describes the caring process of how a client attains or maintains health or dies peacefully. Caring represents all of the factors the nurse uses to deliver health care to the client.
The basic focus of all these theories is meeting the needs of clear or assisting clients to overcome health problems within the health-illness continuum. The importance of providing holistic care scientifically is also emphasized.

3.4 Theories from other disciplines

Now let us examine other common theories used in Nursing but from other disciplines. Among them are developmental theories from psychology, Maslow's hierarchy of human needs, which is a motivational theory.

Table 2: Summary of Development According to Stage Theorists

FREUD'S PSYCHOSEXUAL THEORY

Stages and Ages	**Characteristics of Stages**	**Theory Addendum**
Oral-sensory (birth to 12-18 months infancy	Activities involving mouth such as sucking, biting, and chewing are chief source of pleasure	Child deprived of sufficient sucking might attempt to satisfy this need later in life through activities such as gum chewing, smoking, and overeating.
Anal-muscular (12-18 months 3yr.) toddler hood	Sensual gratification is derived from retention and expulsion of feces. Smearing is common activity	External conflict may be encountered when toilet training is attempted and later result in behaviours such as constipation, tardiness, or stinginess
Phallic-locomotion (3-6yr) pre-school	Manipulation of genitalia results in pleasurable sensations. Masturbation begins and sexual curiosity becomes evident	Emergence of Oedipus and Electra complexes for male and female respectively, occurs. Brashness, bashfulness, and timidity may be expressions of fixation at this stage
Latency (6yr to puberty) school-age	This is tranquil period when Freud believed sexual drives were dormant; however, child may engage in erogenous activities with same-sex peers	Child's use of coping and defense mechanisms emerge at this time; and sexual interest may be sublimated through vigorous play and skill acquisition
Genital (puberty through adulthood) adolescence and adult-hood)	Genitalia become center of sexual tension and pleasure. Sexual hormone production stimulates development of heterosexual relationship	This is time of biological upheaval, when immature emotional interactions often occur in early phase. In time, ability to give and receive mature love develops

ERIKSON'S PSYCHOSOCIAL THEORY

Stages and Ages	**Characteristics of Stages**	**Theory Addendum**
Trust versus mistrust (birth to 1yr) (infancy)	Care giver's satisfaction of infant's basic needs for food and sucking, warmth	When basic needs of infant are not met or are met inadequately, infant becomes suspicious,

Mode: taking in and getting Virtue: hope	and comfort, and love and security consistently and sensitively results in trust	fearful, and mistrusting. This is evidenced by poor eating, sleeping, and elimination behaviours
Autonomy versus doubt and shame (1-3yr) (toddlerhood) Mode: holding on and letting go Virtue: will	Child develops beginning independence while gaining control over bodily functions of undressing and dressing, walking, talking, feeding self, and toileting. Self-control begins.	If toddler's developing independence is discouraged by parents, child may doubt personal abilities; if child is made to feel bad when attempts to be autonomous fail, child develop shame
Initiative versus guide (3-6yr) (preschool) Mode: Intrusive attack and conquest Virtue: purpose	Child develops initiative when planning and trying out new things. Behaviour of child is characterized as vigorous, imaginative, and intrusive. Conscience and identification with same-sex parent develop	Parental restrictiveness may prevent child from developing initiative. Guilt may arise when child undertakes activities in conflict with those of parents. Child must learn to initiate activities without infringing on rights of others
Industry versus inferiority (6-12 yr to puberty) (school age) Mode: doing and producing Virtue: competence	Child wins recognition by demonstration of skill and production of things and develop self-esteem through achievements. Children is greatly influenced by teachers and school	Feeling of inferiority may occur when adult perceive child's attempt to learn how things work through manipulation to be silly or troublesome. Lack of success in school, development of physical skills, and making of friends also contribute to inferiority
Identity versus role confusion (puberty to 18-21) (adolescence) Virtue: fidelity	Individual develops integrated sense of "self." Peers have major influence over behaviour. Major decision is to determine a vocational goal.	Failure to develop sense of personal identity may lead to role confusion which often result in feeling of inadequacy, isolation and indecisiveness. Psychosocial moratorium

		provides extra time for making vocational decision
Intimacy versus isolation (18-21 to 40 yr) (young adulthood) Virtue: love	Task is to develop close and sharing relationship with others, which may include sexual partners	Individual unsure of self-identity will have difficulty developing intimacy. Person unwilling or unable to share self will be lonely
Generativity versus self-absorption or stagnation (40-65 yr) (middle adulthood)	Mature adult is concerned with establishing and guiding next generation. Adults looks beyond self and expresses concern for future of world in general.	Self-absorbed adults will be preoccupied with personal well-being and material gain. Preoccupation with self leads to stagnation of life
Ego integrity versus despair (65 yr to death) (Older adulthood) Mode: acceptance Virtue: wisdom	Older adult can look back with sense of satisfaction and acceptance of life and death	Unsuccessful resolution of this crisis may result in sense of despair in which individual views life as series of misfortunes, disappointments and failures

MASLOW'S THEORY OF HUMAN NEED

Stages and Ages	**Characteristics of Stages**	**Theory Addendum**
Physiological needs Safety needs Belongingness and love need Esteem needs Self-actualisation	Physiological needs include food, beverages and sleep. Satisfying safety needs allows individual to feel safe and secure. Belongingness allow individual to affiliate with and be accepted by others Esteem allows individual to gain approval of others Self-fulfillment potential is recognized.	Theory of motivation depict individual driven to fulfill potential, capacities, and talents to become unique being. Person moves up and down hierarchy as life situations change

Before ending this discussion on theories, you need to understand the basic characteristics, which are as follows.

3.5 Basic characteristics of a theory

- Theories are interrelating concepts to create a different view of the phenomena in the last Unit theory was defined as interrelated concepts. This interrelatedness between concepts can result in another dimension of view particular phenomena.
- Theories must be logical. This involves orderly reasoning and the inter-relationship between the concepts must be sequential.
- Theories should be relatively simple yet generalizable.
- Theories should he testable.
- Theories should assist to contribute to knowledge through research. Theories can be utilized by the practitioner to guide and improve practice
- Theories must be consistent with other theories.

3.6 Role of theory in nursing

- It is utilized in designing models for nursing practice
- It guides nursing practice either in health promotion maintenance or restoration.
- It guides future direction for research for improvement of care. . It assists in explaining approaches to practice.
- It provides knowledge to improve practice.
- It assists to identify domains and goals of nursing practice.

SELF-ASSESSMENT EXERCISE

i. Now in your own words describe each of the theories and list the common point amongst them.
ii. Study Table 2. *Stages* and *ages* refer to the normal, expected development which can be predicted because it is physiological within limits. Characteristics of stage refer to the normal expectation of the stage of development. *Theory addendum* refer to the various reaction and development in the individual.
iii. After the study, list the phases of development by friend and Erickson. What implication does it have for the nurse?

4.0 CONCLUSION

In this Unit, you have learned about theories in nursing. A brief historical development was given, various nursing theories and theories used in

nursing were discussed. The basic characteristics and the role of theory in nursing were highlighted.

5.0 SUMMARY

The role of theory in any discipline cannot be over-emphasized. The more theories are developed and tested the easier it will be to improve the quality of practice. It is the backbone of research for evidence-based practice. To improve the knowledge base of any discipline there should be a strong relationship between theory, research, and practice. The practical uses of theories will be further demonstrated in other courses as you advance in the program.

6.0 TUTOR-MARKED ASSIGNMENT

1. Briefly outline the historical development of nursing theories.
2. List five nurse theorists.
3. Discuss five nursing theories that you are conversant with.
4. Briefly discuss the importance of theory in nursing.

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UNIT 3 INTRODUCTION TO NURSING PROCESS AS A FRAMEWORK FOR NURSING PRACTICE

CONTENTS

1.0 INTRODUCTION

Now that you have learnt about concepts and theories, models and frameworks, this unit will provide you with information on the process of giving nursing care to client. The framework is called *Nursing Process.* This involves how information is obtained from clients/patients, the diagnosis of nursing problem and how plans are made to either give information to prevent reoccurrence of disease, care and ameliorate the suffering and then identify if the purpose of giving the care has been achieved. It is assumed that you now know that human beings are holistic comprising of

physical, physiological, social, emotional and spiritual dimensions (bio psychosocial beings).

When individuals respond to a given thing, condition, or incidence, it is usually as a whole person for instance, as the eye sees danger, the whole body gets ready and often the individual runs away from the danger. Also, when you are beaten in school for bad behavior it is not only the part that the cane touched that pains but also the whole of you, to the extent of crying. Your physical, physiological, social and emotional being had been disturbed by the beating.

2.0 OBJECTIVES

By the end of this, you will be able to:

- define the nursing process and identify the five phases
- list five benefits of nursing process
- list five purposes for using nursing process
- discuss each phase of the nursing process.

3.0 MAIN CONTENT

The Nursing Process is the underlying scheme that provides order and direction to nursing care. It is the essence of professional nursing practice. It is the tool and methodology of nursing practice and it assists the nurse in arriving at decisions, predicting and evaluating consequences. How is it defined?

3.1 Definition

It can be defined as a deliberate intellectual activity whereby the practice of nursing is approached in an orderly systematic manner. It is a scientific approach or problem-solving approach to nursing practice. It deals with problems specific to nurses and their clients where client may be an individual, family or community. To use the nursing process effectively, nurses need to understand and utilize appropriate concepts and theories from biological, physical and behavioral sciences. All these provide the framework. Students of nursing using the nursing process are learning to behave as professional nurses in practice. It is a very important tool for you to learn as a basis for practice. It does not only provide you with the methodology for diagnosing clients' problems, it provides means for evaluating the quality of nursing care given by nurses and assures their account- ability and responsibility to the client/patients. There are many definitions by various authors but let me quote the World Health Organization's (WHO) definition which says:

The nursing process is a term applied to a system of characteristic nursing interventions in the health of individuals, families and/or communities. In detail it involves the use of scientific methods for identifying the health needs of the patient/client/family or community and for using these to select those which can most effectively be met by nursing care; it also includes planning to meet these needs, provide the care and evaluate the results. The nurse in collaboration with other members of the health care team and the individual or groups being served, defines objectives, sets priorities, identifies care to be given and mobilizes resources. He/she then provides the nursing services whether directly or indirectly. Subsequently, he/she evaluates the outcome. The information feedback from evaluation of outcome should initiate desirable change in subsequent interventions in similar nursing care situations. In this way, nursing becomes a dynamic process lending itself to adaptation and improvements.

The process which means something is cyclic has 5 logical steps/phases, which consist of:

- Assessment
- Nursing diagnoses
- Planning
- Implementation
- Evaluation

The list above as said earlier is a forward movement through each discrete phase. It may not always follow but an assessment must always begin the process and leads to a nursing diagnosis. Nursing diagnosis is always derived from assessment. However, during diagnosis, planning, implementation and evaluation phases reassessment can lead to immediate changes in each of the phases. Reassessment may lead to a change in diagnosis, which could lead to a change in planning implementation and evaluation as the process continues (see Fig. 1 above). Practice also provides information. A holistic view during the assessment.

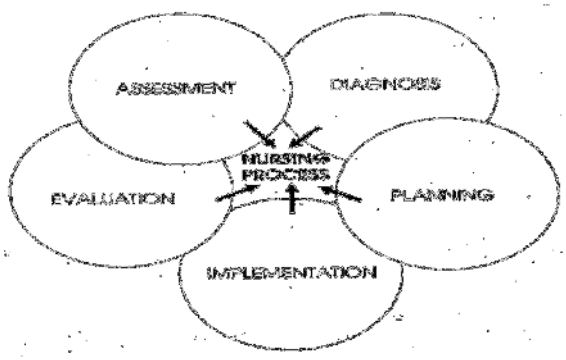

Fig. 1: The nursing process

3.2 Historical Development

The use of framework to guide practice started almost as early as the history of modem nursing, as you will discover in the following discussion. A framework for practice is to ensure some standardization and individualization of nursing care to clients. The philosophy of Nursing as earlier discussed include the fact that individuals are unique and each person responds in a unique way to situations including ill health.

Potter and Perry (1998) highlighted that the term *nursing process* was first introduced by Lydia Hall in 1955 although the term had been used in education and practice for 30 years. Hall described the client/nurse relation- ship as "nursing at, to, for: and with the client". While Hall was propounded her approach, other nurses' leaders like Dorothy Johnson (1959), Ida Orlando (1961) and Emestine (1963) (See Module on theories) introduced a 3-step nursing process model into nursing education and practice. The common thing in each of the model is the issue of the nurse first identifying or assessing clients' needs. Steps 2 and 3 were different and only Wiedenbach included evaluation as a component.

In 1967 another nurse leader called Lois Knoules presented a process model that she called five D's that is:

1. Discover
2. Delve
3. Decide
4. Do
5. Discriminate

These 5 steps are similar in a way to the current use of the nursing process. In 'Discover' and 'Delve' which are the first 2 phases, the nurse collects data or information on the health status of the client and then selects a plan of action on how to assist the client to resolve the health problem. (Decide) and the nurse carries it out (Do). In the last phase 'Discriminate' the nurse assesses the client reaction to the nursing care given.

In 1967 the Western Interstate Commission of Higher Education listed the steps in the process as perception, communication, interpretation, interaction and evaluation.

In 1969 Dolores Little and Dories Camevali used four steps in their care plan-Assessment, Planning, Implementation and Evaluation. In 1973, the concept of nursing diagnosis was introduced and the steps became five, that is, assessment, diagnosis, planning, implementation and evaluation.

Ever since the use of nursing process became an approach in clinical nursing practice for determining nursing care given to individual clients. It is a standard for practice and a requirement for accrediting many schools and practice setting in the United States. In Nigeria currently, only few hospitals are using it even though the Nursing and Midwifery Council has approved it, integrated it in curriculum and is required for licensure. You will be learning more about it as you progress in the course.

These were all attempts in the past by nurse leaders to provide a scientifically I sound process of providing nursing care. Remember nursing is an art and a t science. The art is the skill used and science is the scientific principles or rationale for doing what at a specific time (not trial and error, not intuition not guess work). Nursing actions are based on clinical judgement. Study the table below to identify the comparison of the nursing process with the other approaches of problem identification. The focus of nursing process is problem identification and resolution. Problem Solving and scientific method are also theoretical approaches used to identify and resolve problems in nursing and other professions.
Table 1: Steps in Problem *Solving,* the Scientific Method and the Nursing.

Table 1: Steps in Problem Solving, the Scientific Method and the Nursing

Problem solving	Scientific Method	Nursing Process
Encountering problem	Recognizing problem	Assessing
Collecting data	Collecting data	Formulating nursing diagnosis
Identifying exact nature of problem	Formulating hypothesis	Planning
Determining plan of action	Selecting plan for testing hypothesis	Implementing
Carrying out plan	Testing hypothesis	Evaluating
Carrying out plan evaluating plan in new situation.	Interpreting results	
	Evaluating hypothesis	

As a beginner, you need to know the purpose and advantages for the use of nursing process.

The purposes for using nursing process as a methodology for practice are:

- To identify the client's health needs
- Determine priorities of care, goals and expected outcome.
- Establish a nursing care plan to meet needs.
- Provide nursing interventions to meet needs
- Evaluate the effectiveness of nursing care in achieving client goals.

3.3 Assessment phase

This is the first phase in the nursing process with two sub-phases of data collection and analysis. Reflect on how you used to gather the various

chemicals together in your chemistry class before you start analyzing the reactions or results.

3.3.1 Definition

There are many definitions by nursing theorists and writers, but it can simply be defined as follows:

Assessment consists of systematic and orderly collection and analysis of data about the health status of the client to make nursing diagnosis. As mentioned earlier, a nursing diagnosis is derived from assessment. It is imperative that the data is comprehensive enough to provide holistic view and for correct diagnosis to be made, which also results to appropriate planning implementation and evaluation.

Accurate assessment is vital to the process and it is the basis for all other stages of the process. Accurate data is also needed for auditing and research. Several guidelines for systematic collection of data are available and Nigeria also has one.

3.3.2 Steps in assessment

The steps in assessment as the first phase of nursing process include:

- *Collecting data:* Gathering information about the client/patient.
- *Validating data:* Making sure your information is accurate.
- *Organizing data:* Clustering them into groups of information that help you identify pattern of health or illness.
- *Identifying patterns/testing first impressions:* Making a tentative decision about what a certain pattern of information may mean
- *Reporting and recording data:* Reporting and recording abnormalities to expedite treatment, recording assessment findings to communicate current status (Alfaro-LeFevre 1996).

These steps will only be listed here, without detailed discussion, which will come up in the other units of the Programme. As a beginner without knowledge of path physiology, anatomy and physiology details will be confusing at this stage.

The process of assessment itself can be categorized into:

- History taking physical examination
- Review of Records
- Nursing diagnostic procedures.
  Skills for effective assessment:
- Communication skills

- Interpersonal skills
- Observation skills
- Recording and reporting skills.

All these must be done in a conducive environment Details of all these will be provided in later units.

3.4 Nursing diagnosis

This is the second phase of the nursing process. It is derived from assessment.

3.4.1 Definition

There are many definitions by different experts in the field but, first, let us do an exercise.

SELF-ASSESSMENT EXERCISE

First check the word "diagnosis" in your English dictionary. Who can use it? Do some individuals only use it?
Answer

Nursing diagnosis is a decisive statement concerning the clients nursing needs. It is based on clients' concern and actual or potential (those that may occur in the future if action is not taken now) problems that may be symptoms of physiological disorder or behavioral, psychological, or spiritual problems. The diagnostic statement is derived from nurses' inferences from data gathering during assessment coupled with nursing, Science and humanistic concepts and theories. The diagnoses are ranked in order of priority based on Maslow's hierarchy of need, degree of threat to level of wellness and consideration for clients and family opinion. There is a diagnostic process details of which will be discussed in the next nursing course.

It is worth noting that nursing diagnosis is different from medical diagnosis even though, both are derived from physiological, psychological, socio-cultural, developmental and spiritual dimensions of the client (see Figure 1). Re-examine Carpenit's and Gordon's. It implies education, capability and licensure. It is something within nurses' jurisdiction to identify and treat. The word diagnosis is also used by other professionals like doctors, lawyers, so don't attribute the work to a particular profession.

Now, let us see how the experts define *nursing diagnosis:*

Abdella (1957). “The determination of the nature and extent of nursing problems presented by the individual patients or families receiving nursing care.”
Durand, Prince (1966) "A statement of a conclusion resulting from a recognition of a pattern derived from a nursing investigation of the patient".

Gebbie, Lavin (1975) "The judgement or conclusion that occurs as a result of nursing assessment.

Bircher (1975) "An independent nursing functions. ..An evaluation of a client' s personal responses to his human experience throughout the life cycle, be they developmental or accidental crises, illness, hardship, or other stresses."

Aspinall (1976) "A process of clinical inference from observed changes in patient's physical or psychological condition; if it is arrived at accurately and intelligently, it will lead to identification of the possible causes of symptomatology”. Gordon (1976)

"Actual or potential health problems which nurses, by their education and experience, are capable and licensed to treat." Roy (1982)
"Nursing diagnosis is a concise phrase or term summarizing a cluster of empirical indicators representing patterns of unitary man." Shoemaker (1984)

"A nursing diagnosis is a clinical judgement about an individual, family, or community which is derived through a deliberate, systematic process of data collection and analysis. It provides the basis for prescriptions for definitive therapy for which the nurse is accountable. It is expressed concisely and includes the etiology of the condition when known."

Capenito (1987)

"A nursing diagnosis is a statement that describes the human response (health state or actual/potential altered interaction pattern) of an individual or group which the nurse can legally identify and for which the nurse can order the definitive interventions to maintain the health state or to reduce, eliminate, or prevent alteration."

Nanda (1990) "A nursing diagnosis is a clinical judgement about individual, family, or community responses to actual and potential health problems and life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable."

Carlson *et al.* (1991) "Nursing diagnosis is a summary statement about the health status of a client(s) derived through the assessment process and requiring intervention from the domain of nursing."

Modified from Carlson J.H. et *al.*, *Nursing Diagnosis: A Casestudy* Approach, Philadelphia, 1991, Saunders.

3.4.2 Differences between medical diagnosis and nursing diagnosis

Medical	Nursing
It is the identification of a disease condition that the doctor is licensed to treat.	Statement of client actual or potential response to a health problem that the Nurse is licensed and competent to treat.
Goal is to identify and design a treatment plan for curing the disease ort pathological process.	Goal is to identify actual and potential client response to condition and design Individualized care.
Diagnosis is the same throughout illness	Diagnoses are many and changes as client problem are resolved.
It is often not holistic but disease oriented.	It focuses on total person within the context of family and community.

3.4.3 Advantages of Using Nursing Process

The benefits of using nursing process as a framework are both for clients and nursing profession.

- Client actively participates in his care.
- Care is comprehensive and individualized.
- Quality of care is provided.
- Encourages efficient use of nursing time and resources.
- Documentation of care is better.
- Nurses demonstrate professional competence, responsibility and accountability.

Now let us briefly examine each phase, the detailed description will be given later in another course.

3.5 Assessment scenario

An 18-year-old SS 2 girl came into a health center with complaints *of* vomiting, headache, backache, high temperature, inability *to* eat, sleep and rest. She is also worried about her examination that is coming up soon. Parents live in Abuja. Medical diagnosis after examination was Malaria. On physical examination, temperature was 39°C, p. 84, R22, B/P 100/70.

Blood sample shows malarial parasite +++

SELF-ASSESSMENT EXERCISE

From the above history, think of what actual nursing diagnosis will be and based on the complaints which are physiological and psychological to mention a few. Are your responses like these.

Complaints	**Possible Nursing Diagnosis**
Hot body temperature 390^{o}	Altered body temperature
Headache and body ache	Altered body comfort-pain
Vomiting, dry lips and mouth	Potential fluid volume deficit
Lack of sleep	Sleep pattern disturbance
Worried.	Anxiety.

Having studied the above table is nursing diagnosis different from medical diagnosis?

There is taxonomy of nursing diagnosis by North American Nursing Diagnosis Association; the organization has been designated from the development, utilization, monitoring, research and a clearing House for new diagnosis.

Diagnosis can be made on individual family or community (see the appendix for examples) Now let us go to the next phase of the process, which is planning

3.6 Planning

3.6.1 Definition

Planning is a universally used concept. It can be defined as the act or process of interpreting the facts of a situation, determining a line of action to be taken in the light of all facts and the objectives sought, detailing the steps to be taken in keeping with the action determined, making provision to establishing checks and balances to see how close performance comes to the plan (Arndt and Huckabay 1988).

Planning is the third phase of the nursing process. To plan is to project into the future what is to be done. The plan for providing nursing care is to determine what can be done to assist the client in preventing illness, maintaining health and reducing problems that have arisen.
It is very important as mentioned earlier to involve the client in everything you do with them for them and to them. Planning involves the mutual setting of goals and objectives, judging priorities and designing methods to resolve actual or potential problems. Planning like other phases has a process. The following are the steps in planning.

3.6.2 Steps in planning nursing care

Potter and Perry (1991) identified the following as the steps in planning:

1. Setting priority
2. Setting objectives
3. Selecting appropriate nursing interventions
4. Writing a care plan

3.6.3 Setting priority

What is priority setting? It is the process of establishing order or sequencing order in the delivery of nursing care. This is based on logic, concept and theory. Also, it is based on pressing needs of the client to sustain life.

Note that nursing diagnoses have been identified earlier. The nurse now arranges the diagnoses based on client's needs and well-being at that particular time. The decision is often based on the following:

- Actual life-threatening nature of condition
- Potential health-threatening condition
- Client's perception of problem
- Nursing Principles, concepts and theories.

Remember the lectures on concept principles and theories? Which of the theories is often used to guide priority setting? Maslow's hierarchy of needs.

Example:

A person who is ill is brought in by his relation and you observe that:

- He is bleeding slightly from an injury to the arm.
- He is not breathing properly
- Relative tells you he is complaining of hunger.

Based on Maslow's theory, which problem will you tackle first? Other information that may guide the nurse in setting priority are results of diagnostic examination and changes in the client's responses. As highlighted earlier, it is important to plan with our clients and family. In prioritization too, clients must be fully involved. How active they are during the period is dependent on their state of health. In clients that are acutely ill, the nurse takes responsibility for planning and setting priorities. He is gradually encouraged to be independent and take part as his health improves.

3.6.4 Setting objectives

What is an objective? This should not be new to you. Objectives or outcomes are used interchangeably. An objective describes an expected outcome, the behavior, which the client should be able to perform, and the condition under which the behavior is to occur. You will come across the concepts of goal, objective and outcome in other courses where it will be discussed in great detail. The change in time. Let us examine the types of objectives based on time frame.

Types of objectives: Short Term-they are objectives that the outcome are expected almost immediately, or within a short period or couple of hours to a day e.g., client temperature will reduce from 40° to 37°c within 2 hours.

Intermediate objectives are those that the expected outcome or changes in client's condition are expected within a few weeks to a month, e.g., client body weight will increase from 50kg-55kg within one month .

Long term objectives are changes in clients' condition or human responses as expected within months of care intervention e.g., client will be able to walk with crutches in 3 months. Please note that the way the objective is constructed makes it easy to evaluate at the end of 2 hours, 1month or 3 months. What then are the criteria for stating good objective or. how do you write a good statement that is focusing on the clients and clients' problems. Let us exalll1ne the process.

Component of an objective: Each objective must have a performer (client) j an action verb that describes the performance and standard and condition 1 if necessary, that is used to measure performance within a time frame e.g., client temperature will reduce from 40°c to 37°c in 2 hours.

The use of appropriate action verb makes the objective measurable e.g., "reduce" There are many verbs, but behavioral ones are better, e.g. identify, illustrate, demonstrate, etc.

Guideline for writing objectives:

- It should always begin with "client", "client will", for it to be client centred.
- It must be derived and relevant to the nursing diagnosis.
- It must be stated in behavioral terms, realistic, feasible, measurable, and achievable within a time frame.
- The objectives must be arranged serially based on priority.
- Words that are not open to several interpretations should be used.

You will need to practice setting the objective using examples of the assessment of a friend or colleague. Check nursing care plan in any medical-surgical textbook. Practice makes perfect. The next step in planning is:

3.6.5 Selecting appropriate nursing interventions

First, what are nursing interventions? Interventions are what the nurse plans to do to help the client or the nurse and client plan to meet the objective already stated which will promote health, prevent illness reduce the suffering or problem that client has brought, or assist him in adjusting to situations. Therefore, nursing interventions are planned ways based on science, nursing- science, theories, principles that nurse or nurse/client/family's choice to achieve already stated objectives. Since there are many things available to resolve a problem, the most appropriate ones for the nursing diagnoses must be selected. These scientifically-based ways of assisting a client resolve health problem, need, etc. are performed by nurses but some can be prescribed by other professionals like doctors. The intervention can therefore be within the independent role of the nurse or dependent (prescribed by doctors) or interdependent (Nurse, doctor Dietician). (These are terms you should be familiar with, if not, check them in the nursing text). The number of interventions varies depending on the objectives. These actions too must be sequential e.g., for a client that has fever-Nursing diagnosis-altered body temperature hypothermia (39) related to malarial infection.

Nursing action or intervention will include

- Removing blanket and client clothing
- Exposing and encouraging fluids
- Exposing and fanning-plus giving prescribed analgesic e.g. Panadol.

How quickly the fever goes down depends on each client's responses. What guides the nurses in choosing an action? The following will be a guide.

3.6.6 Guidelines for selecting appropriate nursing intervention/action/strategies

The planned action must be:

- Based on nursing and scientific knowledge
- Safe for the patient
- Within standard and policy stated

- Achievable with the available resources (materials, money and time)
- In line with other therapies.
- Agree with the client and client's cultural values and background.

All these are considered when actions are being planned by the nurse e.g. in the process of reducing fever in a woman, exposure-is scientific based-radiation (remember your physics) but her breasts will be covered in the process. She will not be stark naked.

The last phase in planning is writing a Nursing care plan. First, what is a care plan?

3.6.7 Writing a nursing care plan

A care plan can be defined as a written guideline for client care that is organized in such a manner that it provides at glance care that is being provided and will be provided. It is a blueprint of care being given because it contains nursing or independent, dependent and interdependent actions, which are all coordinated by the nurse. It is the basis for implementing and evaluating care given. This blueprint has various formats based on the institution and theory. In Nigeria the format consists of the following headings:

Format of Nursing Care Plan

Nursing Diagnosis	Objective	Intervention
Altered body Temperature Hyporthemia 40°C	Client body temperature will reduce from 40°C to 37°C in 2 hours.	— Expose — Fans — Give cold drinks (if allowed) — Monitor temperature half hourly and report — Give prescribed drugs-panadol, chloroquine etc.

The following headings are used in one way or the other by different institutions.
See examples of care plans in any current medical/surgical text;

- Nursing diagnoses
- Objectives or intended outcome.
- Nursing action/order/intervention
- Scientific principles/rationale
- Evaluation

Examine the example below
Nursing action as you observe from above are stated in Order form e.g. fan' client/monitor. Give prescribed drugs etc. Having planned you now carry out the order and this is now called implementation.

3.7 Implementation

This is the fourth step of the nursing process. According to the English dictionary, it means to put into effect according to a definite plan or procedure.

3.7.1 Definition

It refers to the action or actions initiated to accomplish the defined goals and objectives. It is the actual giving of nursing care e.g., exposing and fanning the client as stipulated in the nursing care plan. As mentioned earlier client may be a person, a group, family or community. We know that is a biopsychosocial being so nursing action can holistically be towards any of these.

The relationship between the client and nurse is dependent on the philosophy that the nurse and client have about human beings nurses and clients, interaction between nurses and client. If human beings are considered to be unique, then nursing action should reflect this uniqueness. Also, this phase draws heavily on intellectual interpersonal and technical skill of the nurse.

Actions for implementation are also prioritised as goals and plans. The nurse or assistant under the supervision of the nurse may carry out actions. The client and family can also carry actions as organized and agreed upon. George (1990) categorizes nursing action into:

- Counseling-teaching
- Providing physical care
- Therapeutic communication {verbal and non-verbal).
- Carrying out delegated medial therapy
- Co-ordination of resources
- Referral to other sources.

Nursing action must be initiated by nurses without direction because the nursing diagnosis is within nursing domain. Nurses must be clear about their independent and dependent roles. The implementation phase is completed when the nursing client is satisfied and recording done. Ensure that rights of parties are protected by seeking consent before intervention. Standard and quality is evident in the process of providing care, and its evaluation can be better measured by consumers.

3.8 Evaluation

Fifth and relative last phase of the nursing process because frequently it does not end the process. It may even start another chain of events.

3.8.1 Definition

The appraisal of the client's behavioral changes due to the actions of nurse. What is being evaluated are the objectives not the interventions or nursing actions. Such questions like the following can be asked.

- Were the goals and objectives met?
- Were there identifiable changes in client's behaviour?

If these are not affirmative, why? And what are the actions to be taken. For the objectives not fully achieved a reassessment is needed. Evaluation can be categories into three structure, process and outcome. Structure evaluation relates to appropriateness of equipment to carry out the plan. Process evaluation focuses on activities of the nurse as she provides care or at the end of it to ascertain the quality of care and standardization.

Outcome evaluation is based on behavioral changes. If you recall the earlier example of high temperature, the objective set was that: Clients temperature will reduce from 39°C to 37°c within 2 hours. To evaluate this objective, the temperature will be measured at the end of 2 hours and compared to ascertain whether objective is fully or partially achieved. The outcome of the measurement should be communicated to the client and a reassessment done if objective is not fully achieved to identify additional scientifically based nursing care to enhance achievement of goals. Structure and process evaluation are usually carried out by the nurse, other nursing administration or both within an agency. Evaluation can also be summative and formative. Summative evaluation occurs when the condition is being monitored before final the time stated in the objective e.g. within the 2 hours in the case of 1/2 hourly temperature taking. Describe a personal or friends situation of ill health. List the problems expressed. List steps taken by the nurse, the director and other health care providers. What was the medical diagnosis? What were the actions taken by the nurse?

SELF-ASSESSMENT EXERCISE

Differentiate between nursing and medical diagnosis.

4.0 CONCLUSION

The nursing process is a tool that all nurses in training must learn to use. For effective use of the process, the nurse needs to apply concepts and theories from nursing, biological, physical and behavioral sciences and humanities to provide a rational for clinical judgement. This is just overview of the process; more detailed discussion will be provided as you proceed in the programme. You will learn that the process has not been adopted nationwide in all clinical settings.

5.0 SUMMARY

We have been briefly discussing the basic tool of nursing practice called the nursing process. It was defined and the five steps identified and briefly discussed, the purpose and advantage were highlighted. Below is a summary of the steps of Nursing process.

Summary of Nursing Process

Component	Purpose	Steps
Assessment	To gather, verify, and communicate data about client so database basic is established.	1. Collecting nursing health history. 2. Performing physical examinatio 3. Collecting laboratory date 4. Validating data 5. Clustering data. 6. Documenting data.
Nursing diagnosis	To identify health care needs of client, to formulate nursing diagnoses.	1. Analyzing and interpreting 2. Identifying client problems 3. Formulating nursing diagnosis 4. Documenting nursing diagnosis
Planning	To identify client's goals, to determine priorities of care, to determine nursing strategies to achieve goals of care.	1. Identify client goals 2. Establishing expected outcomes 3. Selecting nursing actions 4. Delegating actions 5. Writing nursing care plan 6. Consulting
Implementation	To complete nursing actions necessary for accomplishing plan.	1. Reassessing client 2. Reviewing and modifying existing care plan. 3. Performing nursing actions
Evaluation	To determine extent to which goals of care have been achieved.	1. Comparing client response to criteria 2. Analyzing reasons for results for results and conclusions 3. Modifying care plan.

6.0 TUTOR MARKED ASSIGNMENT

1. a) What do you understand by the nursing process?
   b) List four reasons why the process must be learnt by the nurse in training.

c) List 3 benefits of nursing process to the client and 2 to the profession of nursing.

2. a) Compare and contrast 3 differences between medical and nursing diagnosis.
b) Discuss the phases of the nursing process?

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MODULE 3 NURSING AND CARING

UNIT 1 COMMUNICATION IN NURSING

CONTENT

1.0 INTRODUCTION

The importance of communication for effective nursing care delivery was highlighted in the last unit. Now a full discussion will be provided. A tool that stands out in our day-to-day life is communication. Communication is a process by which messages are transmitted from one person to another person or group to bring about changes in behavior. Communication is an expectation and the elements will give you a full picture required. A man perceives, sees and hears largely what he intends or plans to hence ideas; feelings or information when passed must be clearly expressed with appropriate words, information, body gestures and pronunciation.

Nursing activities are interactive. An understanding of communication will assist determine, plan and implement effective and efficient care based on nurse-client relationship.

In this unit, we shall explore the general concept of communication, the steps to healthy communication for the overall benefit of the sender (nurse) and the receiver (patient).

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- describe the concept of communication
- recall the process of communication for daily application in your routine nursing actions
- appraise the role of communication in the nurse-client relationship.

3.0 MAIN CONTENT

3.1 Types of Communication

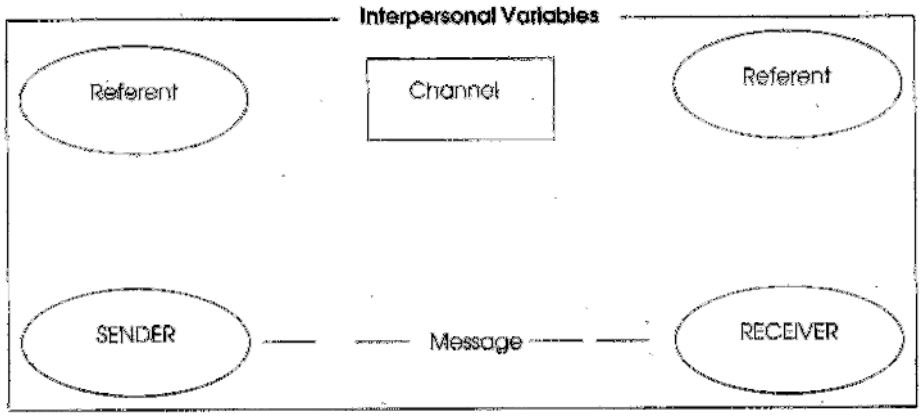
Communication is all we do to create understanding in the minds of others, to effect changes, motivate them, give information and entertain. Let's now examine various types/methods of communication.

a. *Verbal (oral communication):* This includes speaking, speeches, lectures and ward rounds (in the hospital).
b. *Non-verbal communication:* This includes facial expressions, gestures physical contact, voice tones, personal appearance, time and space management.
c. *Visual communication:* Logos as in billboards advertisement, stickers.
d. *Written communication:* Books, letters, ward reports, statistics (inpatient), internal memos, newspapers.
e. *Unwritten communication:* Covers (a + b)
f. *Use of information technology:* This includes computer, telephone, telex, fax, e-mail.

Nursing practice employs various types of communication identified above depending on the patient/client situation.

3.2 The process of communication

The key elements of the communication process are:
Communicator (sender)
Message (Channel of Communication)
Audience (Receiver)
This is S-M-R model of communication, which is used in nursing care.
Now examine this sketch showing the process of communication.



Communication between people occurs when one person (you or the paper you are reading now) has information he wants to transmit to another (You). Messages are sent either verbally or non-verbally (formally or informally) by one or more recipient sense organs-sight, touch, (Fill in the rest).

The co-stimulus is then sent to the brain where it is perceived (decided and interpreted). The perception results in some types of responses from the receiver. In the process, there could be noise, which could be from the sender, receiver, or objects around. Anything that distorts the process of communication is regarded as noise.

SELF-ASSESSMENT EXERCISE

i. Create an atmosphere of communication with your next-door neighbour.
ii. Employ the process of communication and identify sources of noise (if any).
iii. Now go into action and report back.

Face-to-face communication: Offers opportunity for feedback and clarification. The sender (you) must ensure that the message you are sending is clear, concise, no ambiguity with the proper medium.

3.3 Principles of communication

- The principles of communication to be kept in mind by all health professionals are:
- The Communicators and receiver's perceptions should be as close as possible (understand needs, views, and interests)
- The message must embody the objectives: the language must be simple, accurate, adequate, clear, specific, appropriate, timely and in tune with the mental and socio-economic level of the audience.

- Communication should be two-way: between the sender and the receiver with effective feedback.
- Communication should involve as many sense organs as possible (touch, smell, task, hearing and visual).
- Direct communication is more effective.

3.4 Steps in communication (Nursing)

Effective communication for health care (nursing) involves the transformation of health knowledge into messages which can be readily understood, accepted and put into action by intended audiences. The following steps will assist your communication skills in the practise of nursing.

1. Define clearly what you are trying to promote.
2. Decide exactly your target population e.g. mothers in antenatal in childcare and members of the family.
3. Knowledge about the present health and beliefs of the target audience.
4. Find out if the new behaviour requires new skills.
5. Inquire if the idea you want to communicate has been introduced to the community. If so, what is their response?
6. Investigate the target audience's present source of information about health.
7. Select communication channels and media which are most capable of reaching or influencing target audience e.g. -Interpersonal channels among the community.

- Mass media -radio, TV, newspaper, the internet.
- Small media -posters, cassettes and leaflets, etc.

Media can be mixed so that target audience receives the same message from all channels.

8. Design health messages that are practical, brief, culturally and socially appropriate.
9. Develop your materials and try them out.
10. Repeat and adjust messages at intervals to reinforce because people's health knowledge and behavior change over some time.

Barriers to communication

Barriers in the process of communication can occur at any setting (nursing inclusive). These can be.

Physiological -	Any difficulty in hearing or seeing,
Psychological -	Emotional disturbances e.g. neurosis
Environmental-	Noise, Invisibility, Congestion
Cultural -	Level of knowledge and understanding of beliefs and attitude.

NOTE:

- Always identify barriers (if any) and remove to achieve effective communication.
- Use appropriate methods, e.g. audio for a blind person, video for a person who cannot hear.
- Communicate at a suitable time when there is no distraction. Seek to understand the level of knowledge, understanding, belief and attitudes of people while communicating.

3.5 Nurse-patient communication

The objective of nurse-patient communication reveals that communication is the vehicle by which a nurse learns to know her patient, determine her patient's needs and how to meet them.

Communication in nursing falls into 4 categories concerning the care of the clients. These are reporting, directing, conferring and referring, Communication is not an end to itself, rather a means towards attaining the goal of a therapeutic nurse-patient relationship. Validation is important to convey time feelings and meanings in communication. The Nurse must ensure and validate what the patient requires from her and that the patient is receiving accurate messages from her because information rightly given to patients influences their recovery.

SELF-ASSESSMENT EXERCISE

i. List 4 principles of communication.
ii. Who are the target audiences for family planning?
iii. Health message designed should be…….

4.0 CONCLUSION

Communication is an essential element in establishing the nurse-patient relationship lowest death rates in hospitals are traceable to interaction between the nurse and physician and the resulting co-ordinate response to

the clients' needs. An effective use of communication requires persistent and conscious application of principle outlined to effect the desired change. While communication alone cannot produce well-coordinated and continuous care, a lack of it can very often result in inferior care.

5.0 SUMMARY

In this unit, we have been able to establish communication as an important tool for nurse-patient therapeutic relationship. We examined the types, process. principles, steps as well as barriers to effective communication in Nursing.

By now, you should have formed your own concept of communication that you require to be able to effectively carry out your nursing practice.

6.0 TUTOR -MARKED ASSIGNMENT

1. Communication is an expectation of information from a sender through a medium to the receiver.
   Outline the barriers to effective communication in nursing practice.
2. What is the concept of nurse patient relationship for holistic Therapeutic care?

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UNIT 2 INTERPERSONAL RELATIONSHIP IN NURSING

CONTENTS

1.0 INTRODUCTION

Interpersonal relationship is the heart of nursing practice. It is a form of communication that occurs between two people or within a small group. It is often face to face, healthy and most frequently used in Nursing situation, which allows for problem-solving, sharing of ideas, decision making and personal growth.

Interpersonal relationship is a major tool for effective nursing practice as each encounter with clients such as carrying out any procedure requires exchange of information. The nurse's understanding of the communication skills will also assist in relating with other staff members who may have different opinions and experiences. A meaningful interpersonal relationship offers a great deal of help by the nurse to a client.

This unit will examine in detail the interpersonal relationship in nursing with their effect on therapeutic management of clients.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- describe the concept of interpersonal relationship and its application to nursing care.
- discuss the phases of a therapeutic helping relationship.
- explain the variables of interpersonal relationship and the applied models.

3.0 MAIN CONTENT

3.1 Interpersonal relationship

Communication begets relationship. Without it, there is no organization as this is the only means of influencing the behavior of the individual. Interpersonal communication/relationship goes on directly between individuals (nurse and client), either verbal or non-verbal.

Verbal: Words that we hear or see in writing. *Non-verbal:* Sounds, sight, odor and touch.

Pre-verbal: Proceeds the ability to form words e.g. screams in babies. Interpersonal relationship is utilized in nursing activities such as counseling, collecting blood specimen, taking a medical history, group situations like classroom, committee meeting, intra professional dialogue, with physicians, social workers, therapists and even relatives of patients. These help the nurse later to develop an intra-personal thought to develop measures of assisting in the care of the client.

3.2 Variables of interpersonal relationship

There are variables in interpersonal relationships. These include referent, sender, message, channels, receiver and feedback. A careful understanding of these (knowing that communication is complex, involving many verbal and non-verbal symbols and messages exchanged between persons) is crucial as any slight change or modification can affect the overall expected result.

Referent: This represents the stimulus, which motivates a person to communicate with another. It may be an object experience, emotion, idea or act. It is what ignites the relationship.

Sender: This is the encoder, the person who initiates the interpersonal relationship. The sender now may be the receiver later

Message: This is the information being sent or expressed by the sender. It must be clear and organized no, with professional jargon while relating with the patient. If symbols are being used, it must be concise and not mixed up

Channels: This represents the medium through which it is being sent. This can be auditory, visual and tactile sense. Placing a hand on an individual while relating depicts the use of touch as a channel

Receiver: This is the decoder, the one to whom the message is sent. But the receiver and sender have so much in common as they can interchange their roles in the relationship processed.

Feedback: This is the message returned to the sender. It helps to reveal whether the meaning of the message is received.

The nurse in interpersonal relationship with client assumes major responsibility unlike in the social relationship when both persons involved assume equal responsibility for seeking openness and clarification.

3.3 Techniques of interpersonal relationship in nursing

Nurses send messages in the verbal and non-verbal modes, which are closely bound together during interpersonal interaction with clients and relations. During the art of speaking, we express ourselves through movements, tone of voice, facial expressions and general appearance. As the nurse learns the skills of communication, she is also expected to master the techniques, these includes:

- ***Clarity and brevity****: Effective communication should be simple, short and direct. Fewer words spoken result in less confusion. A nurse taking patient history starts with bio-data, what is your name? How old are you? where do you come from? Because of the variables involved, clarity is required to get the appropriate answer. Using examples can even make an explanation easier to understand. Repetition also makes communication easier. Brevity is best achieved by using words that expresses an idea simply "Tell me where you feel the pain most" Is better than "describe to me the location of the discomfort." This is necessary especially while eliciting information from patients or relation when arriving the hospital.*

- ***Vocabulary:*** Lack of understanding of the sender's words and phrases by the receiver can make communication unsuccessful thereby affecting the relationship. Nurses should avoid professional jargon while relating with patient, as they may become confused and unable to follow instructions. The first expression and outlook can frighten the patient.

- ***Denotative and connotative meaning****:* Single words do have different meanings. While the denotative meaning is one shared by individuals who use a common language. Connotative meaning is the thought, feelings or ideas that people have about the word. The expression of "The condition is serious" may suggest to families that clients are close to death, but a nurse does not see things that

way. When nurses communicate with clients, they should carefully select words that cannot be easily misinterpreted. This is important when explaining conditions, treatment, or purpose of therapies to patients and relatives.

- ***Pacing Interpersonal relationship gives credence to pace or speed****: Talking rapidly, using awkward pauses and speaking too slowly can convey an unintended message. The nurse should avoid awkward pauses during an explanation and instead use proper pacing by thinking about what to say before saying it. The nurse should also observe for non-verbal cues from the client that might suggest confusion or misunderstanding.*

- ***Timing and relevance****:* The nurse must be sensitive to the appropriate time for discussions. The best time for interaction is when a client expresses an interest in communication. Individual's interest and needs are considered alongside with appropriate timing to achieve optional results.

- ***Humour****:* Humour is a powerful tool in promoting well-being. Laughter helps relieve stress-related tension and pain, increases the nurse's effectiveness in providing emotional support to clients, and humanizes the experience of illness. Humour has been shown to stimulate the production of catecholamines and hormones that enhance feelings of well-being, Im- prove pain tolerance, reduce anxiety, facilitate respiratory relaxation, and enhance metabolism.

Nurses can use humour in conversations with clients by cracking jokes, sharing humorous incidents or situations. This procedure quietens a fearful, tense, emotionally grieved and tense patients. Humour opens up a patient to share their griefs and be more self-disclosing. It is an effective approach in helping clients to interact more openly and honestly.

SELF-ASSESSMENT EXERCISE

i. What is the main difference between interpersonal and intrapersonal relationship?
ii. With your background understanding of communication in Nursing.
iii. identify 5 problems that may result during the process of communication.
iv. Identify 4 techniques of interpersonal relationship that are non-verbal.

4.0 CONCLUSION

The nurse uses skills of interpersonal communication to develop a relationship with clients that allows understanding of them as total persons. This helping relationship is therapeutic, promoting a psychological climate that brings positive client change and growth. The relationship also focuses on meeting the client's needs. Although the nurse is expected to gain much satisfaction from the relationship to carry out her expected role to the client, clients should be the primary recipient and determiners of benefits.

Interpersonal relationship seeks to provide physical and psychological comfort to the client. The nurse's action considers the clients' preferences. A helping relationship between the nurse and client does not just happen it is built with care as the nurse uses therapeutic communication techniques. The characteristics involved in the interaction are trust, empathy, caring, autonomy and mutuality.

5.0 SUMMARY

This unit has examined interpersonal relationship in Nursing with information on variables and techniques of interpersonal relationship. A full, detailed discussion on communication was done last semester in a course titled Nature of Nursing. See Unit 20 for reference.

6.0 TUTOR -MARKED ASSIGNMENT

1. a) List the six variables of interpersonal relationship
   b) Compare and contrast between interpersonal and intra-personal relationship in nurse-patient care.
2. a) List and comment on the importance of the five (5) techniques employed in interpersonal relationship.
   b) Give five examples of nursing procedures requiring interpersonal relationship.

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UNIT 3 INFECTION CONTROL

CONTENT

1.0 INTRODUCTION

Infection is the multiplication of micro-organism/infectious agents within the body tissue causing disease in the host (human and animal). What happens under this circumstance depends on the difference in magnitude between two opposing forces namely: those of infection and the hosts resistance. The outcome is determined by the ability of the micro-organism to adhere, invade and damage the host versus the hosts defence mechanism. It may be severe or mild. Various groups of microorganisms interact with human beings to cause infection, these includes: bacteria, viruses, fungi, protozoa and parasitic worm. Human beings and animals play host to population of microorganism which lives on the skin or mucous membrane. The microorganism that are capable of causing disease are termed pathogens or infectious agents.

Certain aspects of bacteria regularly inhabit different parts of the body where they constitute the normal flora of the area. While some are harmful, others are not but they ensure their survival and growth. However, since they are circumstantial, a change in the circumstances can make them harmful e.g. flora from rectum and vagina when pushed in can cause infections. One may then ask if infection control is possible. The answer is simply yes.

In this unit, we shall examine the infection control with the understanding of infection phases, course and chain of infection, predisposing factors as well as nursing interventions of infection control.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- describe the course of infection
- enumerate the chain of events that link the reservoir of infectious agents with the
- susceptible host
- discuss the factors that predispose one to infection
- analyze the measures for infection control.

3.0 MAIN CONTENT

3.1 Infection Phases

Infection occurs and extends over three (3) identified phases, these are: incubation, acute illness and recovery/convalescent phases.

Incubation Phases

This is the period between the entry of microorganism to the body and the initial clinical manifestation of the infection. At this stage, the microorganism multiplies while the host defense rises up to the challenge to counter the infection. The host is asymptomatic of the disease but sheds off the infectious agents and may become carriers. When the host overcome the causative organism no obvious signs and symptoms of the disease is apparent only laboratory examinations can detect the host.

Acute Illness Phase

Here, the disease reaches its full intensity due to greater force exerted on the host by the invading microorganism. The duration of the acute illness varies from a few hours to weeks and the disease**.**

Convalescence Phase

This is the stage when the clinical manifestation of the disease subsides. Most infectious disease is self-limiting and recovery takes place over a short and defined period. The prognosis depends on the disease and management while death can occur from some highly virulent diseases or due to complications.

3.2 Types and Chain of Infections

The following types of infection are explained below to further assist your understanding of the concept of infection and enhance your practice.

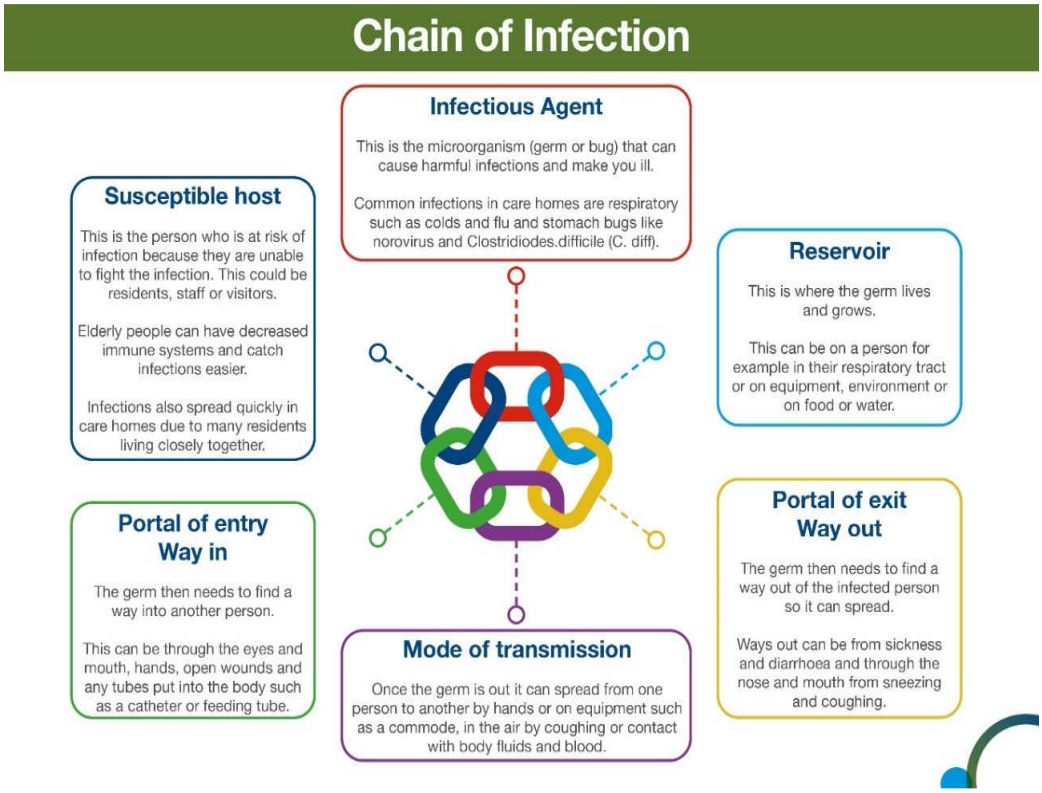
1. **Local Infection:** when infection is confined to an area or spot.
2. Generalized Infection: infection that is disseminated throughout the body.
3. **Focal Infection:** when infection spreads from a confined area to other parts of the body.
4. **Mixed Infection:** when infection is due to more than one type of pathogen.
5. **Primary Infection:** the infection of a host by another type of infection during an infection.
6. Infection may also be sudden (acute) or manifest later with high resultant effects (chronic).

Chain of Infection

Infection results from a chain of events that links the reservoir of infection agents with the susceptible host. These are:

- Mode of escape from the reservoir.
- Means or route of transmission.
- Models of entry into the susceptible host.

The chain of event is hereby represented diagrammatically:



Source: https://www.nipcm.hps.scot.nhs.uk/media/1579/care_homes_chain_of_infection_graphic.jpg

3.3 Predisposing Factors to Infection

The manifestation of infection in any host is dependent on the following factors **Age**

Children are more vulnerable to infection than adults due to the compromise of humoral and cellular immunity. The changes occur with puberty, pregnancy and menopause which also accounts for diminished resistance to viral infections. The elderly are more susceptible to autoimmune disease and cancer increased with advanced ageing.

ii Occupation

Certain occupation provides increased exposure to infection than others e.g. industrial, sea and hospital workers

iii. **Exposure to Cold**

When a man is exposed to cold it causes a lowering of the body temperature below normal. This reduces blood supply to superficial tissues and suppresses natural defense mechanisms.

iv. Nutritional Imbalance

Protein and caloric undernutrition is a prevalent cause of impaired cell media-led immunity. Without the required nutrients and energy, the production of antibodies, lymphocytes and the chemical mediators of the immune response is impaired. There is a decrease in immuno-competence due to excessive intake of cholesterol and fats.

v. Stress

Naturally occurring persistent stress accompanied by poor coping alters the body's immunocompetence. (See unit 8 on stress and adaptation).

vi. Drug and Other Therapeutic Intervention

Some commonly used antibiotics may impair immune functions. All drugs are capable of initiating a hypersensitivity reaction.

vii. Life Style

Life behaviours/style such as smoking, drinking and indolence can precipitate infection.

Activity 2

- Considering the aforementioned factors, did any of the factors applied to you when last you had an infection?
- What precautionary measures did you take?

3.4 Infection Control

Infection control is the effort made to maintain a microorganism free environment. These include:

- Improving and supporting the host defaces through intact skin, mucus membrane and cilia, white blood cells, antibodies and immunizations.
- Cilia in the respiratory tract filter the air we breathe in and remove the microorganism which may cause infection. The secreted mucus like hydrochloric acid (HCL) from Gastro Intestinal Tract is acidic and protective. Proper nutrition rich in proteins, carbohydrate, fats and vitamins should be encouraged as these helps to produce antibodies and enhanced natural resistance against infections. Adequate rest should be observed while appropriate fluid intake helps to wash off micro-organism that have been ingested except where contraindicated, Personal hygiene and environmental care is to be encouraged.

Destruction of causative organism.

This is usually through the use of drugs. Give prescribed drugs to maintain effective drug concentration. It should be taken as prescribed, find out if the individual is allergic and watch out for side effects as these can throw the patient open to further infection.

Prevention of eh transmission of infective agents to others through isolation, sterilization, barrier nursing, aseptic techniques, ethical asepsis. Quarantine, bed spacing, proper waste disposal, health education, hand washing (soap and running water) to take place before and after carrying out a procedure.

Some of these methods of infection control in bullet three will be explained briefly as follows:
Barrier Nursing: The patient is not isolated in any room but nursed in an open ward screened. Every item being used for him/her is strictly kept with there and used exclusively for him/her.

Isolation: A separate room or cubicle is reserved for the patient where s/he is nursed. This is usually done in conditions that are infectious like Tuberculosis.

Sterilization: It is a process by which all microorganisms including spores are destroyed completely. There is no half measure as an item is either sterile or not. It is achieved by subjecting the material either to heat, chemical, gamma, irradiation or gases. Sterilization can be physical or chemical.

Physical Sterilization: It is usually accompanied by the use of dry heat and radiation. These alter the internal function of the organism thus rendering them inactive. The most common method under this is dry and wet heat. Dry heat (as in oven) will kill organism by oxidation process while moist heat (steam) coagulates protein within the cell. Sterilization becomes effective when the heat is sufficient to destroy the micro-organism.

Radiation: Non-iodizing and ionizing radiation are used for physical sterilization and disinfection. They cause the death of microorganism by altering their essential metabolic processes. The most common type of non-ionizing radiation is the ultra-violent rays. Ionizing radiation is used for pharmaceuticals, foods, plastic and other heat-sensitive items.

Chemical Methods/Sterilization: Chemical sterilization implores liquid solutions/gases. Objects to be sterilized are immersed in a solution or exposed to fumes in a chamber for a specified time. Examples of this include Ethylene Oxide, Chlorine compounds, Hibitane lotion, Polyvidone Iodine and Methylated spirits.

3.2 Nursing Intervention at Every Infective Stage

The nursing intervention at every infective stage stems from assessment, planning and evaluation. There are five (5) potential problems relevant to most patients with infections. These include:

a. physical and social isolation
b. altered nutrition
c. alteration in comfort
d. Maintaining functioning of other body systems
e. Alteration in self-management.

SELF-ASSESSMENT EXERCISE

i. Mention 5 groups of microorganisms that cause infection
ii. Who is a carrier?
iii. Give 3 examples each of physical and chemical methods of sterilization.
iv. What is the major difference between barrier nursing and isolation?

4.0 CONCLUSION

The development of infection of dependent on the nature of the interaction between the host and microbial agent. The stages of infection are seven-fold and the knowledge of factors influencing the interaction of the host and microbial agent has led to more effective preventive/control measures. While remarkable progress has been made to control infection, the place of health education cannot be overemphasized. The hospital should have in place an infection control policy for the prevention and transmission of infection.

5.0 SUMMARY

This unit presented an overview of infection control with particular reference to infection phases, types and chains of infection redisposing factors and nursing intervention at every infective stage.

6.0 TUTOR-MARKED ASSIGNMENT

What are nosocomial infections? Identify eight (8) ways of controlling nosocomial infections?

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UNIT 4 HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

You will recall that we explored the concept and components of Primary Health Care in the Nature of nursing course of which Health education was one. Health education is a process by which individual or group of persons learn to prevent diseases, promote and maintain or restore health through voluntary adaptation of health behaviour**.** The importance of health education was strongly highlighted by Alma Ata Conference. It was pointed out that community participation is crucial to ensure optimum utilization of health resources. It was also stressed that health is an individual responsibility and every individual need to be health conscious so that he may observe healthy living practices.

You know already that preservation of good health is dependent on following good health practices. Health education and communication about healthy practices bring about a change in health behaviour so that harmful; health practices can be given up and good health practices can be reinforced. This unit presents to you the definition, growth, principles, practices, and levels of health education. The interpersonal relationship of health education with communication is already dealt in module 3 unit 2

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- explain his/her own concept of health education
- list the objectives of health education

- describe how health education can be planned and methods of delivery.

3.0 MAIN CONTENT

3.1 Definition of terms

Health: It is a state of complete physical, mental, social and spiritual wellbeing and not merely the absence of diseases or infirmity (World Health Organization, 1948**).**

Education: It is the process by which there is a behavioural change resulting from an experience undergone.

Health Education: A process that informs motivates and helps people to adopt and maintains health practices for a healthy lifestyle, advocates environmental changes as needed to facilitate this goal and conducts professional training and research towards the same end (National Conference on Preventive Medicine, U.S.A). This is working definition that is more of practical value. Health education is a process of known information which has the purpose of promoting health (Pearce, 1980). Health education is also described as a process by which habits, attitudes and knowledge are changed to choose the path leading to better health. Success in health education depends on a great deal on the skills of communicating with the community (WHO, Health Panel). It is also seen by many as a process of positively changing or influencing peoples' health knowledge, attitudes and behaviour through their own actions (Ewles and Simnelt, 1985 and Tones, 1990). It is an all-round process which involves the whole life thereby helping people to help themselves live a healthful life.

3.2 Growth of Health Education

Health education has begun with people being systematically interested in general sanitary progress, social and material causes which can impede their health. In 1875, Maryland State of Health emphasised that the health of the public is dependent on the public conviction about health. Health education initially was the responsibility of Public Health personnel until the 2nd quarter of the century when it became formally recognized as a speciality and a major function of Public Health. The development of newer interpretation of public bought about the need to do things with people and to get people accept an increasing responsibility for their own health.

Clair Turner at the Massachusetts Institute of Technology later recognised health education academically with the development of specialized

graduate curriculum in 1922. Its global acceptance for knowledge acquisition and practice has brought its operation beyond the hospital setting to community, schools, churches, mosques and the public at large.

3.3 Purposes of Health Education

Health education is a process that informs, motivates and helps people to adapt and maintain healthy practises and lifestyles. The three main purposes of health education will be discussed below:

- **Informing people**

Informing people is the right of an individual. It is a prerequisite to proper awareness and assessment of one's duties and rights. Health is a basic right of all human beings, so is health information. Only informed community will aspire, work, demand and fight for its right, that is, health. Health information helps people in becoming aware of their health problems and guides them to appropriate solution for the same.

- **Motivating people**

Only information is not enough. Information that alcohol or tobacco is harmful for health does not ensure that people will leave them. Besides informing, it is also necessary to motivate people to adopt certain behaviour. Health education must provide learning experiences, which favourably influence habits, knowledge and attitude. Consumers should make choice and decisions about health matters.

- **Guiding people into action**

Motivation must be accompanied by guidance to achieve the expected behaviour. People need to adopt and maintain healthy practices and lifestyle.

3.4 Process of Health Education

The process involved in health education as identified includes: assessment, objectives setting, readiness, implementation and evaluation. Note that a similar process is involved in nursing care. See module 2 unit 3 for details. The nurse is expected to identify, plan, implement, and evaluate concerning the patient's knowledge and behaviour.

3.5 Principles of Health Education

Health education brings together the art and science of Medicine and the principle and practice of general education. It involves teaching, learning

and inculcation of habits concerned with healthful living. The guiding principles are:

- Issues to be discussed must be interesting (or made interesting) to the people.
- Personal involvement in form of group discussion, panel discussion and workshops.
- Start health education from what the people knew before the unknown.
- Study the people's level of understanding, literacy and education to ensure prompt comprehension.
- Reinforcement and repetition at intervals is useful.
- Motivation: incentives must be incorporated for good and bad habits.
- The education should role model any issue being taught. Consider this Chinese proverb. "If I hear it, I forget it. If I see it, I remember it. If I do it, I know it."
- Make the whole attractive, palatable and acceptance with necessary methods.

SELF-ASSESSMENT EXERCISE

3.6 Health Education in Nursing

Health education is a continuous professional activity in nursing at all levels. It places on the nurse a sense of responsibility to:

- Supply relevant, accurate information about general and specific health matters to patients and relatives.
- Teach patients and relatives on self-care, avoidance of complication and reduction of consequences of ill health.
- Teach patient and relatives how to cope effectively with disability both in hospital and after discharge.
- Communicate effectively, appropriately and sensitively with patients and relatives.

SELF-ASSESSMENT EXERCISE

i. Why do you need to health educate?
ii. Mention 4 problems in health education.

4.0 CONCLUSION

Nurses have limitless opportunities to practice health education regardless of the nursing specialty. Health education can occur at both formal and informal settings whenever and wherever the nurse fulfils her professional

function). The only limitation is when the nurse fails to appreciate or recognized those occasions and opportunities which are favourable. A health educator desirous to affect the people for good must be sympathetic and friendly, knowledgeable and one who practices what he teaches (role model) talks the language of the people, uses different methods of health education (as identified by you in SELF-ASSESSMENT EXERCISE4), uses audio-visual and proper medium of communication to be an effective communicator and achieve the desired result (change of life style for healthful living).

5.0 SUMMARY

In this unit, we have examined health education concerning the definition, growth; principles purposes and processes. We also considered its relationship to nursing and exercises to check your progress on the unit.

6.0 TUTOR-MARKED ASSIGNMENT

A health educator must possess certain qualities to be effective in his/her assignment. Comment in not less than 2 pages on four (4) of the qualities. Discuss the three (3) specific objectives of health education.

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MODULE 4 PROMOTING PHYSIOLOGICAL AND PSYCHOLOGICAL HEALTH

UNIT 1 PAIN MANAGEMENT

CONTENTS

1.0 INTRODUCTION

Everyone at one point or the other has experienced some type or degree of pain. Despite its universality and eternal presence among mankind, the nature of pain remains an enigma. Pain is a complex experience that is not easily communicated; yet it is one of the most common reasons for seeking health care. It is the chief reason people take medication and a leading cause of disability and hospitalization. Pain is subjective and highly individualized and its interpretation and meaning involve psychosocial and cultural factors. In other words, the person experiencing pain is the only authority on it. Besides, no two persons experience pain in the same way and no two painful events create identical reports or feeling in a person. And as the average life span increases, more people have chronic disease, in which pain is a common symptom. In addition, medical advances have resulted in diagnostic and therapeutic measures that are often uncomfortable. One therefore cannot but agree with Berman *et al.*, (2016) that pain is one of the most common problems faced by nurses, yet it is a source of frustration and is often one of the most misunderstood problems that the nurse confronts. The truth however is that when patients are comfortable, encouraging necessary activities often become easier both for the patient and the nurse. This explains why much of nursing care revolves round relieving pain and ensuring comfort. This unit therefore discusses pain in its entirety with a particular focus on pain management strategies.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- discuss the nature and concept of pain
- identify major causes of pain
- differentiate between acute and chronic pain
- discuss common misconceptions about pain
- outline factors influencing people's response to pain
- discuss pain-relieving strategies.

3.0 MAIN CONTENT

3.1 Nature and Concept of Pain

Pain of any kind is difficult to define, because of its subjective nature. Pain is much more than a single sensation caused by a specific stimulus. Pain is a complex mixture of physical, emotional, and behavioral reactions. Pain is subjective and highly individualistic, and interpretation and meaning of pain involve psychosocial and cultural factors. Pain cannot be objectively measured, such as with x-ray examination or blood test, and although certain types of pain create predictable signs and symptoms, often the nurse can only assess pain by relying on the clients' words and behaviour. This coupled with the fact that the nurse along with the physician and other health practitioners cannot see or feel to which they attend, makes the person experiencing pain the only authority on it. No wonder a noted pain theorist, McCaffery (1980) defined pain as "what the person experiencing it says it is; and existing whenever he says it does". Therefore, to help a client gain relief, the nurse must believe that the pain exists.

The most commonly accepted definition however is that of the International Association for the Study of Pain (IASP) which acknowledges the multi-factorial nature and the importance of individual interpretation and experience: Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described by the patient in terms of such damage (Blair, 2002). Pain has also been defined, and occasionally still is, on a philosophical and religious basis as punishment for wrongdoing. Aristotle defined pain as well as anyone when he wrote that it is the 'antithesis of pleasure the epitome of unpleasantness' (Brooker & Waugh, 2013). Brooker & Waugh, (2013) submitted further that another typical definition depicts pain as basically an unpleasant sensation referred to the body which represents the suffering induced by the psychic perception of real, threatened, or phantasied injury. Pain could therefore be viewed as a

protective physiological mechanism. A person with sprained ankles for instance avoids bearing full weight on the foot to prevent further injury, warning the body that tissue damaged has occurred. Even though pain may warn of tissue injury or disease, it should be noted that the degree of pain is not necessarily in direct proportion to the amount of tissue damage, nor tissue damage always present when pain occurs.

3.2 Prejudices and Misconceptions

Health personnel often hold prejudices against patients/clients in pain, especially those suffering from chronic pain, except where the client manifest objective signs. Berman *et al.,* (2016) outlined the following as common biases and misconceptions about pain:

- Drug abusers and alcoholics overreact to discomfort.
- Patients/Clients with minor illnesses have less pain than those with severe physical illness.
- Administering analgesics regularly will lead to drug dependence.
- The amount of tissue damage in an injury can accurately indicate pain intensity.
- Health care personnel are the best authorities on the nature of the patient's/client' pain.
- Psychogenic pain is not real.

Unfortunately, all people are influenced by prejudices based on their culture, education, and experience. As such the extent to which nurses allow themselves to be influenced by prejudices may seriously limit their ability to offer effective pain relief. It is the realization of this fact that makes Berman *et al.,* (2016) to assert that the nurse must acknowledge his/her prejudices and of course view the experience through the patient's eyes to be able to render meaningful and formidable assistance to the patient.

3.3 Types of Pain

There are several ways to classify pain. Pain can be classified based on its duration, location and causes. As such the following are the different typologies of pain that exist:

Classification based on Duration

Acute Pain

Acute pain is the sensation that results abruptly from an injury or disease and usually it is short-lived. DeLaune & Ladner, (2011) defined it as pain that follows an acute injury, disease, or types of surgery and has a rapid

onset, varying in intensity (mild to severe) and lasting for a brief time. The client can frequently describe the pain, which may subside with or without treatment (DeLaune & Ladner, 2011). Acute pain however serves a biological purpose. It acts as a warning signal through activation of the sympathetic nervous system which causes the release of catecholamine neurotransmitters, such as epinephrine that gives rise to various physiologic responses similar to those found in fight reaction (Guyton, 2021).

Acute pain is usually confined to the affected area (localized) and sometimes resolves with or without treatment after a damaged area heals. Could however lead to chronic pain if the cause is not discovered or not cared for properly (DeLaune & Ladner, 2011). In addition, acute pain seriously threatens recovery and therefore should be one of the nurses' priorities of care. For example, acute post-operative pain hampers the patient's ability to become mobile and increases the risk of complications from immobility (Berman *et al.*, 2016).

Chronic Pain

Chronic pain is prolonged, varies in intensity, and usually last more than six months (Berman *et al.*, 2016), sometimes lasting throughout life. Onset is gradual and the character and the quality of the pain changes over time. Chronic pain is associated with a variety of health problems such as cancer, connective tissue diseases, peripheral vascular diseases and musculoskeletal disorders, and posttraumatic problems such as phantom limb pain and low back pain. While it is true that it is a symptom associated with many of the common primary care conditions, it may also occur as a distinct entity. The effects of chronic pain are far-reaching, and are at least as important as its cause. The degree of chronic pain varies depending on the types of problems and whether it is progressive, stable, or capable of resolution. The patient/client with chronic pain often has periods of **remission** (partial or complete disappearance of symptoms) and **exacerbations** (increase in severity). However, chronic pain may be severe and constant i.e. unrelenting. This sort of pain is referred to as

Intractable pain

Chronic pain presents a major challenge to primary care and since chronic pain persists for extended period, it can interfere with activities of daily living and personal relationship. It stimulates a huge number of prescriptions, investigations and referrals, causes frustration in its resistance to treatment, and leaves patients and doctors with low expectations of successful outcomes. Hence, can result in emotional and financial burdens sometimes leading to psychological depression. Thus, its management requires the effort of an interdisciplinary health care team

otherwise it may become an overwhelming frustrating experience for both the sufferer and the caregiver. While treatment of acute pain tends to focus on its cause, with a view to a cure, treatment of chronic pain must also focus on its effects, to limit disability and maximizing potential. Assessment and management must be multidimensional and rehabilitative, and agreed, realistic treatment goals are important. The goal of nursing nonetheless must be to reduce the patient's perception of pain and to promote patient's and family adaptation through identification and enhancement of coping strategies (DeLaune & Ladner, 2011; Guyton, 2020).

Classification based on Pain Location

Pain may be categorized about the area of the body where it originates.

Superficial Pain: Originates in the skin or mucous membranes. The source usually can be located easily because there are many nerve endings in the affected structures. The patient often describes superficial pain as prickling, burning, or dull.

Deep Pain: Pain emanating from inner body structures. Could manifest with vomiting, blood pressure changes, or weakness. Unlike superficial pain, the patient may have difficulty in pinpointing the exact location of deep pain. It is sometimes referred. Patient more often than not describes it as aching, shooting, grinding, or cramping.

Central Pain: Believed to originate within the brain itself (in the pain interpretation, and/or receiving centers)

Referred Pain: This is pain felt in a location different from the actual origin e.g. pain felt in the scapular region secondary to diseases of the gall bladder.

Phantom Pain: This is used to describe pain felt in an area that has been amputated.

Angina Pain is pain associated with cardiac pathology while **Neuralgia** is an intense burning sensation that follows a peripheral nerve. (Brooker & Waugh 2013; Berman *et al., 2014*)

3.4 Causes of Pain

There are many causes of pain. According to Brooker & Waugh (2013) these causes can be broadly grouped into three viz:
Physical Causes: Physical causes include: Muscle tightness (secondary to muscle spasm and resultant decrease in blood supply to that muscle);

disease; infection; trauma; space-occupying lesions (tumor); metabolic factors; burns and temperature extremes.

Chemical Causes: Chemical factors include caustic chemicals and toxins such as alcohol, drugs, cigarettes, and pollution in the air and water.
Psychogenic Causes: That is, originating from the mind and has no identifiable physical cause. Can be as severe as pain from a physical cause.

3.5 Pain Perceptions and Reaction or Response

There are two facets to pain – perception and reaction or response. Pain perception is concerned with the sensory processes when a stimulus for pain is present. The threshold of perception is the lowest intensity of a stimulus that causes the subject to recognize pain. This threshold is remarkably similar for everyone though some authorities have theorized that a phenomenon of adaptation does occur; that is the threshold of pain can be changed within certain ranges (Berman *et al., 2014).*

While it may be true that there are no specific pain organs or cells, an interlacing network of undifferentiated nerve endings receives painful stimuli. Sensation is transmitted up the dorsal gray horn cells of the spiral cord, then to the spinothalamic tract and eventually to the cerebral cortex. Following pain impulse transmission within the higher brain centers including the reticular formation, limbic system thalamus and sensory cortex, a person then perceives the sensation of pain. However, there is an interaction of psychological and cognitive factors with neurophysiological ones in the perception of pain. Meinhart and McCaffery (1983) described the three interactional systems of pain perception as sensory-discriminative, motivational-affective, and cognitive-evaluative. In addition, the Gate Control Theory suggests that gating mechanism can also be uttered by thoughts, feelings and memories. In essence the cerebral cortex and thalamus can influence whether pain impulses reach a person's consciousness. This realization that there is a conscious control over pain perception helps explain the different ways people react and adjust to pain.

Pain Reaction

The reaction or response to pain is concerned with the individual's method of coping with the sensation. This comprises the physiological and behavioral responses that occur after pain is perceived.

Physiological Responses

Berman *et al.,* (2016) submitted that as pain impulses ascend the spinal cord towards the brain stem and thalamus, the autonomic nervous system become stimulated as part of the stress response. Acute pain of low to moderate intensity, and superficial pain elicit the "flight or fight" reaction of the general adaptation syndrome. Stimulation of the sympathetic branch of the autonomic nervous system results in physiological responses such as: dilation of bronchial tube and increased respiratory rate; increased heart rate; peripheral vasoconstriction (pallor, elevation in blood pressure); increased blood glucose level; diaphoresis; Increase muscles tension; dilation of pupils; and decreased gastrointestinal motility. However, if the pain is unrelenting, severe, or deep, typically originating form involvement of the visceral organs (such as with a myocardial infarction and colic from gallbladder or renal stones), the parasympathetic nervous system goes into action resulting in the following responses: pallor; muscles tension; decreased heart rate and blood pressure; rapid irregular breathing; nausea and vomiting; weakness and exhaustion. Sustained physiological responses to pain could cause serious harm to an individual. Except in some cases of severe traumatic pain, which may send a person into shock, most people reach a level of adaptation in which physical signs return to normal. Thus a client in pain will not always exhibit physical signs.

Behavioral Responses

White paraphrasing the work of Meinhart and McCaffery (1983) on behavioral responses to pain identifies the three phases of a pain experience as: **anticipation, sensation**, and **aftermath**. The **anticipation** phase according to her occurs before pain is perceived. A person knows that pain will occur. The anticipation phase is perhaps most important, because it can affect the other two. In situations of traumatic injury in foreseen painful procedures a person will not anticipate pain. Anticipation of pain often allows a person to learn about pain and its relief. With adequate instruction and support, clients learn to understand pain and control anxiety before it occurs. Nurses play an important role-helping client during the anticipation phase. With proper guidance, clients become aware of the unknown and thus cope with their discomfort. In the situation clients are too fearful or anxious, anticipation of pain can heighten the perception of pain severity.

She stated further that the **Sensation** of pain occurs when the pain is felt. According to her, the ways that people choose to react to discomfort vary widely adding that a person's tolerance of pain is the point at which there is an unwillingness to accept pain of greater severity or duration.

Howbeit, the extent to which a person tolerates pain depends on attitudes, motivation and values.

She noted that pain threatens physical and psychological well-being and that client may choose not to express pain, considering it a sign of weakness. In her words 'often clients believe that being a good client means not expressing pain to avoid bothering people around them. In addition, client may not express pain because maintaining self-control is important in their culture. The client with high pain tolerance can endure periods of severe pain without assistance. In contrast, a client with low pain tolerance may seek relief before pain occurs. The client ability to tolerate pain significantly influences the nurse perception of degree of the discomfort. Often the nurse is willing to attend to the client whose pain tolerance is high. Yet it is unfair to ignore the needs of the client who cannot tolerate even minor pain she declared. Typical body movements and facial expressions that indicate pain include holding the painful part, bent posture, and grimaces. A client may cry or moan. Often a client expresses discomfort through restlessness and frequent request to the nurse. However, a lack of pain expression does not necessarily mean that the client is not experiencing pain. It is equally important to note that unless a client openly reacts to pain it is difficult to determine the nature and extent of the discomfort.

She submitted that the **aftermath** phase of pain occurs when it is reduced or stopped. Even though the source of discomfort is controlled, the client may still require the nurse's attention. Pain is a crisis. After a painful experience client may experience physical symptoms such as chills, nausea, vomiting, anger, or depression. If there are repeated episode of pain, aftermath responses can become serious health problems. She therefore concluded that the nurse should help clients gain control and self-esteem to minimize fear over potential pain experiences.

Factors in Pain Perception

Perception of pain is individualized and since pain is complex, numerous factors influence an individual pain experience. Some of these are:

Age: Developmental differences among different age groups can influence how children and older adults react to the pain experience. Infants and young children have difficulty in understanding pain and those that have not developed full vocabularies encounter difficulty in verbalizing pain. To help such children, it has been suggested that the nurse employs simple but appropriate communication techniques to enhance their understanding and description of pain. The nurse may show a series of pictures depicting different facial expressions, such as smiling, frowning, or crying and ask the children to point to the picture that best

describes how they feel (Berman et al, 2016). School-aged children and adolescents many times try to brave and not give in to pain. Adults' ability to interpret pain may be occluded by the presence of multiple diseases with varied but similar manifestations. Besides, adult may not report pain for various reasons ranging from fear of unknown consequences, fear of serious illness/death, to such erroneous notions as – 'it is not acceptable to show pain'. Aging adults may not feel acute pain because of decreased sensations or perceptions.

Sex/Gender: It is doubtful whether gender by itself is a factor in pain expression. Results of studies comparing pain tolerance in males and females to say the least have been at best confusing. As such the only conclusion that could be safely made is that there are certain cultural factors influencing the effect of gender on pain perception.

Culture: Culture influences how people learn to react to and express pain. People respond to pain in different ways, and the nurse must never assume to know how patients/clients will respond. However, an understanding of the cultural background, socioeconomic status, and personal attributes help the nurse to more accurately assess pain and its meaning for patients/clients (Berman et al, 2016).).

Anxiety: The relationship between pain and anxiety is complex. Anxiety often aggravates pain sensation and tense muscle reinforces it while pain may induce feelings of anxiety. Potter & Perry, (2009) states that emotionally healthy people are usually able to tolerate moderate or even severe pain better than those whose emotions are labile.

Meaning of Pain: The meaning that a person attributes to pain affects the experience of pain. A person will perceive and cope with pain differently if it suggests a threat, loss, punishment, or challenge (Potter & Perry 2009).

Fatigue: Fatigue heightens an individual perception of pain i.e. amplifies it and decreases coping abilities.

Previous Experience: Each person learns from painful experiences. If a previous experience was very painful, a person may not feel great pain when the experience is repeated. This probably explains why people who are chronically ill and have almost constant pain often learn to tolerate it.

Attention and Distraction: The degree to which a patient focuses on pain can influence pain perception. According to Gil (1990), increased attention has been associated with increased pain whereas distraction has been associated with a diminished pain response. This concept is applied

in some of the pain-relieving interventions (relaxation and guided imagery) employed by nurses.

Family and Social Support: People in pain often depend on family members for support, assistance, or protection. An absence of family or friends tends to make pain experience more stressful. The presence of parent is especially important for children experiencing pain (White, 1995)

Neurological Status: A patient/client neurological function can easily affect the client's /patient's pain experience. For instance, any factor that interrupts or influences normal reception or perception will automatically affect client's awareness and response to pain. This explains why patients with spinal cord injury, peripheral neuropathy, multiple sclerosis e.t.c. may experience pain differently from patient with normal neurological function.

3.6 Pain Management

On a general note, nursing interventions for relieving the client's pain can be summarized as follows: understanding the patient; understanding the nature and extent of pain; removing the source of pain and decreasing pain stimuli; offering emotional support; and teaching concerning pain. Since a patient's background is very likely to influence his reaction to pain, a good starting point will be to learn about the patient including his medical history, diagnosis and the physician's plan of therapy. The nature of pain and the extent to which it affects physical and psychological well-being is also crucial to determining the choice of pain relief therapies/measures. This, the nurse can establish through good observational techniques and adequate history taking. However, since pain is a complex phenomenon, several treatment options have been developed over the years and it takes a careful selection of the measured beat suited for every particular case but in some cases the much-needed relief is only secured through combination therapy. The different measures/therapies employed by nurses in the management of pain are however paraphrased below:

Cutaneous Stimulation: One way to prevent or reduce pain perception is through cutaneous stimulation, the stimulation of a person's skin to relieve pain. A **massage, warm bath, application of liniment, hot and cold therapies, and transcutaneous electrical nerve stimulation (TENS)** are simple measures that provide cutaneous stimulation. Although the specific way in which cutaneous application works is not very clear, some authorities have attributed their action to their inducing the release of **endorphins**, a naturally occurring analgesic substance that blocks the transmission of pain (White, 1995). While others have believed that they relieve congestion or promote circulation and oxygenation,

thereby relieving pain (Brooker & Waugh, 2013). **Heat** for instance, is said to offer pain relief by increasing blood flow to an area of inflammation or infection. In addition, heat also reduces joint stiffness, relaxes smooth muscles, and reduces peristalsis. Little wonder that it is being employed in the management of some abdominal pain painful infiltrated intravenous sites.

Cold: when applied, on the other hand, penetrates the muscle thereby helping to reduce muscle spasm and inflammation. Cold also prevents bleeding and edema through vasoconstriction. Although not the primary treatment for pain cold compresses are effective in reducing pain after orthopedic surgery (Bolander, 1994). **Massage** and **back rub** are yet other low costs, safe to use cutaneous stimulation. Massage may lessen pain by relieving congestion and/or promoting circulation and oxygenation, and enhancing muscular relaxation. **TENS** involves stimulation of nerve beneath the skin with a mild electric current passed through external electrodes. The therapy requires a physician's order. TENS unit consists of a battery-powered transmitter, lead wires and electrode which are placed directly over or near the site of pain. Hair or skin preparations should be removed before attaching the electrodes. When a client feels pain, the transmitter is turned on. The TENS unit crates a buzzing or tingling sensation. The client may adjust the intensity and quality of skin stimulation. The tingling sensation can be applied as long as pain relief lasts. TENS is effective for the postoperative procedure for example, removing drains and cleaning and repacking surgical wounds Brooker & Waugh, 2013).

Distraction: This technique is more effective with the short, mild pain **lasting** a few minutes than severe pain, though can be combined with pain medications to enhance pain relief. It is achieved by encouraging the person in pain to focus on a particular image or stimulus other than the painful one. In this way, the person's attention becomes drawn away from the painful stimuli with the resultant decrease in perception of such painful stimuli. In some instances, distraction can make client completely unaware of pain. For example, a client recovering from surgery may feel no pain while watching a football game on television, only for the pain to resurface when the game is over. An adolescent who feels pain from a fractured foot bone only after he finished playing a basketball game, is yet another example. Therefore, distraction does not only decrease one's perception of pain but also improves one's mood while giving a sense of control over the painful situation.

In what looks like a pathophysiologic approach, Potter & Perry, (2009) explained that the reticular activating system inhibits painful stimuli if a person receives sufficient or excessive sensory input. With meaningful sensory stimuli, a person can try to ignore or become less aware of pain.

She asserted further that pleasurable stimuli also cause the release of endorphins to relieve pain. This possibly explains why the most effective distraction techniques are those that the individual finds interesting and those that stimulate the senses - hearing, seeing, touching, and tasting. Moving activities are equally useful. For example, children and even adults that are in pains can be made to watch television or listen to favorite music or play indoor games. These activities keep the person occupied leaving no room for boredom, anxiety, loneliness all of which tend to aggravate pain. Furthermore, disturbing stimuli such as loud noise, bright light, unpleasant odour, and argumentative visitor can increase pain perception. Therefore, the nurse needs to reduce disturbing stimuli. Some distraction techniques are:

- **Slow rhythmic breathing**: In slow rhythmic breathing (SRB), the nurse asks the client to stare at an object, inhale slowly through the nose while the nurse counts 1, 2, 3, 4. The nurse encourages the client to concentrate on the sensation of the breathing and to picture a restful screen. This process continues until a rhythmic pattern is established. When the client feels comfortable, he or she can count silently and perform this technique independently.
- **Massage and slow rhythmic breathing**: The client breathes rhythmically as in SRB but at the same time massages a painful body part with stroking or circular movements.
- **Rhythmic singing and tapping**: The client selects a well-liked song and concentrate attention on its words and rhythm. The nurse encourages the client to hum or sing the words and tap a finger or foot. Loud, fast songs are best for intense pain.
- **Active listening**: The client listens to music and concentrate on the rhythm by taping a finger or foot.
- **Guided imagery**: In guided imagery the patient/client creates an image in the mind, concentrates on that image and gradually becomes less aware of pain. The role of the nurse is to assist the patient/client to form an image and concentrating on the sensory experience. Asking the patient/client to close his or her eyes and imagine a pleasant scene, and then describing something pleasurable is one way this is achieved.
- **Relaxation and Guided Imagery:** It is a fact that patients/clients can alter affective-motivational and cognitive pain perception through relaxation and guided imagery. Relaxation per see is mental and physical freedom from tension or stress. However, for effective relaxation, the client's cooperation is needed. The nurse describes the techniques together with common sensations that the client may experience in detail. The client uses such described sensations as feedback. The client may sit in a comfortable chair or lie in bed. A light sheet or blanket for warmth tends to help the

client feel more comfortable and the environment should be free of noises or other irritating stimuli.

The client may have guided imagery and relaxation exercises together or separately. The nurse, acting as a coach guides the client slowly through the steps of the exercise. The nurse's calm, soft voice helps the client focus more completely on the suggested image, and it becomes unnecessary for the nurse to speak continuously. If the client shows signs of agitation, restlessness or discomfort, the nurse should stop the Self-Assessment Exercise and begin later when the client is more at ease. Progressive relaxation of the entire body takes about 15 minutes. The client pays attention to the body, nothing areas of tension. Some clients relax better with eyes closed. Soft background music may be helpful. Note that considerable practice is needed to achieve consistent pain reduction and it may take five to ten training sessions before clients can efficiently minimize pain.

Progressive relaxation Self-Assessment Exercise really, involves a combination of controlled breathing exercises and a series of contractions and relaxation of muscle groups. The client begins by breathing slowly and diaphragmatically allowing the abdomen to rise slowly and the chest to expand fully. When the client establishes a regular breathing pattern the nurse coaches the client to locate any area of muscular tension, think about how it feels, tense muscle fully and then completely relaxes them. This creates the sensation of removing all discomfort and stress. Gradually the client can relax the muscle without tensing them. When full relaxation is achieved perception is lowered and anxiety towards the pain experience becomes minimal. Relaxation technique provides clients with self-control when pain occurs reversing the physical and emotional stress of pain. The ability to relax physically also promotes mental relaxation. Examples of relaxation technique include medication, Yoga, guided imagery, and progressive relaxation exercises. Relaxation with or without guided imagery relieves tension-headaches, labor pain, anticipated episode of acute pain (for example a needle stick), and chronic pain disorders.

- **Anticipatory Guidance:** The modifying anxiety directly associated with pain, helps in not only relieving pain but also enhancing the effect of other pain-relieving measures. This is because knowledge about pain helps client/patient control anxiety and cognitively gains a level of pain relief (Walding, 1991). White, (1995) asserted that it is important to give clients/patients information that prevents misinterpretation of the painful event and promotes understanding of what to expect. According to her, such information includes:
- Occurrence, onset and expected duration of pain

- Quality, severity and location of pain
- Information on how the client's/patient's safety is ensured
- Cause of the pain
- Methods that the nurse and client/patient use for pain relief.
- Expectations of the client/patient during a procedure.

A typical example of anticipatory guidance is preoperative teaching on incisional pain and methods used to control it. It has been observed that this helps the patient to adapt better postoperatively.

Biofeedback

Potter & Perry (2009) paraphrasing the work of Flor et al. (1983) defined Biofeedback as a behavioral therapy that involves giving individual information about physiological responses (such as blood pressure or tension) and ways to self-assessment Exercise voluntary control over those responses. This therapy is particularly effective for muscle tension and migraine headache. The procedure employs electrodes, which are attached externally. These electrodes measure skin tension in microvolts. A polygraph machine visibly records the tension level for the client to see. The client learns to achieve optimal relaxation, using feedback from the polygraph while lowering the actual level of tension experienced. The therapy takes several weeks to learn.

Acupuncture

Acupuncture literally means "needle piercing." It began with the discovery that stimulating specific areas on the skin via insertion of very fine needles affects the physiological functioning of body's processes. These specific areas/points on the skin are called acupoints. These acupoints are in very specific locations and lie on channels of energy called meridians. It has traditionally been taught as a preventive form of health care, but has also been found useful in the treatment of a variety of acute and chronic conditions. Acupuncture has been used for over 3,000 years in China as a major part of their primary health care system. In modern times, it is used for the prevention of and treatment of diseases, for the relief of pain, and as an anesthetic for surgery. There are various painless, non-needle methods of acupuncture administration, including electrical stimulation, ultrasound, and laser. Acupressure is based on the principles of acupuncture. This ancient Chinese technique involves the use of finger pressure (rather than needles) at specific points along the body to treat ailments such as arthritis, tension and stress, aches and pains, and menstrual cramps. This system is also used for general preventive health care. Shiatsu is a Japanese word that means "finger pressure." Pressure is applied to points in the body using fingers, palms, elbows,

arms, knees, and feet, working on the body's energy system. Different techniques are used to relieve pain and release energy blockages.

Pharmacological Management of Pain

Quite a number of pharmacological agents provide satisfactory relief from pain. These agents are generally referred to as analgesics ranging from mild to strong analgesics. They stand out as the most widely employed pain-relieving measure and are quite potent. Although most, especially the narcotic analgesics, require a physician's order, the nurse's judgment in the use of medications and management of clients receiving pharmacological therapies help ensure the best pain relief possible. Analgesics can be broadly classified into four groups viz:

- **Non-narcotic Analgesic:** Provides relief for mild to moderate pain. Example includes Paracetamol.
- **Non-Steroidal Anti-Inflammatory Drug (NSAID):** Just like the non-narcotic analgesics NSAID also provides relief for mild to moderate pain especially those associated with rheumatoid arthritis, surgical and dental procedure, episiotomies and low back problems. But unlike the Non-narcotic analgesics non-steroidal anti-inflammatory drugs (NSAIDS) act by inhibiting the action of the enzymes that forms prostaglandin. With less prostaglandin released peripherally, the generation of pain stimuli is blocked. A reduction in pain sensitivity also occurs.
- **Opioids:** Opioids are generally prescribed for severe pain such as malignant pain. Neurotransmitters and opiate receptors are located in the dorsal horn of the spinal cord. Administration of opiates such as morphine results in the opiates binding to receptors and inhibiting the releases of substances P., as a result, transmission of painful stimuli to the spinal cords is blocked. In addition to the above, morphine sulphate and diamorphine hydrochloride raises the pain threshold and at the same time reduce associated fear and anxiety, thereby reducing pain perception.

- **Adjuvants or Co-analgesics** – These include such drugs as anticonvulsants, antidepressants, and muscle relaxants. Adjuvant analgesics are prescribed for those clients/patients whose pain is less responsive to analgesics alone, usually due to specific co-existing pathophysiology such as neuropathic pain due to nerve compression. The administration of tricyclic antidepressants such as amitriptyline and imipramine create an analgesic effect, as well as an antidepressant effect. The tricyclic inhibits the normal reuptake of serotonin at nerve terminals. With one serotonin present in nerve terminal, pain transmission is inhibited (Potter & Perry, 2009)

Note: As good and effective as the pharmacological management of pain is, it has its own disadvantages. This is because every drug is a potential poison and there is no drug without its adverse effect. This therefore calls for a thorough understanding of the actions, indications, dosages, routes of administration, side effects, and contraindications of each of these drugs for maximal benefit.

SELF-ASSESSMENT EXERCISE

List out the prejudices and misconceptions people have about pain.
What are the factors that influence individual's perception of pain?

4.0 CONCLUSION

Pain is not easy to define and the varied meaning attached to the word pain is an eloquent testimony of the difficulty inherent in explaining this complex phenomenon. Much of the difficulty encountered in understanding and precisely defining the term is attributable to the subjective nature of pain. Pain is a frequent and important problem in primary care, with far-reaching implications. Since pain is such a common problem faced in all health care settings, and one that not only threatens patient's comfort but also readily incapacitates, no effort should therefore be spared at procuring potent pain-relieving measures. Many approaches to management are possible, and a multi-dimensional approach, in discussion with the patient, is the most helpful.

5.0 SUMMARY

Pain could be physical, chemical or Psychogenic in origin. It comprises the components of reception, perception, and reaction. Knowledge of these three components of pain provides the nurse with guidelines for determining pain-relief measures as pain experience is influenced by a variety of variables such as age, gender, culture, anxiety, to mention a few. Eliminating sources of painful stimuli is a basic nursing measure for promoting comfort. The nurse individualizes pain relief measures by collaborating closely with the patient/client, using assessment findings and trying a variety of interventions. Measures that have proven helpful include: verbally acknowledging the presence of the pain; allowing patients to ventilate their feelings; listening attentively to what the client says about the pain; providing adequate information; conveying an attitude that you care; employing distraction, relaxation and guided imagery, cutaneous stimulation, biofeedback, or analgesic administration as the case may be. Good judgment and due caution are however important before utilizing any of these measures. All said and done, the nurse should not become frustrated when relief measures fail to fully control pain while being careful not to offer false reassurance.

6.0 TUTOR-MARKED ASSIGNMENT

Mrs. Jones, a known arthritic and ulcer patient reported at your clinic with complaints of longstanding intermittent pain that is now growing worse. Attempt a classification of pain. What pain relief measures would be appropriate for the nurse to use in the management of Mrs. Jones?

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UNIT 2 STRESS AND ADAPTATION

CONTENTS

1.0 INTRODUCTION

Modern man is faced with the paradox of stress. Everyone experiences stress from time to time and normally a person can adapt to long-term stress or cope with short-term stress until it passes. Stress places a heavy demand on a person, and if the person is unable to adapt, illness can result.

Stress is an essential part of our lives providing us with the impetus for vitality, drive and progress. Stress is the body response to the daily or everyday pressure of the body reaction to excessive demand by the trying to maintain equilibrium among its internal process. Conversely, it is also stress which is the root of a multitude of sociological, medical and economic problem. Stress can be mild, moderate and severe with behaviours that decrease energy and adaptive responses. The leading Cayuse of death today involves lifestyle stressor which precipitates stress with resultant effect on health-illness continuum. It is this cause and effect that this unit intends to examine stress and adaptation considering its concept, models of stress and stressor, factors influencing response to stress, adaptation and stress management for improved patients' care.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- explain the concept of stress and stressor
- discuss four (4) models of stress as they relate to nursing practice
- describe stress-management techniques required for client's care.

3.0 MAIN CONTENT

3.1 Concept of Stress and Stressor

There can be no stress without a stressor. Stress is any situation that can upset and prevent an individual from relaxing naturally. Stressor is the stimuli that precipitate the change in a man. Stress as a stimulus, do tax the adaptive capacity of the organism to its limits and which in certain condition can lead to a disorganization of behaviour and maladaptation which may lead to diseases.

Stress is a common denominator of the adaptive reaction in the body. It is any situation in which a non-specific demand requires an individual to respond physiologically and psychologically as well as taken an action. Stress can lead to negative or counterproductive feelings or threaten emotional well-being; threatens the way a person normally perceives reality, solves problems or think; threatens relationship and sense of belonging and a person's general outlook on life, attitude towards loved ones, job satisfaction, ability to problem solve and health status. Stress response is initiated by the individual's perception or experience of the major change.

The stimulus precipitating the response is called the **stressor** which may be physiological, psychological, social, environmental, developmental, spiritual, or cultural and represent unmet need. Stressors may be internal such as (fever, pregnancy, menopause and emotion such as guilt; and external which originates outside a person such as marked change in environmental temperature, a change in family or social role or peer pressure.

Activity 1

- Have you ever been faced with stress? Yes or No
- If yes, what is/are the cause?
- How did you recognize that you were under stress?
- What did you do?
- What other sources of stress do you know?

Now that you have attempted Activity 1, discuss your views with another colleagues/learner before you continue.

3.3 Models of Stress and Stressor

Models of stress refers to classes of stress which are used to identify the stressors for a particular individual and predict that person's responses to them. These models are useful for planning individualized nurse care plan to help a client cope with unhealthy, non-productive response to stressors.

There are four (4) models of stress namely:

- Response Based Model (RBM)
- Adaptive Based Model (ABM)
- Stimulus – Based Model (SBM)
- Transaction- Based Model(TBM)

**Please follow as we discuss these models concerning nurse client therapeutic care.*

i) Response Based Model (RBM)

RBM special the particular response or pattern of responses indicating a stressor. Selye, S. (1976) in his classic research into stress identified two physiological responses to stress namely: The local adaptation syndrome (LAS) and the general adaptation syndrome (GAS). While LAS is a response of a body tissue, organ, or part of the stress of trauma, illness, or other physiological change, the GAS is a defense response of the whole body to stress. Individual stress response is purely physiological and never modified to allow cognitive influences, but RBM does not allow individual differences in response patterns (No flexibility).

ii) Adaptation Based Model (ABM)

ABM states that there are four (4) factors that determines whether a situation is stressful or not. These are: ability to cope with stress; practices and norms of the person's peer groups; impact of the individual to adapt to a stressor; and the resources that can be used to deal with the stressor. ABM is based on the fact that people experience anxiety and increased stress when they are unprepared to cope with stressful situation.

iii) Stimulus-Based Model (SBM)

SBM focused on distributing or disruptive characteristics within the environment. The classical research of Holmes and Rahe (1978) identified stress as a stimulus resulting in the development of the social

readjustment scale which measures the effects of major life events on illness. The following verdicts have been summed up for:

1) Life changes events are normal.
2) People are passive recipients of stress and their perceptions of the events are irrelevant.
3) All people have a common threshold of stimulus, and illness results at any point after the threshold.
4) Transaction Based Model (TBM).

TBM views the person and environment in changing, reciprocal, interactive, relationship. It was developed by Lazarus and Folkman (1984) with a focus on the stressor as an individual perpetual response rooted in psychological and cognitive process.

3.3 Factors Influencing Response to Stressors

The response to any stressor is dependent on physiological functioning, personality, behavioural characteristics and the nature of the stressor. The nature of the stressor involves the following factors:

i) **Intensity:** minimal, moderate or severe.
ii) **Scope:** limited, medium, extensive.
iii) **Duration:** time lag.
iv) Number and nature of other stressors.

Activity 2

- As a following to activity I, briefly comment in not more than a page, how the above underlined influences your response to the identified sources of stress.

3.4.1 Sources of Stress

The common sources of stress are classified under the following headings:

A) Stress problems at home: these include

- Problem with co- tenants or neighbours
- Fear of attack by armed robbers
- Looking after dependants
- ……
- …… (complete the last two)

B) Stress provoking situations in the society:

- Erratic supply of electricity water and fuel
- Reckless driving and traffic hold-ups
- Insecurity
- …….
- ……. (complete the rest)

C) Stress provoking situation at work:

- having too much to do
- too much pressure and repeated deadlines
- poor physical working conditions
- ……..……

Activity 3

Now recap on the sources of stress above and compare with your write up in

3.5 Adaptation to Stressors

Adaptation is the process by which the physiological dimensions change in response to stress. The focus therefore in health care is on a person's family's or community's adaptation to stress because many stressors cannot be avoided. It involves reflexes, automatic body mechanisms for protection, coping mechanisms and instincts.

Adaptation is an attempt to maintain optimal functioning. To do this, persons must be able to respond to such stressors and adapt to the required demands or changes. It requires an active response from the whole person (physical, developmental, emotional, intellectual, social and spiritual). Adaptation response can be physiological or psychological.

Physiological Response

This model of stress response can be either Local Adaptation Syndrome (LAS) or General Adaptation Syndrome (GAS). See Self-Assessment Exercise1 in 3.2. An example of LAS is reflex (pain) and inflammatory response. The GAS consists of alarm reaction, resistance and the exhaustion stage.

1st Stage ALARM STAGE

Mobilization of the defence mechanisms of the body and mind to cope with the stressors.

2nd Stage RESISTANCE STAGE

Stabilization is attempted and success if achieved the body repairs damaged tissue that may occur if not exhaustion is the next stage.
3rd Stage:

i) **RECOVERY STAGE:** Repairs done, the body goes back to full functioning
ii) **EXHAUSTION STAGE:** The body can no longer resist stress and if it continues, death may occur.

Psychological Response:

Exposure to stress threatens one's basic needs. The threat whether actual or perceived, provides frustration, anxiety and tension. The psychological response otherwise referred to as coping mechanisms is adaptive behaviors which assist the person's ability to cope with stressors. These behaviors are directed at stress management and are acquired through learning and experience as a person identifies acceptable and successful behaviors. The behavior includes:

i) Task Oriented Behavior

Use of cognitive abilities to reduce stress, solve problems, resolves conflicts and gratify needs. The three types of task-oriented behaviors are attack behaviour, withdrawal behaviour, compromise (by substitution or omitting the satisfaction of needs to meet other needs or to avoid stress).

ii) Ego Defense Mechanism

These are unconscious behaviors that offer psychological protection from a stressful event. It is used by everyone and helps protect against feelings of unworthiness and anxiety.

3.6 Management of Stress

The management of stress is classified into 3 headings for easy assimilation and understanding.
i) Reducing stressful situation through:
a) Habit formation
b) Change avoidance
c) Time blocking
d) Time management
e) Environment modification.
ii) Decreasing physiological response through:
a) Regular exercise

b) Humour
c) Nutrition
d) Rest
e) Relaxation

iii) Improved behavioural and emotional responses to stress through:

a) Support systems: family, friends, colleague, to be included in the stress management.
b) Crisis intervention
c) Enhancing self-esteem.

3.2 Nursing Intervention in Stress

The nurses understanding of the physiological and psychological indicators of client management easier. Since each client has specific perceptions and responses to stress, the nurses' ability to assess, individual needs, diagnose in relation to stress, plan the levels of care, implement and evaluate will assist greatly in determining the effectiveness of stress management technique for the overall benefit of the client.

SELF-ASSESSMENT EXERCISE

i. Identify 3 physiological changes in the body that goes for Local Adaptation Syndrome (LAS)
ii. Identify the physiological changes in the body that goes for General Adaptation Syndrome.
iii. What are the support system's roles in alleviating stress in an expectant mother who is due to be put to bed in a week?

4.0 CONCLUSION

Each person reacts to stress differently according to perception of the stressor, personality, prior expectations with stress and use of coping mechanism.

The stages of illness development in stress-related diseases are 7 in all.

Stage 1: short stress situation (no risk)
Stage 2: moderate stress situation (at risk)
Stage 3: severe stress situation
Stage 4: early clinical sign
Stage 5: symptom
Stage 6: disease or disability
Stage 7: death

At any stage, there may be physical complaints such as nausea, vomiting, diarrhea or headache. Physical appearance also changes. The identification of the mind-body interaction is crucial for predicting the risk of stress-related illness. A nurse by mere studying the effects of a stressful lifestyle or event in a client can also assess the coping mechanism required by the client.

5.0 SUMMARY

This unit has examined the concept of stress and its relationship to health and illness. The various models of stress were also highlighted to help the nurse understand the causes and response to stress. Stress management techniques directed at changing a person's reaction to stressors were also discussed to assist the nurse in helping client manage stress carefully.

6.0 TUTOR-MARKED ASSIGNMENT

What is your concept of stress? Identify and discuss the four (4) models of stress as they relate to nursing practice.

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UNIT 3 SEXUALITY AND GENDER ISSUES

CONTENTS

1.0 INTRODUCTION

Sexuality is the process of becoming and being a man or woman with all its attending manifestations. Sex as a topic or an issue has long been considered a “taboo” for proper adult conversation. People hardly want to talk about it openly, however, in the last two decades, knowledge about sex and discussion of sexuality have come to be recognized as important and necessary for human development.

Sexuality health has also been recognized as being relevant in the overall component of well-being. In the face of this recognition, there is still lack of knowledge regarding human sexuality among many adults including health care providers. Clients are often reluctant to raise questions related to sexuality, the nurse in her bid to provide holistic care must assume the responsibility of initiating discussion of relevant sexual topics within client’s current developmental and health status. Acquisition of knowledge and desensitization towards sexual understanding of the vast range of normal sexual behaviour.

This unit will consider sexuality and gender issues in relation to personal attitudes and beliefs, sexuality counseling and disorders with the peculiar nursing process which enables health care provider (nurses) to be non-judgmental and more effective in working with clients.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

- state the concept of sexuality and gender identity
- identify various attitudes towards sexuality
- discuss the nursing intervention about sexuality and gender issues.

3.0 MAIN CONTENT

3.1 Concept of Sexuality

Sexuality is described as the sense of being a female or male. It has biological, psychological, social and ethical components. It influences and is influenced by life experiences. The biological aspect of sexuality is the act of sexual activity. Sex may be used for pleasure and reproduction. The activity can be controlled or curtailed due to life's change or a choice for brief or prolonged periods. Being born with female or male genitalia social roles is the main ingredient to the emergence of sexuality.

The adult sexuality has four major divisions:

- Biological sex
- Sexual behaviour
- Core gender identity
- Sex role imagery

Biological Sex:

This is determined at conception and refers to individual's physical attributes. This is based on the inherent genotype X and Y chromosomes. Female foetus receives two x chromosomes from the mother and a Y Chromosomes from the father. Initially, the genitalia of the foetus are undifferentiated, when the sex hormones begin to cue fatal tissues, the genitalia assumes male or female characteristics with corresponding underlying hormonal, neutral, vascular and physical components.

Core Gender Identity

This refers to one's sense of being a man or a woman and is established early in life, usually by 3years of age. Apart from the sex determination in utero with the aid of C. T. Scan, at this age, the child is known whether he is a boy or a girl. As children begin to explore and understand their own bodies, they combine this information with the way that society treats them to create images of themselves as girls or boys. It is the core gender

identity that corresponds to the physical attribute of the individual and self-concept development.

Sex Role Imagery

It refers to the learned behaviour that the particular society subscribes to their men and women. Sex imagery is complex because it includes the myriad beliefs about what is labeled feminine or masculine in a society. It also conveys the appropriate image of sexual conduct for particular social groups. It is important as it represents much of the learned behaviour which influences human choice and life-style.

Sexual Behaviour

This is the acting out of sexual expressions, feelings and beliefs. It is a combination of human behaviour and varies from how one walks to how and with whom one relays with sexually. These behaviours include promiscuity, masturbation, sexual preference (oral or genital) and the likes.

3. XY Chromosomes gives rise to ---------- foetus.
4. XX Chromosomes gives rise to ---------- foetus.

Sexual Anatomy and Physiology

Female Sex Organs

The female genitalia comprise of the external and internal organs. The external sex organs, collectively called the vulva includes the mons veneris, labia majora, labia minora, clitoris and vagina opening. The internal sex organs include the vagina, uterus, fallopian tubes and ovaries. Menstruation and menopause are the main physiological features of female sex organs.

The male sex organs is made up of the penis, testicles, epididymis and ductus deference, the prostate gland, seminal vesicles and cowpers glands whose secretions become part of the ejaculated semen.

Attitudes towards Sexuality

Attitudes towards sexual feelings and behaviours change as people grow older. These changes become traditional or liberal because of societal changes, feedback from others, and involvement in religious or community groups. Individuals reveal themselves as females or males by their gestures, mannerisms, clothing, vocabulary and patterns of sexual activity.

Factors Influencing Attitudes

Two main factors that help shape sexual attitudes and behaviors are biological factors and personality. Other powerful factors that are involved include religious beliefs, society and traditions.

Clients Sexual Attitudes

Everyone has sexual value system which are acquired throughout life. These make it easy for a client to deal with sexual concerns in a health care setting or it becomes an obstacle to expressing it.

Nurses Attitudes Towards Sexuality

Nurses should deal with personal attitudes by accepting their existence, exploring their sources and finding ways to work with them. Nurses are part of the society and her professional behaviour must guarantee that clients receive the best health care possible without diminishing their self-worth. The promotion of sex education and honest examination of sexual values and beliefs can help in reducing sexual biases that can interfere with care. The nurse should give clients information about sexuality and this does not imply advocacy. Clients require accurate honest information about the effects of illness on sexuality and the ways that it can contribute to wellness.

Sexuality Counseling

Sexuality complaints are determined during history taking. An acceptable to open up makes sexuality an acceptable topic to discuss. Once the nature of the problem has been identified, treatment commences under the hinges of sexuality counseling. Sexuality counseling operates at four (4) levels:

- **Permission:** this involves letting the client realize or be reassured that the client realizes or be reassured that s/he is normal and may continues doing what s/he has doing.
- **Limited Information:** this involves only providing information specific to the patients concerns or problem. A closed monitoring by the nurse is made possible by the assumed change in behaviour or action.
- **Specific Suggestions:** these may be a suggested course of action through more in-depth education and sexual exercise.
- **Intensive Therapy:** highly individualized and provided by professionals who have advanced experience and knowledge in the sex therapy field.

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Disorders of Sexuality

Disorders of sexuality can occur in each of the four areas of sexuality can occur in each of the four area of sexuality (see 3.1), but most disorders are psychosexual in origin. These disorders include:

1. Variation in sexual expressions classified by object choice and sexual aim.
- Tran sexuality in which an individual appears to have a gender identity at odds with his or her physical self.
- Ambiguous genitalia which presents a genitalia different from the physical gender identity on the child.
- Sexual concerns over performance are also prevalent in which an individual doubts his or her necessary physical attribute to attract, satisfy and keep a sexual partner.
- Sexual dysfunction in the form of impotence, premature ejaculation, frigidity, dyspareunia and vaginism. It can be as a result of psychological or physical factors.

Sexuality and Nursing Process

Sex as a natural, spontaneous act that passes easily through some recognizable physiological stages and culminates in satisfaction for both partners. Nurses should expect to encounter clients who have problems with one or more of the stages of sexual behaviour excitement, plateau, orgasm and resolution).

Many nurses are uncomfortable talking about sexuality with clients, but they can reduce their discomfort using the nursing process which includes assessment, diagnosis, planning, implementation and evaluation.

The assessment level considers the factors affecting sexuality: physical relationship, lifestyle and self-esteem factors. These assist in eliciting the exact cause of sexual concerns or problems of the client/patient. As a follow up to the assessment, altered sexuality patterns and sexual dysfunction are recognized as approved nursing diagnosis. The difference is in whether the client perceives problems in achieving sexual satisfaction or expresses concern regarding sexuality.

The planning of nursing care is dependent on client’s needs, and should include referrals to resources to promote achievement of goals after contact with the nurse is discontinued.
Nursing interventions (implementation) should address client alterations in sexual patterns or sexual dysfunction generally to raise awareness, assist clarification of issues or concerns, and provide information. An

acquisition of specialized education in sexual functioning and counseling may provide more intensive sex therapy.

Evaluation of the impact of nursing process on sexuality is determined by client or spouse verbalizations whether achievement of goals and outcomes has been achieved. Sexuality is felt more than observed and sexual expression requires an intimacy not amenable to observation. Clients are expected to verbalise concerns, share activities and satisfaction as well as relate risk factors. Outcomes are evaluated, the client, spouse and nurse may need to modify expectations or establish more appropriate time frames to achieve the target goals.

SELF-ASSESSMENT EXERCISE

i. Mention three examples of sex role imagery beliefs for male and female alike.
ii. When does sex role imagery learning begins and ends?
iii. Using levels two and three what will be your guiding principle in the sexuality counseling of an Acquired Immune Deficiency Syndrome (AIDS) patient/client.

4.0 CONCLUSION

Sexuality is an integral component of personhood and therefore may have an impact on or be affected by health status. The nurse therefore needs to be clear about his or her own sexuality and moral beliefs about sex and reproduction before addressing the needs of the patient. Sex will always remain a controversial issue because of ethical value

systems. Facts of conception, development conception and sexual diseased transmission may be taught but cannot be totally separated from ethical issues.

The nurse has many opportunities to be a promoter of good health in the fields of sex and reproduction which should be utilized at every available opportunity. No one should be left out (male or female) as the responsibility for sexual health transcends all borders. With sensitivity and insight, the nurse can assist the client in assuming responsibility for decisions about sexuality thus enhancing their total health**.**

5.0 SUMMARY

This unit on sexuality and gender issues reflected on the concept of sexuality stressing the four (4) major divisions of adult sexuality, brief anatomy and physiology of the sexual organs, attitudes towards sexuality and counseling in the face of sexuality disorders. The levels of nursing intervention were also identified to appropriate the client's expectation of health care from the nurse.

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6.0 TUTOR-MARKED ASSIGNMENT

1. What are the key elements in the concept of sexuality?
2. Briefly describe the interrelationship of the four aspects of sexuality.

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