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DEPARTMENT OF NURSING SCIENCE

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NSC 211 - FOUNDATION OF PROFESSIONAL NURSING II

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PROCESS AND PRACTICE IN NURSING

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STUDY SECTION 1: INTRODUCTION TO NURSING PROCESS

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1.0 Introduction

Foundations of Professional Nursing II exposes students to the basic nursing procedures used in nursing practice and the ethics guiding the nursing profession. This study section will identify the basic nursing procedures used in care giving (for disease control and promotion of health) with the aid of a tool (called the nursing process). This is facilitated through effective communication process and adequate interpersonal relationship when giving care.

2.0 Learning Outcomes

After reading this study section, the student will be able to:

- Identify the basic nursing procedures used in nursing practice
- State the importance of nursing process
- Apply the steps in nursing process for disease control and promotion of health.
- Discuss the legal aspects in nursing profession
- Explain the need for effective communication and interpersonal relationship in care giving
- Describe the different ways of promoting sustainable health, thereby removing the agent, condition or stimulus inhibiting health promotion.

3.0 Main Content

3.1 What is Nursing Process?

Nursing process is often defined as the application of critical thinking to client care activities. The nursing process can also be defined under three dimensions, namely:

1. By purpose
2. By organization
3. By properties

1) **By Purpose:** The primary purpose of the nursing process is to manage each client care scientifically, holistically and creatively. To do this successfully, the nurse needs intellectual, technical, interpersonal, ethical/legal competences, as well as the willingness to use them creatively when working with the clients to promote wellness, prevent disease or illness, restore health and facilitate coping with altered functioning.

2) **By Organization:** Nursing process has been traditionally defined as a systematic method for assessing health status, diagnosis, health care needs, formulating a care plan, initiating and implementing the plan and evaluating the effectiveness of the care plan.

3) **By Properties:** There are seven properties of the nursing process. These include systematic, dynamic, interpersonal, flexible, theoretically-based, goal-oriented and universally applicable.

a. **Systematic:** Nursing process is a systematic method that directs that nurse and client as together determine the need for nursing care, plan and implement the care and evaluate the results.

b. **Dynamic:** Nursing process is dynamic, because it involves continuous change. It is an ongoing process focused on the changing responses of the client that are identified throughout the nurse-client relationship.

c. **Interpersonal:** Nursing process is interpersonal. Always at the heart of nursing is the human being. It is interactive because the interactive nature is based on the reciprocal relationship that occurs between the nurse and the client family and other health professionals.

d. **Flexible:** Nursing process is flexible because the flexibility of the process may be demonstrated in two contexts.
    - It can be adapted to nursing practice and any setting or area of specialization dealing with individuals, groups or communities.
    - Its phrases may be used sequentially and concurrently i.e. the nursing process is most frequently used in sequence. However, the nurse may use more than one step at a time.

e. **Theoretically- based:** Nursing process is theoretically- based because the process is devised from a broad- based knowledge including the sciences and humanities and can be applied to any other theoretical models of nursing.

f. **Goal- oriented:** Nursing process is goal- oriented because it offers a means for nurses and clients to work together to identify specific goal related to wellness promotion, disease and illness prevention, health restoration and coping with altered functioning, which are most important to client and to math them with appropriate nursing actions.

g. **University- Applicable:** Nursing process is universally applicable. The one constant in health care is changed. Once nurses have a working knowledge of the nursing process, they find that they can practice nursing with well or ill persons, young or old in any type of practice setting.

Importance of Nursing Process

The use of nursing process has many advantages are as follows

1) The nursing process provide a framework for meeting the individual needs of the client, the client's family/ significant other (s) and the community.
2) The steps of the nursing process focus the nurses attention on the individual human responses of the client/ group to a given health situation, resulting in a holistic plan of care addressing their specific needs.
3) The use of nursing provides an organizational, systematic method of problem solving, which may minimize dangerous errors or omissions in caregiving and avoid time- consuming repetition in care and documentation.
4) The use of nursing process enables nurses to have control over their own practice. This enhances the opportunity for nurses to use their knowledge, expertise and intuition, constructively and dynamically to increase the likelihood of a successful client, outcome. This in turn promotes greater job satisfaction and professional growth.
5) The use of the nursing process provides a means of assessing nursing economic continuation to client care.

Characteristics of Nursing Process

1. It is orderly and systematic
2. It is interdependent
3. It is a framework for providing nursing care to individuals, families and communities.
4. It provides specific care for individuals, families and communities.
5. It is client centered, using the client's strengths
6. It is appropriate for use throughout the lifespan
7. It can be used in all setting
8. It is goal- directed

Purpose of the Nursing Process

The following are the purposes of the nursing process:

1. To identify the client's health status and actual or potential health care problems or needs (through assessment).
2. To establish plans to meet the identified needs
3. To deliver specific nursing interventions to meet those needs
4. To apply the best available care giving evidence and promote human functions and responses to health and illness.

5. To protect nurses against legal problems related to nursing care when the standards of the nursing process are followed correctly.
6. To help the nurse perform in a systematically organized way their practice.
7. To establish a database about the client's health status, health concerns, response to illness, and the ability to manage health care needs.

3.2 Steps of Nursing Process

The nursing process consists of five steps

i) Assessment (ii) Diagnosis (iii) Planning (iv) Implementation (v) Evaluation. The steps of the nursing process are not separate entities but overlapping continuing sub processes. Apart from understanding nursing diagnoses and their definitions, the nurse and behaviors of diagnoses, related factors to the selected nursing diagnoses. The steps of the nursing process are detailed below.

1. Assessment (What Data is Collected?)

The first phase of the nursing process is assessment. It involves collecting, organizing, validating, and documenting the client's health status. This data can be obtained in a variety of ways. Usually, when the nurse first encounters a patient, the nurse is expected to assess to identify the patients' health problems as well as the physiological, psychological and emotional state and to establish a database about the client's response to health concerns or illness and the ability to manage health care needs. Critical thinking skills are essential to the assessment, thus requiring concept- based curriculum changes.

Collecting Data

Data collection is the process of gathering information regarding a client's health status. The process must be systematic and continuous in collecting data to prevent the omission of important information concerning the client.

Note:

The best way to collect data is through head and toe assessment.

Types of Data

Data collection about a client generally falls into objective or subjective categories, but data can also be verbal and non-verbal.

a. **Objective data or sign:**
Objective data are overt, measurable, tangible data collected via the senses such as sight, touch, smell or hearing and compared to an accepted standard such as vital signs, intake and output,

height and weight, body temperature, pulse and respiratory rates, blood pressure, vomiting, distended abdomen, presence of edema, lung sounds, crying, skin color, and presence of diaphoresis.

b. **Subjective data or symptoms:**
Subjective data involve covert information, such as feelings, perceptions, thoughts, sensations or concerns that are shared by the patient and can be verified only by the patients, such as nausea, pain numbness, pruritus, attitudes, beliefs, values and perceptions of the health concern and life events.

c. **Verbal data:**
Verbal data are spoken or written data such as statements made by the client or by a secondary source. Verbal data requires the listening skills of the nurse to assess difficulties such as sheering, tone of voice, assertiveness, anxiety, difficulty in finding the desired word and flight of ideas.

d. **Non- verbal data:**
Non-verbal data are observable behavior transmitting a message without words such as the patient's body language, general appearance, facial expressions, gestures, eye contact, body language, touch, posture, and clothing. Non-verbal data obtained can sometimes be more powerful that verbal data, as the client's body language may not be congruent with what they really think or feel. Obtaining and analyzing non-verbal data can help reinforce other forms of data and understand what the patient really feels.

Sources of Data

Sources of data can be primary, secondary and tertiary. The client is the primary source of data, while family members, support persons, record and reports, other health professionals, laboratory and diagnostics fall under secondary sources.

1. **Primary Source:**
The client is the only primary source of data and the only one who can provide subjective data. Anything the client says or reports to the members of the healthcare team is considered primary.

2. **Secondary Source:**
A source is considered secondary data. If it is provided from someone else other than the client but within the client's frame of reference. Information provided by the client's family or significant others are considered Secondary sources of data if the client cannot speak for themselves, is lacking fact and understanding or is a child. Additionally, the client's records

and assessment data from other nurses or other members of the healthcare team are considered Secondary sources of data.

3. **Tertiary Source:**
   Sources from outside the client's frame of reference are considered Tertiary sources of data. Example of tertiary data include information from textbooks, media and nursing journals, drug handbooks, surveys, and policy and procedural manuals.

Methods of Data Collection

The main method used to collect data are health interviews, physical examination and observation. Let's explain each method used in data collection.

1. **Health Interview:**
   The most common approach to gathering important information is through an interview. An interview is an intended communication or a conversation with a purpose. For example, to obtain or provide information, identifying problems of mutual concern, evaluate change, teach, and provide support or counseling or therapy. One example of the interview is the nursing health history, which is a part of the nursing admission assessment patient interaction is generally the heaviest during the assessment phase of the nursing process so rapport must be established during this step.

2. **Physical Examination:**
   Aside from conducting interviews, nurses will perform physical examination, referencing a patient's health history, obtaining a patient's family history, general observation can also be used to gather assessment data. Establishing a good physical assessment would later on, provide a more accurate diagnosis, planning and better interventions and evaluation.

3. **Observation:**
   Observation is an assessment tool that depends on the use of the five senses (sight, touch, hearing, smell and taste) to learn information about the client. This information is related to characteristics of the client's appearance functioning, primary relationships and environment. Although nurses observe mainly through sight, most of the senses are engaged during careful observations such as smelling foul odor, hearing or auscultating lung and heart sounds and feeling the pulse rate and other palpable skin deformation.

2. Diagnosis (What is the Problem?)

The second step of the nursing process is the nursing diagnosis. The nurse will analyze all the gathered information and diagnose the client's condition and needs. Diagnosing involves analyzing data, identifying health problems, risks and strength and formulating diagnostic statements about a patient's potential or actual health problem.

3. Planning (How to Manage the Problem?)

Planning is the third step of the nursing process. It provides direction for nursing interventions. When the nurse, any supervising medical staff, and the patient, and the nurse will plan a course of treatment that takes into account short and long – term measurable goal for the expected beneficial outcome.

Types of Planning

Planning starts with the first client contact and resumes until the nurse- client relationship ends preferably when the client is discharged from the health care facility.

a. **Initial Planning:**

Initial planning is done by the nurse who concludes the admission assessment. Usually, the same nurse will be the one to create the initial comprehensive plan of care.

b. Ongoing Planning:

Ongoing planning is done by all the nurses who work with the client. As a nurse obtain new information and evaluate the client's response to care, they can individualize the initial core plan further. An ongoing care plan also occurs at the beginning of a shift. Ongoing planning allows the nurse to:

i. Determine if the client's health status has changed

ii. Set priorities for the client during the shift

iii. Decide which problem to focus on during the shift

iv. Coordinate with nurses to ensure that more than one problem can be addressed at each client contact.

c. **Discharge Planning:**

Discharge planning is the process of anticipating and planning for needs after discharge to provide continuity of care, nurses need to accomplish the following**:**

i. Start discharge planning for all clients when they are admitted to any health care setting.

ii. Involve the client and the client's family or support persons in the planning process.

iii. Collaborate with other health care professionals as need to ensure that bio-psychosocial, cultural and spiritual needs are met.

Developing A Nursing Care Plan

A nursing care plan (NCP) is a formal process that correctly identifies existing needs and recognize potential needs or risks. Care plan provide communication among nurses, their patients, and other health care providers to achieve health care outcomes. Without the nursing care planning process, the quality and consistency of patient care would be lost.

4. Implementation (Putting the Plan to Action)

The implementation phase of the nursing process is when the nurse puts the treatment plan into effect. It involves action or doing and the actual carrying out of nursing interactions outlined in the plan of care. This typically begins with the medical staff conducting any needed medical interventions.

Interventions should be specific to each patient and focus on achievable outcomes. Actions associated with a nursing care plan include monitoring the patient for signs of change or improvement, directly caring for the patient or conducting important medical tasks such as medication administration, education and guiding the patient about further health management and referring or contacting the patient for a follow up.

Skills Used in Implementing Nursing Care

When implementing care, nurses need cognitive interpersonal, and technical skills to perform the care plan successfully.

i. **Cognitive Skills:** are also known as intellectual skills are skills involve learning and understanding fundamental knowledge including basic sciences, nursing procedures and their underlying rationale before caring for clients. Cognitive skills also include problem- solving, decision making, critical thinking, clinical reasoning, and creativity.

ii. **Interpersonal Skills:** are skills that involve believing, behaving, and relating to others. The effectiveness of a nursing action usually leans mainly on the nurse's ability to communicate with the patient and the members of the health care team.

iii. **Technical Skills:** are purposeful "hand-on" skills such as changing, a sterile dressing, administering an injection, manipulating equipment, bandaging, moving, lifting and repositioning clients. All of these activities require safe and competent performance.

5. Evaluating ("Diet The Plan Work")

Evaluating is the fifth step of the nursing process. This final phase of the nursing process is vital to a positive patient outcome. Once all nursing intervention actions have taken place, the team now learns what works and what doesn't by evaluating what was done beforehand. Whenever a healthcare provider intervenes or implements care, they must reassess or evaluate to ensure the desired outcome has been met. The possible patient outcomes are generally

explained under three terms: the patient's condition improved, the patient's condition stabilized, and the patient's condition worsened.

Steps in Evaluation

Nursing evaluation include:

1. Collecting data
2. Comparing collected data
3. Analyzing client's response relating to nursing activities
4. Identifying factors that contributed to the success or failure of the core plan
5. Continuing, modifying or terminating the nursing care plan and
6. Planning for future nursing care

Below are the explanation of steps in evaluation

1) **Collecting Data:**
The nurse recollects data so that conclusions can be drawn about whether goals have been fulfilled. It is usually vital to collect both objective and subjective data. Data must be documented concisely and accurately to facilitate the next part of the evaluating process.

2) **Comparing Data with Desired outcomes:**
The documented goals and objectives of the nursing care plan become the standard or criteria by which to measure the client's progress whether the desired outcome has been met, partially met or not met.

- The goal was met; when the client response is the same as desired outcome
- The goal was partially met; when either a short term outcome was achieved but the long – term goal was not, or the desired goal was incompletely attained.
- The goal was not met.

3) **Analyzing client's Response relating to Nursing activities:**
It is also very important to determine whether the nursing activities had any relation to the outcomes whether it was successfully accomplished or not

4) **Identifying factors contributing to success or failure:**
It is required to collect more data to confirm if the plan was successful or a failure. Different factors may contribute to the achievement of goals. For example, the client's family may or may not be supportive, or the client may be uncooperative to perform such activities.

5) **Continuing, Modifying, or Terminating the Nursing care plan:**
The nursing process is dynamic, but cyclical. If goals were not sufficed, the nursing process begins again from the first step. Reassessment and modification may continually be needed to keep them current and relevant depending upon general patient condition. The plan of care

may be adjusted based on new assessment data. Problems may arise or change accordingly. As clients complete their goals, new goals are set. If goals remain unmet, nurses must evaluate the reasons these goals are not being achieved and recommend revisions to the nursing care plan.

6) **Discharge Planning:**
Is the process of transitioning a patient from one level of care to the next. Discharge plan are individualized instructions provided as the client is prepared for continued care outside the health care facility or for independent living at home. The main purpose of a discharge plan is to improve the client's quality of life by ensuring continuity of care together with the client's family or other health care workers providing continuing care.

4.0 Conclusion

Nursing practice needs criticality to perform. In order to enhance this, the nursing process was introduced. The process aids the patient journey from admission to discharge. Therefore, good knowledge of the different steps is essential for proper practice.

5.0 Summary

This study section explained the concept of the nursing process and the various step in the nursing process.
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6.0 Questions

1. The nursing care plan is a part of the nursing process. True or false.
2. The initial step in the nursing process is……..
3. The last step in the nursing process that helps the nurse to know if their plan worked is……

Answers

1. True
2. Assessment
3. Evaluation

7.0 References/ Further Reading

Cooper, K, & Gosnell, K. (2022). Adult Health Nursing. 9th Edition. Evolve.

Taylor, C., Lillis, C., Lynn, P. & LeMone P. (2015). Fundamentals of Nursing: The Art and Science of Person-Centered Nursing Care. 8th Edition. Wolters Kluwer.

STUDY SECTION 2: BASIC NURSING PROCEDURES

CONTENTS

1.0 Introduction

Nursing is a skillful occupation and there are some practices that needs to be carried out. Let us define what nursing procedure is. This section will explain what these procedures are and how they should be carried out in details.

2.0 Learning Outcomes

At the end of this study section, the student will be able to:

1. identify some basic nursing procedures
2. explain the identified procedures
3. discuss history taking and documentation process in nursing
4. explain the procedure of admission and discharge

3.0 Main Content

3.1 Concept of the Nursing Procedure

Nursing procedure is a health- related procedure that is commonly taught in nursing education programs and normally performed by registered nurse or licensed practical nurse when implementing the nursing plan care. The basic nursing procedures are carried out in different levels. Below are the procedures:

1. Ward cleaning, cleaning of patient's unit
2. Care of Hospital equipment, cleaning disinfection of equipment
3. Taking of vital signs
4. Weighing patient
5. History taking and documentation
6. Bed-making (simple unoccupied and occupied bed)
7. Bed-bathing

Ward Cleaning

The nurse is expected to supervise ward aides in carrying out this procedure so as to ensure safe and clean environment for the patient/clients.

Objectives

1. To maintain a safe and healthy environment
2. To prevent and control the spread of pathogenic organism.

Equipment on Trolley

1. Basic of soapy water
2. Two pieces of duster
3. Receiver of waste
4. Scouring powder if necessary
5. Antiseptic solution if required.

Procedure

1. Remove all articles on the articles on the locker to the bedside bench temporarily.
2. Collect thrash in the receiver for waste
3. Rinse duster in the soapy water and squeeze dry
4. Use firm even strokes from top to bottom
5. Using the damp duster, clean bedside and inside locker, wipe with dry duster and replace the articles.
6. Following the pattern in item, fire clean the chair, tables and bed stools etc.
7. Use scouring powder to remove stains/ marks on the articles
8. Leave towel and face cloth neatly on the towel rack of the bedside locker
9. Clean polished surfaces with damp duster and wipe dry
10. Arrange all the beds on a straight line
11. Wash basin, duster and return to the proper places.

Note:

- Window curtains and screens are sent to the laundry at least twice yearly
- Sterilizers are washed daily and prepared for use
- Bedpans and urinals should be washed, disinfected and sterilized after use.

Care of Hospital Equipment (Cleaning and Disinfecting Equipment)

Proper care and maintenance are very important for proper functioning of equipment. There are general principles of care which are:

i. All objects to be disinfected or sterilized should first be thoroughly cleaned to remove all organic matter (blood and tissue) and other residue.
ii. All items used in patient care should be kept clean and in proper working condition
iii. All medical instruments and other items used for patient care must be cleaned and disinfected or sterilized before use on another patient.
iv. Refer to the manufacturer's instructions for use of the appropriate type of disinfectant and the best method of cleaning and sterilizing each piece of medical instrumentation.
v. Ethyl or isopropyl alcohol (70% - 90%) is used for chemical disinfection.
vi. For routine cleaning of most of the items, ammonium germicidal detergent is available
vii. Cleaning and decontamination should begin as soon as possible after use as blood and body fluids can cause pitting of instruments and if left to dry can be difficult to remove.
viii. When transport to the decontamination area is going to be delayed, soiled instruments should be moistened with a wet towel or enzymatic solution.
ix. Decontamination and packaging should not be performed in patient care areas.
The equipment you use in the hospital for patient must be in good conditions always. Otherwise, it will not be possible to offer flawless medical support to the patient.

Taking Vital Signs

Vital signs are also known as **Cardinal signs**. They are basic indicators of the physiological status of the body. They include measuring the Temperature, Pulse, Respiration, Blood pressure. It is a clean procedure.

Purpose:
1. To monitor the condition of the patient
2. To aid diagnosis of the patient
3. To obtain baseline data.
4. To detect early any abnormality

Requirement
1. Thermometers (oral or rectal) in a container of disinfectant solution (Dettol 1:40/ salon 1:20) glycothymoline for oral thermometer.
2. 2 Gallipots of wet (water) and dry swab
3. A receiver for use swabs
4. Lubricant e.g., Vaseline or key jelly, liquid paraffin (if rectal) patient's own towel (if by axilla)
5. Watch with seconds hand or a pulse meter
6. Pen (blue, red or black) for writing
7. Temperature charts
8. A receiver with lotion and gauze for used thermometer.

Measuring Body Temperature

The site for checking temperature

i. Oral
ii. Rectal
iii. Axillary
iv. Tympanic membrane

Indication

1) Before, during and after administration of any drug that affects temperature control function
2) Before and after any nursing intervention that affects temperature of the patient
3) To monitor patient's condition
4) To observe for changes or alteration in health status
5) Routine assessment during admission

Procedure

1. Ascertain the method to be used and explain the procedure to the patient
2. Wash hands
3. Prepare equipment
   - Wipe thermometer fry using a clean dry cotton swab from bulb to stem allowing solution distribute over the thermometer
   - Shake down the mercury by holding thermometer between thumb and forefinger at the tip of the stem. Shake at wrist level.
4. Check temperature

a) For oral method, place bulb at the base of the tongue on the side of the frenulum

- Instruct patient to close the lips not the teeth around the thermometer
- Leave the thermometer in place for 2 – 3 months for Rectal method
- Don't clean gloves
- Apply lubricant to bulb of thermometer
- Using the non- dominant hand expose the anus raising upper buttocks
- Instruct patient to breathe deeply and insert thermometer into anus
- 3.5 – 4cm in adults, 1.5cm in infants, 2.5cm in children
- Do not force insertion
- Hold thermometer in place for 1 – 2 minutes for Axillary method
- Place bulb in the center of the axilla, ensure it is not observed from behind
- Hold in place for 3 – 5 minutes

5. Remove thermometer

- Wipe using a cotton swab from the stem to bulb
- Read the temperature, holding thermometer at eye level and rotate it till reading is visible and read accurately

- Shake down the mercury level and replace in disinfectant solution or in a safe dry place (if personal)
- Document temperature, wash hands and replace equipment.

Measuring Pulse

Pulse is defined as the wave of distention or elongation felt in an artery well due to contraction of the left ventricle forcing about 100ml of blood into the already full aorta.

Purpose

1. To establish baseline data
2. To observe for abnormalities in rate, rhythm and volume
3. To assess the state of client's cardiovascular system
4. To determine number of heart beats occurring per minute
5. To access heart's ability to deliver blood to distant areas of the blood vessel. Fingers and lower extremities.

Site for checking pulse

Radial, Temporal, Carotid, Apical, Brachial, Femoral, popliteal, posterior tibial, Dorsalis pedis ulna pulse.

Requirements

1. Wristwatch with second hand
2. Pens
3. Vital signs chart

Procedure

- Explain the procedure to the patient and check if the patient had just been involved in any activity. If so, allow the patient to rest for 10 minutes before taking the pulse.
- Select the pulse site:
  - Assist the patient in comfortable position
  - For radial pulse, keep the arm resting over chest or on the side with palm facing downwards. In a sitting position, keep the arm resting over the thigh with the palm facing downward.
- Palpate and check pulse
  - lace tips of 2 or 3 fingers other than thumb lightly over the pulse site.
  - Count the pulse for 1 minute looking at the wrist watch with a second hand or breast watch
  - Assess for rate, rhythm and volume of pulse and condition of blood vessel.
- Document and report important data and wash hands.

Note:

- Never press two carotids at the time
- Carotid pulse is used for victims with shock and cardiac arrest
- In infants and young children the apical pulse is felt through the stethoscope

Assessing Respiration

Respiration is defined as the exchange of gases between organs and tissues of the body and the external environment. Assessing respiration involves monitoring the inspiration and expiration of a patient.

Purpose

1. To determine number of respiration occurring per minute
2. To assess the rate, rhythm, depth or volume of respiration
3. To assess response of patient to any related therapy medication

Requirements

Wrist watch with second hand, pens (Usually red and blue)

Procedure

1. Explain the procedure to the patient. Assess other vital signs before counting the respirations
2. Close the door and and/or use screen
3. Place patient in a comfortable position preferably sitting or lying with the head of the elevated 45 to 60 degrees
4. Prepare count respirations by keeping your fingertip on the client's pulse
5. Observe the rise and fall of the client's (one inspiration and one expiration)
6. Count respirations for one full minute
7. Examine the depth, rhythm, facial expression, cyanosis, cough and movement assessor
8. Wash hands and record findings on the client's chart (Red colour is used to indicate abnormalities) Report any abnormal findings.

Measurement of Blood Pressure

Purpose

1. To obtain baseline data for diagnosis and treatment
2. To compare with subsequent changes that may occur during care of patient
3. To assist in evaluating status of patient's blood volume, cardiac output and vascular system
4. To evaluate patient's response to changes in physical condition as a result of treatment with fluids or medication.

Requirements

1. Working Sphygmomanometer
2. Stethoscope
3. Chart for recording blood pressure
4. Pen (blue or red)

Procedure

1. Check previous information about patient, care plan and treatment regimen. Prepare all requirements
2. Explain the procedure and reassure the patient. Identify factors likely to interfere with accuracy of blood pressure measurement: exercise, coffee and smoking
3. Wash your hands
4. Assist the client to a comfortable position either a sitting or lying down position and ensure that legs are not crossed.
5. Position the sphygmomanometer of approximately heart level of the patient ensuring the mercury level is zero
6. Select a cuff of approximate size
7. Expose the arm and remove any constrictive clothing
8. Apply the cuff approximately 2.5cm above the point where brachial artery can be palpated. The cuff should be applied smoothly and firmly with the middle of the bladder directly over the artery and tucked at the end.
9. Measure blood pressure by two step method:

A. Palpatory Method

a) Palpate brachial pulse distal to the cuff with fingertips of non-dominant hand.
b) Close the screw clamp on the bulb
c) Inflate the cuff while still checking the pulse with other hand
d) Observe the point where pulse is no longer palpable
e) Inflate cuff to pressure 20 -30 mmHg above point at which pulse disappears
f) Open the screw clamp, deflate the cuff fully and wait 30 seconds.

B. Auscultation

a) Position the stethoscopes earpieces comfortably in your ears.
b) Place the diaphragm over the client's brachial artery
c) Do not allow chest piece touch clothing
d) Close the screw clamp on the bulb and inflate cuff to pressure 30mmHg above the point where the pulse hand disappeared.
e) Open the clamp and allow the aneroid dial to fall to rate of 2 to 3mmHg per second
f) Note the point on the dial when first clear sound heard. The sound will slowly increase in intensity.
g) Continue deflating the cuff and note the point where the sound disappears. Listen for 10 to 20mmHg after the last sound.

h) Release any remaining air quickly in the cuff and remove it
i) If you must recheck the reading for any reason allow a minute interval before taking blood pressure again.
j) Assist the client to a comfortable position. Advice the client based on the reading.
k) Record blood pressure on the client's chart
l) Wash your hands & replace instruments.

Weighing Patients

Accurate measurement of patient weight is an essential part of nutritional assessment but may also inform other aspects of care. Staff carrying out this procedure require training and need to understand the significance of changes in weight. There are procedure to weighing a patient/ client.

Procedure

1. Explain the procedure to the patient
2. Wash your hands. Don gloves as needed
3. Check that the scale is at "0" Readjust if it is not
4. Assist the patient to the scale
5. Provide support while the patient steadies themselves
6. Note the weight once the dial stops moving
7. Assist the patient off the scale and safely back into a chair or bed.
8. Wash hands
9. Record weight and any problems observed that the patient may have had getting onto or off the scale
10. Report any changes in condition or behavior (such as an increase or decrease in weight)
11. Store the scale in a safe place

Patient/client are weighed in every visit to the hospital, we can say checking of patient/client weight is part of vital signs.

Bed Making

We all know what a bed is and we make our bed at our various houses but the making of bed is different in a hospital setting. Before making these beds, there are rules to follow. Which are:

Rules of Bed Making

1. All requirements should be prepared before commencing procedure
2. Two nurses should work together with even movement
3. The patient should be included in every conservation carried out during bed making except patient is too weak to talk. The conservation should not be on personal matters but about patient care.
4. Avoid unnecessarily exposure of the patient

5. Patients face should not be covered with bed clothes.
6. If necessary, extra assistance should be available
7. No flapping of bed linen
8. Pillows should not be shaken near the patient's face. Open edges of pillows should be placed in the opposite direction of the entrance or door
9. Do not allow the linens touch the floor
10. Anything to be put on the bed such as cradle, back rest, bed pan etc. must not touch the floor.
11. Soiled linen should be placed directly into the linen bin.
12. There should be no jerking movement or jarring of the bed.
13. A linen bin should be available for soiled line to be sent for sluicing before being sent to the laundry.
14. When finished, inspect the bed and see if it measures to the highest standard of health and comfort of the patient.

Simple Unoccupied Bed (Admission Bed)

An unoccupied bed is one prepared to receive a new patient or bed made following discharge of a patient

Purpose

The reason why this bed is made

1. To provide clean environment for the patient
2. To reduce the risk of infection by maintaining a clean environment
3. To promote comfort and speedy recovery of the patient.

Requirements

A trolley with the following

1. 2 sheets
2. 2 draw sheets
3. Long mackintosh
4. Counterpane
5. 2 pillows and pillow cases
6. Draw mackintosh
7. Plastic mattress cover

Procedure

Arrange equipment and wheel trolley to near foot of bed, remove chairs and lockers in the way to create space for work.

1. Make sure mattress is right side up. The nurse on whose side the trolley is nearest picks up the linen etc. from the trolley to the bed. Place bottom sheet on the bed with middle fold in center of the bed. Right side long mackintosh fastened first.
2. Mitre the corners at the top. Pull the sheet straight at the bottom of the bed, tuck and mitre the corners
3. Tighten and tuck sheet under mattress along the side from the top to the food of the bed
4. Place draw mackintosh across center of bed with upper edge about 30.5cm from top of mattress. Jack in ends cover with draw sheet; pull and tuck, tucking extra on one side only.
5. Place top on bed with wrong side up. It should be even with top of mattress and middle fold in center of bed. Tuck sheet at bottom of mattress. Mitre the corners
6. Tuck sides very loosely. Upper edges should be about 15cm from top of mattress. Tuck bottom and mitre the corners. Tuck in sides very loosely. Fold top of sheet cover. Place pillows at head of bed making sure that the open ends of pillows case are neatly folded in and turned away from the main entrance to the ward. Tuck bottom of counterpane under the mattress.
- Mitre the corners and leave freely to half at sides. Pull counterpane over pillows to cover the whole end.

Simple admission

On admission of an ambulant patient, fold in the top of counterpane to be of the same length as the top of counterpane to be of the same length as the cover with the top sheet. Turn back one side of the top bedding to allow patient to get into bed.

An Occupied Bed

This refers to a bed made for an ambulant or patient confined in bed.

1. For an Ambulant patient

Requirements

1. 2 chairs or bed strippers
2. Clean linen and draw sheet
3. Soiled linen carrier (Hamper)
4. Screen where necessary

Procedure A (For Ambulant patients)

1. Wheel trolley and hamper to near foot of bed, place chairs at food of bed backing each other, move locker slightly away.
2. Loosen all bedding tucked under mattress starting from top to bottom
3. Unfold counterpane and place on chair.
4. Remove top sheet in the way, (top sheet may be used as bottom sheet)
5. Gather draw sheet and put into hamper (if it is to be used again, shake, fold and place on chair)

6. Place mackintosh on chair and untuck bottom sheet
7. Gather and place in hamper (Soiled linen carrier)
8. Turn mattress if necessary
9. Make bed up to foundation level.
10. Place counterpane on bed, spread out. Tuck bottom under mattress, mitre but do not tuck sides leave to hang
11. Fold top of counterpane inside to be same length as the top sheep
12. Puff up pillows and place neatly at top of bed. Change any dirty pillow cases.
13. Fold top of sheet back over counterpane

Note: One side of the top bedding should be opened in a triangular form for the patient to get into bed.

2. Procedure B (For confined patients)

Method I: Moving patient from side to side

1. Greet and explain the procedure to patient
2. Lie patient flat on one pillow
3. Strip top bed clothes in usual way leaving the patient covered with top sheet (use blanket to cover patient if cold)
4. Place blanket over sheet, upper edge should cover patient's chest. Tuck at bottom. Mitre corners and tuck in sides very loosely.
5. The second nurse removes crumbs from bed, rolls, draw sheet and draw mackintosh separately up to patients back.
6. Untuck bottom sheet, straightens and re-tuck the sheet
7. Pull draw mackintosh straight and tuck
8. Tuck in sufficient to the draw sheet and arrange the rest to be pulled through
9. Roll the patient to the tidied side, moving pillow with him.
10. The assisting nurse should do the same
11. Put patient comfortable back in the middle of the bed
12. Shake and replace pillows making patient comfortable
13. Straighten top sheet over patient. Tuck sheet at the bottom of mattress. Leaving enough at the top to fold over counterpane
14. Mitre the corners and tuck sides of sheet very loosely.
15. Place counterpane over-tucks in bottom and mitre the corners. Counterpane fold-stop inwards
16. Fold top of sheet back over counterpane
17. Remove chairs and straighten bed and locker

Note: If bottom sheet is dirty, roll to back of the patient. Place clean sheet on bed. If draw sheet is dirty, untuck and change same as above. Finish bed making in the used way.

Method II: Move patient from top to bottom

1. Greet and explain procedure to patient
2. Strip bed as for method I leaving patient covered with top sheet or flame Lette.
3. Lift or flex patient's leg
4. Remove crumbs
5. Untuck bottom sheet, straighten and re-tuck
6. Untuck draw sheet and draw mackintosh. Roll lower ends up to patient's buttocks
7. List patients as far down the bed as possible, but not so far that his legs are over the side or the end of the bed.
8. While one nurse supports the patient, the other straightens and tucks in the draw mackintosh and sheet neatly.
9. Straighten mattress, cover bottom sheet and re-tuck, miter end of bottom sheet.
10. The nurse who has been working now supports the patient while the other nurse makes the bed on her own side as already described above.
11. Fluff up pillows and re-arrange
12. Lift patient on to the draw sheet so that he can lie back on the pillows
13. Make the top as for an occupied bed.

Bed Bathing

It is a clean procedure, done for patient that is confined to the bed.

Purpose

1. To clean, refresh and give comfort to patients unable to bathe in the bathroom
2. To provide opportunity for physical observation of the patient
3. To boost patient's morale
4. To stimulate the action of the skin
5. To encourage nurse patient relationship
6. To reduce risk of infection in the wards.

Requirement: A trolley

Top shelf

A. A washing bowl
B. Two jugs for hot and cold water (not steaming hot)

A small tray containing:

C. Bath thermometer, soap in soap dish, Dusting powder or Talcom powder, Comb, Nail scissors, Receiver for mouth wash, Tooth brush/Chewing stick.

Bottom Trolley

1. Two large bath towels
2. One small bath towel
3. Two face flannels (one for the face and the other for the rest parts of the body)
4. Patient's gown or pajamas
5. Clean linens, draw sheet, pillows ships
6. A receiver containing gloves (if there is an open injury on patient's skin)

Other equipment

1. Pail or bucket to receive dirty water
2. Dirty linen bin
3. Screen

Note: If patient is in continent, add the following requirements:

1. Zinc oxide cream or castor oil ointment
2. Toilet roll to clean up the patient
3. Bedpan/urinal
4. Dirty linen bin

Procedure

1. Prepare patient and environment
a) Explain procedure to patient and relative, encourage participation from patient or relative
b) Close windows and door and switch off fan/AC
c) Screen patient & offer bedpan or urinal if patient requires
2. Position bed & patient appropriately
3. Wash hands
4. Lower side rails & wheel trolley to bedside
5. Remove the top bed clothes, strip counterpane leaving the patient covered with one large bath towel.
6. Remove all pillows except one unless patient is dyspnoeic.
7. Mix water in the bowl at a temperature of 38^{o} C (104^{o}F) or to patient's desire)
8. Put on gloves & ask assistant to do so
9. Place other large towel beneath patient and mackintosh if none available on bed
10. Wash face
- Soap the face flannel and wash the face, neck and ears. Pay special attention to folds of the neck
- Towel dry
- Wash the hair with same face flannel if short. Then discard the face flannel and change water.

11. Wash arms & legs
- With the other face flannel

- Wash the arm nearer to you, instruct assistant to wash the arm & hand farther away (left) from you, towel and dry
- Wash the chest and abdomen. Wipe and dry, pay particular attention to the umbilicus
- Wash the lag nearer to you, instruct assistant to wash the leg farther away from you
- Turn the patient to his side and wash the back
- Attend to the pressure areas.

12. Washing the perineal & anal region

- The nurse should use tissue or cotton swab to lean in between legs and anal region before using the flannel
- If patient is able, soap flannel and let him/her wash in between his legs otherwise the nurse should do this for him/her.

13. Wear him/her clothes and make him/her comfortable
14. Comb the hair & trim the nails
15. Remove bath towel and arrange the bed, open windows, remove the screen and trolley
16. Replace all articles and record procedure.

Note:

- Remember to change water if it's dirty
- An assistant will be required in order to carry out this procedure. Assistant may be a nurse, patient's spouse or relative if patient insists
- Observe the patient as you bath him/her: Scars, Rashes, Excoriations, and Swellings etc.

3.2 History and Documentation

A client/patient history is always taking to know accurately about a patient's past and present condition. Let's define what **history taking** is all about.

What is History Taking?

It is a process by which information is gained by a physician by asking specific questions to the patient with the aim of obtaining information useful in formulating a diagnosis and providing medical care to the patient.

Importance of History Taking

1. Obtaining an accurate history is the critical first step in determining the etiology of a patient's illness.
2. Diagnosis in medicine is based on

- Clinical history
- Physical Examination
- Investigation

A large percentage of the time (70%) you will actually be able to make a diagnosis based on the history alone.

Approach to History Taking

There are ways to take history of a patient/client to get accurate diagnosis. These are

- Ensure consent has been gained
- Maintain privacy and dignity
- Ensure the patient is as comfortable as possible
- Summarize each stage of the history taking process
- Involve the patient in the history taking process. There are components of history taking stated below

1. Patient's profile
2. Chief compliant
3. History of the present illness
4. Past medical history
5. Family history
6. Socio-economic history
7. System review

When a nurse is done taking the history of the patient, the nurse proceed in documenting the information collected.

What is Documentation?

It is the record of nursing care that is planned and delivered to individual patients by qualified nurses or other caregivers under the direction of a qualified nurse. It is a vital component of safe, ethical and effective nursing practice whether done manually or electronically. Nursing documentation should fulfill the legal requirements of nursing care documentation.

Method of Documentation

Several methods of documentation are used to organize a nurse's note, sometimes referred to as **Progress notes.** Decisions about which method to use may depend on the organization where you work, which sometimes specify certain methods. Otherwise, it is usually a matter of personal preference. Several approaches are used for this kind of documentation in the nursing process

- DAR (data, action, response)
- APIE (assessment, plan, intervention, evaluation)
- SOAP (subjective, objective, assessment, plan) and its derivatives include
- SOAPIE (subjective, objective, assessment, plan, intervention, evaluation)

Purpose of Nursing Documentation

The primary purpose of documentation of client care is the communication among health care professional to promote continuity of care among departments throughout 24 hours.

1. **Communication**
   The primary purpose of documentation of client care is the communication among heath care professional to promote continuity of care among departments throughout 24 hours.

2. **Legal accountability**
   It serves as legal document. It may be used as evidences in court proceedings.

3. **Research**
   Nursing and health care research is often carried out by studying client records.

4. **Diagnosis**
   Documents are aids in diagnosis patient condition

5. **Assessment**
   The nurse and other health care members gather assessment data from the client records

6. **Education**
   Members of the health team including students utilize these records as an educational tool.

3.3 Admission of Patient

Admission of the ambulant patient to the hospital. The nurse should be polite and very reassuring when the patient arrives on the ward.

Requirements

1. Vital signs tray
2. Patient's folder file
3. Admission register
4. Bed sheet
5. Nursing process/ care plan sheet

Procedure

1. Greet the patient and the patient's relatives if any
   - Take the card from the patient and call the patient by name
   - Introduce yourself to the patient and relatives
   - Ask the relatives to wait in the waiting area
2. Inform the charge nurse of patient's arrival

- Escort the patient to the bedside and introduce her to her neighbors
- Ask the patient what his medical complaint is; fill out all the admission forms.
- Have treatment and/ or operations and anesthetic consent signed if patient is under 21 years of age, have parents or guardian sign the consent.
- Observe patient for signs and symptoms of illness
- Ask about: any allergies, Exposure to communicable disease, colds or TB, diarrhea or any medication

3. The general state of the patient may be observed during all these formalities. Such as
   - Is he calm and relaxed, or tense and anxious?
   - Does he appear to have any special worries?
4. Both patients and relatives will ask questions and the nurse should answer them satisfactorily

5. Information about ward routine, visiting times and other hints for the patient must be given. The nurse must make sure that the relatives meet the change nurse or her deputy before the leave.

6. Receive money and valuable from patients for keep until discharge. This is signed by the patient and the nurse in charge

7. Take vital signs, Height and weight

8. Do a general physical examination from head to toe
   Write relevant information in the nursing record and file into the case note, if the clothes, collect all belongings to be taken home by relatives or friends.

9. Take the patient to the toilet and explain proper use of the toilets when necessary
   - Patient may take shower, if necessary and change unto Hospitals clothes
   - Collect urine sample for routine urine testing

   After the patient gets well, he/she will be discharged and there is a procedure of that.

3.4 Discharge of Patient

At discharge, it is necessary that the nurse should ensure:

- That the patient us physically, mentally and emotionally prepared for the Journey home
- That satisfactory financial arrangements are made with the billing/finance office
- Review health teaching with the patient and his family so that they will have the necessary information concerning his condition, care & needs
- Give a written summary if necessary
- Review and point out adaptations for home situation that the patient is properly in his own clothe when he is ready to leave the hospital.

Equipment

a) A written order of discharge from the doctor
b) Patient's clothes
c) Written instructions for home care, if necessary
d) Any medications, dressing, clinic appointment which are ordered by doctor
e) Wheel chair or stretcher, if needed.

Procedure

These are the procedures to be carried out when discharging a patient:

a) When the doctor writes the order of discharge, the patient and his family are informed
b) All medications which the patient has not used and which are not ordered by the doctor to be taken home, are returned to the pharmacy e.g. ampoules, viral drugs in sachets and the patient is credited with amount returned.
c) Any medications or dressings prescribed by the doctor to be taken home are ordered by the nurse in charge of the ward.
d) A discharge slip, the drug orders and credits are sent with the case file to the pharmacy for billing.
e) When the bill has been completed, the case file is returned to the ward with the bill
f) The charge nurse is responsible for seeing that the patient or his family pay the bill or made some arrangement with the billing office before leaving the hospital
g) When the patient or his family has the money ready, they are taken to the cashier to pay the bill
h) The discharge slip signed by the cashier is brought back to the nurse in the ward
i) The patient should be assisted in getting dressed and ready for departure. Any other assistance may be given as needed.
j) The nurse reviews any necessary health teaching with the patient, gives him his drugs and gives him any clinic appointment slip necessary. Be sure the patient has the necessary information concerning his condition and needs. Give written summary of instructions if necessary.
k) If the patient is unable to walk, provide a stretcher or wheel chair as his condition indicates
l) If the patient leaves the ward, the word "discharge" is written after the last entry on the nurse's notes. If the patient expired, after the last entry writes: "expire"
m) Arrange the case file in the correct order and send to the record office. Fill all heading
n) Clean or disinfect until thoroughly in preparation for the next patient (Carbolization of bed, after final discharge).
o) Put date of discharge in admission discharge book.

4.0 Conclusion

Nursing entail giving care to the patient using different procedures. Good knowledge of these procedures enhances adequate practice.

5.0 Summary

This study section explained some basic procedures, how history is taken and documented. Admission and discharge procedures were also discussed.

6.0 Tutor-Marked Assignment

1. Documentation in nursing is important to enhance continuity of care. **True or False**

2. History taking is very important in making patient diagnosis. The likelihood of having an accurate diagnosis from history alone is as high as

A. 20%

B. 50%

C. 70%

D. 90%

3. …… is also known as vital sign.

Answer

1. True

2. C

3. Cardinal signs.

7.0 References/ Further Reading

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MODULE TWO

ETHICAL AND LEGAL CONCERN OF NURSING

Study Section 1: Ethics in Nursing Profession
Study Section 2: Legal aspects in Nursing Profession

STUDY SECTION 1: ETHICS IN NURSING PROFESSION

CONTENTS

1.0 Introduction
Ethics is a science related to moral actions and one's value system. Many nurses envision ethics as dealing with principles or morality and what is right or wrong. It has to do with action, which caregivers wish people would take, not actions they must take. Ethics are always been an integral part of nursing. This section will explain ethics with regard to the nursing practice in details.

2.0 Learning Outcomes
At the end of reading this study section, the student will be ab
- The concept of nursing ethics
- explain and resolve dilemmas in nursing
- discuss some application of ethical principles in nursing.

3.0 Main Content
3.1 The Concept of Nursing Ethics

Nursing ethics is the study of principles of right and wrong conduct for nurses. It provides the standards for professional behavior. Nursing ethics states the duties and obligation of nurses to their clients, other health professionals, the profession and the community. Ethics promotes the philosophical and theological study of morality, mental judgments and moral problems. Theoretical knowledge that nurse will need to begin professional practice include an understanding of the nature of morals and ethics and basic information about factors that affect moral decisions i.e. values, moral frameworks, professional guidelines and ethical principle.

Ethics of Care

The ethics of care, a nursing philosophy, directs intention to the specific situations of individual patient viewed within the context of their narratives. Theories which are derived directly from the feminist ethic model and especially promote nurturing of patient and caregivers. An ethics of care way of thinking emphasizes the role of feelings, not at the expense of some of the principles but as part of conventional ethics, such as autonomy (self-determination) or beneficence (doing good).

In this model, nurses incorporate a responsibility to care as a part of their professional behavior. Leininger (1988) defines care as "the central unifying domain from the body of knowledge and practices nursing". Some aspects of care include the ability and obligation to appreciate, understand and even share the patient's pain or condition. Using a caring model, your ethical analysis would focus on relationships and client stories. The following are specific perspectives within the ethics of care model:

1. Viewing care as the central force in nursing
2. Promoting dignity and respect for patients as people
3. Attending to the particulars of each individual patients
4. Cultivating responsiveness to others
5. Redefining fundamental moral principles to include virtues such as kindness attentiveness empathy, compassion and reliability.
   An advantage of including the caring perspective and client stories in ethical dialogue is that it tends to focus discussion at the level where the relationship is located, rather than in an intellectual plane.

ETHICAL PRINCIPLES

There are four major principles of ethics which include:

1. Principle of justice
2. Principle of autonomy
3. Principle of beneficence
4. Principle of veracity

JUSTICE

The principle of justice states that equals should be treated the same and that un-equals should be treated differently. In other words, patients with same diagnosis and health care needs should receive the same care. Those with greater or lesser needs should receive different care. In health care, the most common concern about justice relates to allocation of resources and services to

clients. Numerous models have been developed for distributing health care resources. These models include:

i. To each equally
ii. To each according to what can be acquired in the market place
iii. To each merit; this may include future contributions to society
iv. To each according to need

Justice as a principle often leaves in with questions that answers. It raises our consciousness about making decisions but certainly does not determine what the answer should be.

AUTONOMY

The principle of autonomy claims that individuals are permitted liberty to determine their own actions according to plans they themselves have chosen freedom to make one's own decision is respected under the principle of autonomy. The principle refers to the control individuals have over their own lives. Respect for the individual is the corner stone of this principle. Autonomy applies to both decisions and actions. Autonomous decisions have several characteristics. They are as follows:

i. Are based on individual values
ii. Utilize adequate information
iii. Are free from coercion
iv. Are based on reason and deliberation

An autonomous action is one that results from an autonomous decision. Health care professionals often take actions that profoundly affect patient's lives without adequate consultations with the patients.

BENEFICENCE

Beneficence is commonly defined as 'the doing good'. Frankene (1973), involved several duties with this principles which include:

- Not to inflict harm or evil (non-maleficence)
- To prevent harm or evil
- To remove harm or evil
- To promote or do good.

The first duty, not to inflict harm, taken priority over through following duties. Even so, all four duties are obligations that must always be taken into account. Additional consideration may take precedence when there is conflict about the appropriate cause of action. For example, a surgical procedure will inflict harm, on the body, but potentially has long term benefits. The procedure may

be lifesaving or it may diminish pain or increase mobility. In this sense, even though it inflicts harm in the short term, it is justified because of the long term good that will result.

Virtually everyone would agree that causing good and avoiding harm are important to all human beings and certainly to health care professionals. It is therefore surprising how often conflicts center around these principles.

VERACITY

The principle of veracity is defined as "telling the truth". Truth telling has long been identified as fundamental to the development and continuance of trust among human beings. Telling the truth is expected. It is necessary to basic communication and social relationships, are built on individual's right to know the truth.All communication between individuals has the potential to be misleading. It is easy for information to be misunderstood, misinterpreted or not comprehended. Usually, these misunderstands are unintentional. Intentional deception, however is considered morally wrong. Despite that well- established fact, much intended deception occurs between health professionals and people seeking health care. People seeking health care often are not fruitful when giving their health histories. An example that commonly occurs relates to truthfulness, concerning the use of drugs and alcohol or human immunodeficiency virus (HIV) related causes.

At the same time, health care professionals are not always truthful in responding to patient's questions. The nurse may choose to answer only part of a question, rather than giving all the known facts. A long tradition of a double standard in truth telling exists in health care. Health care professionals are not responsible for wrong information given to them by their patients. However, they are responsible for information that they give to patients.

3.2 ETHICAL DILEMMAS IN NURSING

A dilemma is defined as a situation requiring a choice between two equally desirable or undesirable alternatives. In ethical dilemma, each alternative course of action can be justified by two ways in which a person views the course of action based on his/her value system. Issues in health care delivery practices present different alternatives based on whether the issue or course of action is viewed by patient, the health care agency, the legal system or the nurse. Increasingly, staff nurses and nurse managers face difficult decisions caused by tensions between technological capabilities, structure of the budget and quality of life concerns. Nurses in all clinical and functional specialties face the following ethical dilemmas.

1. Need to ratio patient care to conserve scarce resources
2. Need to make treatment and care decision for terminally ill-patients
3. Need to obtain patient's informed consent for care and treatment orders and measures such as
    - Do – not – resuscitate order
    - Withholding/withdrawing nutrition and fluids.
    - Starting/ discontinuing life support system
4. Response to patient request for assisted suicide.

5. Need to balance the patient's need for confidentially and privacy against society's needs for protection from unreasonable risk.
6. Need to protect autonomy rights of children and incompetent adults concerning consent for research participation.
7. Need to protect justice rights of patients who participate in random trails of experimental treatment

   Usually, the dilemma occurs when opposing views are seen for the solution of an issue and a decision must be made. A nurse can best resolve ethical dilemma, by systematically considering all options for solving the dilemma. An ethical dilemma occurs as a result of conflict between moral principles that support different courses of actions

   Ethical dilemmas occur frequently in nursing practice. This is to be expected since nurses focus on life and death issues involving human beings. Many ethical dilemmas arise in nursing because of conflicts between patients, health care professionals and/ or institutions. In order to understand these conflicts, the following areas will be explored.

1. Personal value systems
2. Health care team
3. Patient's rights
4. Institutional and social issues

Personal Value Systems:

A value is the perception of words that is placed on an attitude, action or object. Value system is defined as an enduring organization of beliefs of existence along a continuum of relative importance. Value system are learned beliefs that help a person choose between difficult alternatives. Value system has a beginning foundation on beliefs, purposes, attitudes, qualities and objects that are important to one's patient. Value systems vary from individual to individual. Something important to one individual may hold greater or lesser significant to someone else. For example, a clean, neat home means more significant to some individuals than others. Working on various roles and settings may place nurses in situations that conflict with their moral and ethical value system. For example, of this conflict may be seen in the nurse who believes that it is nurses duty to save lives, yet who is caring for a patient has 'no code' order. This conflict will most likely leave the nurse feeling depressed, guilty or both.

Health Care Team:

All practicing nurses participates as a member of the health care team. This involves cooperation and collaboration with other professionals. As it is true in all situations, between human beings, conflicts can easily develop, particularly in stressful circumstances. These conflicts may be between two nurses, the nurse and physician, the nurse and hospital administration or the nurse and any other health care professional.

Generally, conflict can evolve because of different value systems. One nurse may feel, that assisting abortions is wrong, whereas institutions perform many abortions daily. Some conflict will develop because of individuals who are not respectful to the human rights of the individuals.

Conflicts in human rights often center around one of the ethical principles; i.e. justice, autonomy, beneficence, veracity. In some circumstances, the ethical dilemma may result from a violation of even more basic human rights those guaranteed by the constitution.

Conflicts in Patients' Rights:

In earlier days, health professionals, particularly physicians were considered as all-knowing experts. Very few patients questioned the physician, let alone demanded their basic rights. Now the consumers of healthcare are increasingly demanding to have a say in matters affecting the health care. As consumers have become more aware of their right, conflicts between health care professionals and institutions have developed. Many of the rights demanded by consumers are their legal as well as moral rights and have been un-held by the judicial system.

Consumer health care is demanding to be allowed to make more decisions about treatment, elective surgery and medications. They are exercising their rights as outlined in the patient's bill of right. Especially in the hospital setting, patients are insisting on current information about their condition, prognosis and treatment and their right to refuse treatment. Some hospitals are responding to these consumers attitude by setting up ethics committee to study the type of procedures to be performed or to be discontinued and to determine whether particular patients should or should not receive treatment.

The right identified are as discussed below.

- **Right to Truth**
  The right to patients to know the truth about their condition, prognosis and treatment in an issue between the physician and the patient. The current trend is toward more frankness on the part of the physicians. In the past, the moral obligation to dissolve the truth because the patient has the right to know and adjust to it was often overcame by the professional need to protect the patient from the potential physical or emotional harm that could be caused by knowledge of a critical or terminal condition.

- **Right to Refuse treatment**
  For religious reasons or reasons that are sometimes known only to themselves, patient may have refuse treatment even though lack of treatment may result in their death. The question of refusal of treatment may have to be decided in court. Many time, the courts rule that patient cannot be forced to accept treatment. On the case of a minor child, however, that courts are likely to rule that parents cannot withhold treatment from a child for any reason. The child is usually made a temporary ward of the court and treatment is allowed to begin.

- **Informed Consent**

  The issue of informed consent applies to many health care situations in both legal and ethical ways. Patients have the right to be given accurate and sufficient information about procedure both major and minor, so that their consent for undergoing those procedures is based on realistic expectations.

  Although the responsibility for imparting information about major surgery or complicated medical procedures has with medical professionals, nurses should inform their patients, about the procedure before it is started. In obtaining legal consent, court have generally ruled that consent requires three elements capacity, information and voluntariness. Determination of a patient's capacity involves consideration of the person's age and his/her competence (the mental ability to understand the effects of his/her choice). The information that is provided to the individual must be understandable by the patient. The information given must include the following elements in order to be considered informed:

  ❖ An explanation of procedure(s) results to be done
  ❖ An explanation of the anticipated results of the procedure
  ❖ A description of risks and discomforts
  ❖ An anticipated benefits of the procedure
  ❖ Identification of alternatives
  ❖ An opportunity for questions (and answers)
  ❖ The opportunity to withdraw consent at any time

- **Right to Treatment**

  Health organization identifies basic rights and responsibilities of patients, in which the important one is patient's right to access to care. It is generally held that all patients must be treated with an accepting attitude on the part of the nurses or other health care professionals regardless of the circumstances causing their health problems. Health professional, must be non-judgmental in their decision making.

  In terms of these ethical standards, many health care providers, including nurses find themselves in an ethical dilemma when confronted with the unknown. Recently, this type of ethical conflict has been most prevalent in the care of patient with acquired immunodeficiency syndrome (AIDS). Health care workers providing care to these patients have to weigh the risk of exposure to the disease against that ethical obligation to provide care to their patients. Other ethical conflicts may arise in caring for patients undergoing abortions, providing contraception to teens participating in organ transplant procedures and a multitude of other situation. It is important that nurses recognize conflicts between their personal feelings and their professional ethical (and sometime legal) duties.

3.3 APPLICATION OF ETHICAL PRINCIPLES IN NURSING

The previous note, ethics was discussed and defined in details, now let us discuss the ethical principles in nursing. Ethical principles actually control professionalism in nursing practice

which more than to ethical theories, principles encompass basic promises from which rules are developed. Principles are the moral norms that nursing as a profession both demand and strives to implement to every day clinical practice. Ethical principles that the nurse should consider when making decisions are as follows

- Respect for persons
- Respect for autonomy
- Respect for freedom
- Respect for beneficence (doing good)
- Respect for non-maleficence (avoiding harm to others)
- Respect for veracity (truth telling)
- Respect for justice (fair and equal treatment)
- Respect for rights
- Respect for fidelity (fulfilling promises)
- Respect for confidentiality (protecting privileged information)

These are the principles of ethic in nursing; each of these principles will be explained below:

1. **Respect for Persons:**
   It doesn't apply to clinical situations only, but also to all life's situation. It direct individuals to treat themselves and others, with a respect inherent to man's humanness. It requires recognition on a sense that all mankind shares a common human destiny. The respect to person's need to be simplified as it affects nursing practices.

2. **Respect for Autonomy:**
   It is the right of individual to govern their actions according to their own purpose and reason. Autonomy means that individuals are able to act for themselves to the level of their capacity. Respect for autonomy requires that persons honor other's right to govern him/herself. The legal doctrine of informed consent is the direct reflection of autonomy.

3. **Respect for Freedom:**
   The principle of individual freedom allows the patients to be exempted from control by others to select and pursue personal health goals. Nurses as a group believe that patient should have greater freedom of choice within the nation's health care system. This principle should be observed by staff nurses when planning patient care; by nurse manager when leading subordinates.

4. **Respect for Beneficence:**
   Beneficence principles state that the action one takes should promote good. It dictates that a person is obliged to help others to advance their legitimate and important interests. It requires the balancing of harms and benefits. Benefits promote the client's welfare and health, whereas harm or risks detract from the client's health and welfare. In other words, providing benefits

enhance the other's welfare. Whereas balancing the benefits and harms of intervention are made on the other's behalf.

5. **Respect for Non- Maleficence:**
   The principle of non-maleficence states that one should do no harm. The nurse should interpret the term '**harm**' to mean emotional and social as well as physical injury. Harm is thwarting, defeating or setting back one person's interest through invasive action by another. Many nurses find it difficult to follow the principle when performing treatment and procedures that bring discomfort and pain to patients.

6. **Respect for Veracity:**
   Veracity concerns truth telling and incorporates the concept that individuals should always tell the truth. It requires professional caregivers to provide the accurate reality- based information about their health status and care or treatment prospect. Truth telling is an ethical concern for nurse, because truth is the basis for mutual trust between patient and nurse and trust is the basis for patient's hope of benefit from nursing services.

7. **Respect for Justice:**
   Justice concerns the issue that persons should be treated equally and fairly. This principle of justice requires treating others fairly and giving persons their due respect. When there are resources to distribute in health care, nurses should allocate them in such a way that equal shares go to equal recipients. The following problems complicate the application of justice.
   - Not everyone is equal in every way, sometimes there are situations in which it seems that one person should receive a greater or lesser shove than another.
   - Resources are limited. There is not always enough for each persons to receive an equal share.

8. **Respect for Rights:**

Right is an entitlement to behave in certain way under circumstances, such as nurse's entitlement to freely express personal beliefs and preferences by voting in a political election. Another right is the prerogative to define other's behavior in selected situations such as manager's prerogative to give assignments to subordinates. A right is also a claim to a specific good, service or prerequisite such as tea break time. Right is also used to mean agreement with justice, law and morality.

9. **Respect for Confidentiality:** Confidentiality is the duty to respect privileged information. The principle of confidentiality provides that care givers should respect a patient's need for privacy and use personal information about him/her only to improve care. Nurses should practices confidentiality to decrease patient vulnerability from widespread knowledge of personal information divulged during care.

4.0 Conclusion

Ethics helps to give standard and guide to practice. Nursing ethics gives standard to the nursing practice, helps nurses through is expected of them in order to uphold fairness and morality in practices. Knowledge of ethics has improved the nursing practice over the years, this is what this study section aimed to achieve by increasing the knowledge of student nurses with regard to the ethical principles that guide the nursing practice.

5.0 Summary

This section explained the concept of the nursing ethics. Dilemmas in the nursing practice were discussed, with the application of ethical principles in nursing.

6.0 Tutor-Marked Assignment

1. The principle of non-maleficence states that one should ……..

2. Autonomy is on Patients……

3. it is said that an individual can either accept or refuse care. This right is referred to as ……

Answer

1. do no harm

2. liberty to dictate what care they want to receive

3. right to treatment

7.0 References /Further Reading

Carmi, A. & Schneider, S. (2012). Nursing Law and Ethics. Springer.

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STUDY SECTION 2: LEGAL ASPECTS IN NURSING PROFESSION

CONTENTS

1.0 Introduction

The role of nurses and professional nursing has expanded rapidly within the past five years, to include and expertise specialization, autonomy and accountability, both from legal and ethical perspectives. This expansion has forced new concern among nurses and a heightened awareness of the interaction of legal and ethical principles. Areas of concern include professional nursing practice, legal issues, ethical principles, labor management and employment.

2.0 Learning Outcomes

At the end of reading this study section, the student will be able to:

- identify the sources of law in nursing
- state the functions of law in nursing
- explain the divisions of law in nursing
- discuss the legal practice in nursing

3.0 Main Content

3.1 Sources of Law in Nursing

Laws are set of enforceable principles and rules established to protect society. Legal principles form a framework within which nurse will practice the act of nursing. Law may be defined as external rules of human conduct, backed by the sovereign political authority. Law and morality are intimately related to each other. Law is a system of principles and processes by which members of a society resolve problems and disputes, without restoring to physical force. Contemporary law us a composite of all of the rules and regulation, by which society governs itself.

Law originate from four sources, which includes constitutional law, statutory law, common law and administrative law. Below is the explanation of these sources of law in nursing.

1. **Constitutional Law:** is the judgmental law of the country. It is the law that governs the state. It represents the will of the ultimate and governs the people. They alone determine how it shall be made, revised or amended. It is the constitutional law which determines the structure of the state, its power and duties. It also determines the form of government and its relationship with the various organs of the government.

2. **Statutory Law:** is passed by the legislature or parliament of the state, in accordance with the constitutional law. In other words, statutory laws are enactments of federal and state legislative bodies. These regulates the relationship between citizens and the state, individuals and group, individuals and the others etc. for example, Nigeria Civic Marriage act. The statutory law is created by elected legislative bodies of state (legislative assembly) or the parliament statutory bodies such as Nigerian Nursing Council.

3. **Common Law:** is a body of legal principles that has evolved from court decisions. In other words, it is created by judicial decisions made in courts, where cases are decided.

4. **Administrative Law:** It consists of the rules and regulations established by administrative agencies that have been appointed by the executive branches of government (President or Governor). It is that part of public law, which regulates the conduct of public officials and discharge of their duties. It determines the mutual rights and duties of public officials and citizen.

   The sources of law in nursing have been explained in details. The next part of law to be discussed is the functions of the law in nursing.

3.2 Functions of Law in Nursing

Law has many valuable functions, which are applied to nursing practices: it stated below:

1. It differentiates nursing practice from the practice or other health care profession.
2. It also describes and protects the rights of clients and nurses. Illness and injury render a person with unusual dependence on caregivers. For the most part, institutional caregivers are not personally known to the patients, of all the health personnel, nursing personnel have most frequent and prolonged contact with the patient and his or her significant others and as such, who are most often in a position to intervene protectively on the patient's behalf. Most of the nursing activities are characterized by intimate touching, critical judgment, skillful manipulation and protective vigilance. Ignorance, carelessness or malice would render nurse's administration ineffective or harmful. Consequently, nursing practice is regulated by law that protects patients against deliberate to inadvertent injury by a nurse.

   Law governing nursing practice and management can be divided into laws affecting the nurse as an employee, laws that specify nurse's responsibilities towards patients, laws that regulate nurse's relationships with doctors, laws that specify the nurse's duty to protect the public and laws that specify the nurse's duties for record keeping and recording.

3.3 Division of Law in Nursing

The types of common laws guiding nursing practice include criminal law and civil law. Although both types fall under both federal and state jurisdictions; there is a distinct difference in the purpose of civil and criminal laws. Below is a brief description of these laws is as follows.

A. **Civic Law:**

Civic law includes rules and regulations that specify the required course of action to be followed by an individual in business and social relationships with others. It is concerned with relationships among people and the protection of a person's rights. Although violation of civil law might cause harm to an individual or property, no grave threat to society as a whole usually exists. For example, defamatory statements made about a person might lead to personal problems, but they do not threaten society in general.

There are types of civil law that provide standards for nursing practice include contract law and tort law. We will focus more on tort law which is seen more commonly in a nursing context. Let's explain the laws:

1. **Contract Law:** This law controls legally enforce able agreements between individuals such as employment contracts. A contract maybe explicit (defendant in writing) or implicit (defined by behavior and actions). Many nurses do not have explicit employment contracts.

2. **Tort Laws:** The law deals with the duties and rights among individuals that are not covered by contractual agreements. A tort is a civil wrong such as a claim for malpractice or a negligence usually, which claims for damages. Damages claims are money demands by the plaintiff for compensation of actual harm or injury, inflicted by the defendant. Torts are generally identified under three categories differing by intent of the defendant.

   - **Quasi – International Torts:** It involves speech. There are three torts that fall into this category.
     - Defamation: It occurs when a false communication is made to a third person and the communication is harmful.
     - Slander: It is a defamatory statement made orally
     - Libel: It is a defamatory statement made in writing

   - **Intentional Torts:** is designed to bring about a specific result in the mind of the defendant. Intentional torts include assault, battering, false imprisonment, fraud and invasion of privacy. Intentional torts may be also prosecuted as misdemeanors or felonies under criminal law. For example, a nurse who has been sued for malpractices may also be charged with a homicide, if the patient dies as a result of the nurse's action or in action. So, a patient may sue for damages for assault under civil law and the government may charge the defendant with assault under criminal law and the penalties differ.
     - **Assault:** It occurs when a nurse intentionally places a patient in a position of fear that he/she will suffer harmful or offensive contact

- **Battery:** occurs when intentional, offensive physical contact actually takes place. In the health care context claims for assault and battery most commonly occur when a nurse or a doctor performs a procedure on a patient without consent.
- **False Imprisonment:** involves an intentional or willful detention of the patient without consent or authority to do so. Claims for false imprisonment most commonly occur in mental health or nursing home setting. When patients claims that they admitted and/ or restrained against their will.
- **Fraud:** is willfully or intentionally misleading another person, with the intent to cause legal injury or deprive the person of a right. The nurse may commit fraud when telling a patient lies failing to disclose material information.
- **Invasion of Privacy:** Violation of a person's right to be free from unwanted interference in her private affairs. The right to privacy may conflict with the nurse's duty to report (e.g. reporting a sexually transmitted infection to public health authorities) or the patient may be a public figure whose medical condition is of importance to the public.

➢ **Unintentional Torts:** Negligence and malpractice actions (unintentional torts) may be the torts most familiar to health care professionals. Clients and family members who believe that care unprofessional and did not measure up to the standard of practice's false claims for civil liability. Negligence and malpractice are unintentional torts. Nurses can be negligent without intending to do harm. Negligence is simply the failure to use ordinary or reasonable care, as dictated by the standards of practice and /or by what a reasonable and a prudent nurse would do in the same or similar circumstances. Intent is not an element of negligence. When a nurse or other licensed professional health care provider is negligent and fails to exercise ordinary, it is called Malpractice. In other words, malpractice is simply the professional form of negligence, so it is the form of negligence most relevant to nurses in a professional context.

3.4 Legal Practice of Nursing

To practice nursing legally, a nurse must possess a valid and current license from the appropriate agency in the state where the nurse is employed. Licensure is the process by which a competent authority grants permission for qualified individual to offer his or her skills and knowledge to the public in a particular jurisdiction, where such practice would be unlawful without a license.

The laws governing nursing license include the sections that specify licensing board or council, the compositions and responsibilities, definition of the professional personal educational and evaluation requirements for licensure; testifying procedure for determining proficiency; license procured for license suspension or revocation and penalties for practicing without license.

Licensing Board/ Council

Members of the Nursing Licensure Board appointed by the respective Government form a list of candidates submitted by the professional organization. In Nigeria, we have Nigerian Nursing Council and State Nursing Council. It is customary for the councils to include representatives of the medical and educational communities and elected representatives of the assembly or parliament. There are requirements to be met to get licensure.

Requirements

Most nursing structures specify the following characteristics as a requirement for nurse registered literally:

- Minimum age
- Citizenship
- Demonstration of Moral character
- Educational qualification – general and professional. When a nurse is not dutiful and corrupt, there is punishment for the individual which is:

1. **Suspension or Revocation**
   A license or a registration can be suspended or revoked by the council if a nurse's conduct violates the provisions contained in the licensory structure. Suspension is the temporary denial of the right to practice nursing. Revocation is the permanent withdrawal of permission to practice nursing. Revocation may be instituted for those nurses who are found with the quality of gross immorality, illegal activity or malpractice. Malpractice is negligence or carelessness by the professional personnel. Negligence is the carelessness or failure to act as how an ordinarily prudent person would act under the circumstances.

2. **Employee's Right**
   Nursing groups are becoming more assertive. Consequently, individual nurses are beginning to assert their rights as plaintiff in employment claim cases or in employment conditions, in which nurses are likely to be denied their rights. In such cases of breach of employed contract, nurses can file lawsuit against their employers, to obtain their right.

- Termination of an employee for union organizing efforts
- Discrimination in employment on the basis of sex, age, religion and nationality
- Failure to make payment equally
- Failure to pay compensation during illness and injury related to work
- Sexual harassment and violating employee's right to privacy.

4.0 Conclusion

In any lawless society, there is bound to be chaos. Law help to bring framework for practice. Therefore, to avoid conflict in nursing, every rules and regulations should be followed to avoid several consequences.

5.0 Summary

This study section discussed the various sources of law in nursing and the divisions of law in nursing. Functions of law in nursing and the legal practice in nursing were also explained.

6.0 Tutor-Marked Assignment

1. One of the following is not among the sources law in nursing

A. Administrative law

B. Common law

C. Statutory Law

D. Admission law

2. Nursing practice is regulated by law that protects patients against deliberate to inadvertent injury by a nurse. True or False

3. When care fail to render care to a patient as at when due, it is referred to as ……..

Answer

1. D

2. True

3. Negligence

7.0 Reference / Further Reading

Carmi, A. & Schneider, S. (2012). Nursing Law and Ethics. Springer.

Hendrick, J. (2001). Law and Ethics in Nursing and Health Care. Nelson Thomes Ltd.

MODULE THREE

NURSING AND CARE GIVING
Study Section 1: Effective Communication in Nursing
Study Section 2: Interpersonal Relationship in Nursing
Study Section 3- Disease Control in Nursing

STUDY SECTION 1: EFFECTIVE COMMUNICATION IN NURSING

CONTENTS

1.0 INTRODUCTION
Communication is one of the basic function of human life. For nurses, good communication in health care means approaching every patient interaction with the intention to understand the patient's concerns, experiences and opinions. We all communicate with one another through different means. This section will define what communication is, explain the concept of effective communication and barriers to effective communication.

2.0 LEARNING OUTCOMES
At the end of this reading study section, the student will be able to:
1. define the communication
2. explain effective communication skill
3. discuss some barriers to effective communication.

3.0 MAIN CONTENT
3.1 COMMUNICATION

Communication is the use of words and behaviors to construct, send and interpret messages. It conveys varied messages like information, emotions, human acceptance or rejection. Communication is a dynamic, reciprocal process of sending and receiving messages. These messages may be verbal, non- verbal or both and many involve two or more people.

Communication is something more than just the act of talking and listening, it is:

- A way to meet physical, psychosocial, emotional and spiritual needs
- A process- the act of sending. Receiving, interpreting and reacting to a message

- A content- the actual subject matter, words, gestures and substance of the message.

WHY IS COMMUNICATION IMPORTANT IN NURSING?

Having good communication skills is essential to collaborating on teams with your fellow nurses and colleagues from other disciplines. Nurses who take the time to listen and understand the concerns of each of their patients are better prepared to address issues as they arise resulting in better patient outcomes. On the other hand, poor communication, lack of communication in health care, can lead to patients misunderstanding directions and failing to follow treatment protocols.

Elements of Communication

1. sender
2. receiver
3. media
4. message
5. feedback

3.2 EFFECTIVE COMMUNICATION SKILLS

There are 10 effective communication skills a nurse use with patient/client.

1. **Verbal Communication:**
   Excellent verbal communication is key. Aim to always speak with clarity, accuracy and honesty. It is important to know your audience and speak appropriately according to the person's age, culture and level of health literacy. If you are feeling stressed out or frustrated, be aware of your tone of voice and don't let these emotions leak into your patient interaction. You can:

- Avoid condescending pet names like "honey" or "sweetie" and instead use the patient's first name or name of choice
- Speak in clear, complete sentences and avoid technical jargon
- Encourage patients to communicate by asking open questions like "can you tell me a bit more about that?"

2. **Non- Verbal Communication:**
   Non- verbal communication such as facial expressions, eye contact, body language, gestures, posture and tone of voice is also essential in creating report. Simply smiling can go a long way. You can also:

- Show interest in what the patient is saying by maintaining eye contact and nodding your head
- Smile but don't stare
- Use non-threatening body language that conveys openness

3. **Active Listening:**

Active listening means listening in order to understand the other person's experience. The highest and most effective form of listening requires complete attention and engagement. This skill is important not only for clinical nurses but also for nurse executives and other health care providers as a tool for building trust and commitment with their staff. Active listening includes both verbal and non-verbal communication skills. For example:

- Include minimal verbal encouragement, such as "I understand" and "go on".
- Nod your head but never interrupt

4. **Written Communication:**
   Written communication skills are also essential for effective nurse-to-nurse communication. As a nurse, you will be responsible for creating and updating the patient's medical record. It is critical that medical record is accurate and current so your patients can receive the best care possible. Also, remember to protect patient confidentiality. Some tips:

- Be sure to note accurate dates and times
- Write legibly and clearly, using simple language
- Make notes immediately following patient care so you do not forget anything.

5. **Presentation Skills:**
   Effective presentation skills are most applicable during "handover"- when you are transferring patient care to another nurse or other healthcare providers. These skills will also help you demonstrate your knowledge and expertise clearly in a variety of workplace settings. Such as presenting at conferences, participating in job interviews, giving case reports to physicians, and more it's a good to

- Plan out your presentation and practice
- Pay attention to both your verbal communication and body language

6. **Patient Education (Patient Teach-back):**
   Nurses are in charge of the most of the communication between the healthcare team and patients. This includes informing patients and family members of health condition, diagnoses, treatment plans and medication protocol. This skill is especially important for family nurse practitioners who work with patients and families to provide health and education counseling.
   Patient teach-back: is an effective communication strategy where providers ask patients to repeat the information back to them. This method improves patient understanding and encourages adherence to care institutions. Poor understanding of information can cause patients and their family members to feel anxious or become defensive. For example, you can say:

- Can you repeat the instruction for taking this medicine back to me?
- "Let's review what we just discussed. Can you explain it to me in your own words?"

7. **Making Personal Connections:**

It's important to get to know the person behind the patient. Patient-centered relationships are critical in helping patients feel safe and comfortable. Creating meaningful connections with patients can improve outcomes and trust some ideas:

- Find out a fun about each other

8. **Trust:**
   It's important for healthcare professionals to inspire trust in patients by listening actively and taking every compliant and concern seriously. Building trust takes time. Trust is something that nurse educators and leader should also cultivate as they work to develop the next generation of nurses. To inspire trust, nurse leaders and educators should:

- Always tell the truth
- Share information openly
- Be willing to admit mistakes

9. **Cultural Awareness:**
   You will likely work with people every day who come from a wide range of social, cultural and educational backgrounds. Every patient and co-worker is unique, and its importance to be aware and sensitive. For example, gauge the patient's fluency with English and grade your vocabulary accordingly or bring in a translator of necessary and possible.

10. **Compassion:**
    Compassion can assist in prompting fast recovery from acute illness, enhancing the management of chronic illness, and anxiety.

3.3 BARRIERS TO EFFECTIVE COMMUNICATION

The barriers to good communication skills are many. Poor communication is dangerous as misunderstanding can lead to misdiagnosis and even medication errors. Now let us discuss the barriers to effective communication.

1. **Physical and Environmental barriers:**
   When you launch a healthcare event for patients, many physical and environmental factors limit patients from receiving the message which are:

- **Noise:** The primary type that occurs during transmission level. Noise commonly happen when patients use or watch healthcare show in TV. Poor signal when talking via phone and watching TV may disrupt patients from consuming healthcare information.
- **Message design:** The most challenging part of communication with patients is controlling how patients think about your message. Thus, ensure your message is under a strict proof reading process and avoid wrong word choices, jargon and complex words.

2. **Language Barriers:** If a patient or healthcare professional's language is not the same, it becomes a problem. It creates a challenge to understand the problem of the patient and make the patient understand the treatment process. This barrier can be tackled by learning the client's language, taking the help of an interpreter, showing pictures and using dictionary of the patient's language.

3. **Cultural Barriers:** There are different culture and they have a different way of communication. It makes discussion difficult to understand. Sign languages have different meanings in different cultures. For example; 'thumbs up' is regarded as the 'best of luck' or 'good luck' in most cultures but in Bangladesh, it is taken as a bad gesture or insult. The stereotype is another aspect of cultural difference in communication. There is a generalized view that people from the same cultures mostly have the same stereotypic behavior. Mostly these are negative in nature which impacts the whole communication process.

4. **Emotion:** When a client becomes anxious and emotional, healthcare professionals need to manage those things. They should also keep control of their emotions in order to keep the progress in interview.

5. **Developmental level:** Healthcare professionals should first access the developmental levels of students. Otherwise, it can be a major barrier to communication. For example, talking style with the child will definitely different from an adult. Because abstract thinking may not have developed in the child. So communicators must understand the developmental levels and communicate accordingly.

6. **Use of healthcare jargon:** Most people don't understand healthcare – related words. Using appropriate medical words during conversation may provoke anxiety among patients. So healthcare providers must use words which can be understood by client during discussion.

4.0 Conclusion

The main aim of the health care system to provide appropriate treatment and satisfaction to the client. Effective communication with the client is one of the major way to gain satisfaction of the client.

5.0 Summary

This study section explained the concept of communication. Effective communication skills and barriers to effective communication were discussed.

6.0 Tutor-Marked Reference

1. One of the following is not an elements of communication

A. sender

B. feedback

C. message

D. Concept

2. Listening in order to understand the patients' experience is called…….

3. At the end of patient teaching session, the nurse ask the patient to repeat the information back to them. This process is called…….

Answer

1. D

2. Active listening

3. Patient teach-back

7.0 References / Further Reading

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STUDY SECTION 2: INTERPERSONAL RELATIONSHIP IN NURSING

CONTENTS

1.0 Introduction

A relationship is an interpersonal process where two or more people interact with each other. We meet people in a variety of settings and share our experiences and develop a kind of relatedness. The basis for good interpersonal relationships is respect for human personality with an understanding of the problem of other person. This section will explain what interpersonal relationship in nursing in entails.

2.0 Learning Outcomes

At the end of reading this study section, the student will be able to:

1. explain what interpersonal relationship in nursing means
2. state the factors that enhance interpersonal relationship
3. discus the factors that lead to poor interpersonal relationship

3.0 Main Content

3.1 Interpersonal Relationship in Nursing

Interpersonal relationship is a series of interactions where one individual perceives the other individual as a human being. It can also be defined as a mutually significant experience, where both nurse and patient view each other as unique human beings.

Principles

Below are the principles which one needs to apply in establishing and maintaining interpersonal relationships

- Principles of mutual understanding
- Principle of respect for human dignity
- Principle of personality development
- Principle of honesty, punctuality and trust worthiness
- Principle of stimulation, motivation and encouragement.

Nursing is considered as an interpersonal process, which is often therapeutic, in that people benefit from the interaction. Nursing is a human relationship between the one who is in need of health services and the nurse who is trained and prepared to respond to the need in therapeutic manner. The nurse plays a role in this relationship.

Role of A Nurse in Developing of Interpersonal Relationship

These are the roles a nurse should play to develop interpersonal relationship with the patient.

	Role	**Definition**
1.	Stranger	The role assumed by both the nurse meeting
2.	Resource person	Provides knowledge and answers spec health promotion
3.	Surrogate	Acts as substitute figure that the client wants
4.	Teacher	Identifies learning needs of the client and roles to develop clients interest in medication
5.	Socializing agent	Participates in social activities with her
6.	Manager	Establishes and maintains therapeutic conditions for patient's recovery
7.	Counselor	Facilitates self-directed actions to help patient to change life style

3.2 Factors Enhancing Interpersonal Relationship

Interpersonal factors refer to three factors involving relationship with others. The helpfulness of the support offered by others and satisfaction gained from it are critical to enhance good interpersonal- relationships, cooperation and mutual understanding between nurse and patient's; nurse and nurse and doctor and nurse and patient's relative, are imperative to good interpersonal relationships. The most effective helper (nurse) does not avoid discussion about the dynamics (interaction) occurring within their relationship. Nurse needs to develop some of these characteristics which can help her establish good interpersonal relationship:

I. Listen patiently
II. Talk meaningfully
III. Avoid hasty judgment
IV. Interpret properly
V. Never gossip

VI. Never criticize
VII. Know the other health agencies
VIII. Respect others
IX. Accept constructive criticism
X. Behave as human being towards patient.

3.3 Factors Leading to Poor Interpersonal Relationship

The following factors can lead to poor interpersonal relationship

1. Lack of understanding "how" you respond to others and what you except from them.
2. Lack of interest in work in some personal may burden the other person which may spoil the friendly environment of the department
3. Deliberately ignoring someone without any cause is another factor leading to poor interpersonal relationship.
4. Unwilling to accept help and advice from others may also lead to unhealthy interpersonal relationships.
5. Conflicting ideas might arise from different backgrounds and lead to poor interpersonal relationships.

4.0 Conclusion

Nurses are in constant contact with patients and their families. Good interpersonal relationship skill will help nurses establish nurse-patient relationship. Therefore, nurses are to look inward to identify and avoid those this that factors that can hinder their relationship that will bring therapeutic effect.

5.0 Summary

This study section explains the term interpersonal relationship in nursing. It further highlighted the factors that promote good interpersonal relationship and barriers to interpersonal.

6.0 Tutor-Marked Assignment

The following but ONE help to facilitate interpersonal relationship

A. meaningful talking

B. Active listening

C. Clarity in speaking

D. Judgmental speaking

2. All of the following EXCEPT one can enhance poor interpersonal relationship in nursing.

A. Conflicting ideas

B. Lack of understanding

C. Active listening

D. Lack of interest

3. To effectively enhance interpersonal relationship, nurses must learn not to criticize. **True or False**

Answer

1. D

2. C.

3. True

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STUDY SECTION 3: DISEASE CONTROL IN NURSING

CONTENTS

1.0 Introduction

Nurses are the backbone of the modern medical infrastructure and play a significant role in patient care and disease prevention. We all know what disease is but let us define it in medical way. This study section will explain the concept of disease control in nursing.

2.0 Learning Outcomes

At the end of reading this study section, the student will be able to:

1. define disease
2. explain the concept of disease control
3. explain the disease prevention technique

3.0 MAIN CONTENT

3.1 CONCEPT OF DISEASE

It is a disorder of structure or function in a human, especially one that has a known cause and a distinctive group of symptoms, signs, or anatomical changes.

DISEASE CONTROL

Disease control is the reducing of the numbers of new infections, the number of people currently infected and the number of people who become sick or die from a disease in local settings. There are two types of disease control

1. By preventing contact, and therefore transmission of infection between the susceptible host and the source of infection
2. By reducing the host unsusceptible, either by selective breeding or by induction of an effective artificial immunity.

3.2 Disease Control in Nursing

It addresses factors related to the spread of infections among patients, among staff and between patients and staff. A nurse has a role in every department in a hospital to control disease from surgery to outpatient services, dietetics, safety, first aid, medical record management and community outreach. Disease prevention is building a healthier community at large through various techniques. These disease prevention techniques are divided into three different types.

1. **Primary Prevention:**
   This includes measures taken by healthcare professionals to prevent the onset of a particular disease by encouraging positive health behaviors such as wearing seat belts to prevent vehicular injuries or immunization to reduce mortality rates.
2. **Secondary Prevention:**
   It is identifying individuals with high disease risk factors through screenings and regular care.
3. **Tertiary Prevention:**
   Treating existing diseases in patients by creating a care plan and minimizing future complications. Nurses are pivotal in reducing disease outbreaks and promoting a healthier lifestyle for society. They do this through outreach programs and patient guidance. Nurses ensured that people adhered to medical advisories and observed necessary precautions during and after the pandemic. For example, a nursing performing wound dressing procedure can educate them about the importance of getting a tetanus booster shot taking essential vitamins and antibodies and keeping the wound site clean.

Nursing staff must be well-versed in nutrition, dietary medications and safety simultaneously to ensure they can help their patients lead healthier lives. Nurses are tasked with improving community health by establishing and running health care programs. These programs are staffed and run by nurses, they help to improve health awareness and education in the masses by encouraging

- Regular exercise
- Weight management
- Smoking and drinking cessation
- Disease control for existing diseases
- Regular screening

These programmes help the community to control disease and the nurses are always there to help.

4.0 Conclusion

Nurses are at the forefront of every major medical campaign. This includes immunization drives, helping the community embrace modern medicine and providing hand on care on site. Nursing is one of the few areas of work where the staff works hand-on with patients every day. This helps

them to have the most significant impact on the well-being of their patients. Therefore, nurses must be familiar with the method of disease control, in order to enhance their practice.

5.0 Summary

This study section explains the concept of disease and disease control. Techniques of disease prevention were also discussed.

6.0 Tutor-Marked Assignment

1. A ways to prevent disease are the following EXCEPT

A. Nutrition

B. Good personal hygiene

C. Use of seat belt

D. Chemotherapy

2. Early identification of disease a can help control its spread. **True or false**

Answer

1. D

2. True

7.0 References/ Further Reading

Anderson, M**.** B. (2019). Prevention and Control of Infections in Hospitals: Practice and Theory. Springer.

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MODULE FOUR

PROMOTING SUSTAINABLE HEALTH

Study Section 1: Stress and Adaptation
Study Section 2: Gender Issues
Study Section 3: Sexual Health
Study Section 4: Pain Management

STUDY SECTION 1: STRESS AND ADAPTATION

CONTENTS

1.0 Introduction

Stress is part of human life and people go through it every time but most people do not know anything concerning the cause and what/how stress come about. The note below discusses everything to be known.

2.0 Learning Outcomes

At the end of reading this study section, the student will be able to:

1. explain what stress is
2. identify stressors
3. explain the body response to stress
4. discuss stress management

3.0 Main Content

3.1 **What Is Stress?**

Stress is a feeling of physically emotional tension. Everyone experiences stress as a part of daily life, but each perceive and respond to stress in their own unique way. Stress can also be defined as the body's reaction to a change that requires a physical, mental or emotional adjustment or response. There are agents that cause stress. They are called **Stressors.**

Stressors

Stressor is an agent, condition or other stimulus that causes stress to an organism. It can also be defined as a situation, activity or event that produces stress.

Types of Stress

The sources of stress are infinite; however, stressors are commonly categorized in the following ways

1. **Distress/ Eustress Stress:**
   Distress threatens health and eustress (internally 'good stress') is protective. A passionate kiss can produce a strong stress response as a slap in the face on the Holmes-Rahe stress scale e.g. marriage and divorce receive similarly higher scores.

2. **External/ Internal Stress:** Stressors may be external to the person e.g. death of a family member, a hurricane or something as simple as excessive heat in a room. Stressors may also be internal e.g. diseases, anxiety, nervous anticipation of an event or negative self-talk.

3. **Developmental/ Situation Stress:**
   Are those that can be predicted to occur at various stages of a person's life. For example, most young adults face the stress of leaving home for beginning a career and middle-aged adults must adjust to aging parents, accepting their own physical changes.
   In a sense, developmental stressors may be easier to cope with because they are expected and the person has some time to prepare for them. Situational stressor are unpredictable. For example, you predict that you will experience an automobile accident, a natural disaster or an illness. Situational stressors can occur at any life stage and can affect infants, children and adults equally.

4. **Physiological/ Psychosocial Stress:**
   Physiological stressors are those that affect body structure or function. They may be chemical (e.g. poison, medications), physical or mechanical (e.g. trauma, cold), nutritional (e.g. vitamin deficiency) biological (e.g. viruses, bacteria) or genetic (e.g. in-born errors of metabolism). Psychosocial stressors are external stressors that arises from work, family dynamics, living situation, social relationships and other aspects of our daily lives. People face stress at each stage of their lives. Below are what causes stress throughout the life span.

3.2 STRESSORS THROUGHOUT THE LIFESPAN

The following are common developmental stressors. Not everyone will experience these stressors; However,

Childhood

- Stressors occur primarily in the home
- Absence of parental figures
- Failure of parents to meet needs for safety, security, love and belonging
- Failure of parents to meet basic physiological needs for oxygen, food, elimination, rest and cleanliness
- School-age children may experience stressors at school or among peers.

Adolescence

- Exposure to an expanded environment and a wider circle of friends
- Rapid changes in body temperature
- Need for academic achievement
- Peer pressure
- Maintaining self-esteem, while searching for identity
- Decisions about the future in the areas of school, work and relationships.

Young Adult

- Separation from family, starting college
- Making the transition from youth to adult responsibilities
- Preparing for careers: generation from youth to adult responsibilities
- Financial stressors around partnerships and providing a home for family
- Parenting children

Middle Age

- Career challenges continue
- Child rearing continues, marriage of the children, grand parenting
- Dealing with too many responsibilities e.g. children work, elderly parents, community activities
- Midlife crisis (wanting to escape from one's present life; the person regresses and tries to recapture youth (e.g. by buying new sport car, taking an exotic vacation, engaging in an affair, day dreaming about the ideal life in retirement)

Older Adults

- Losses of family and friends, resulting in loneliness and isolation
- Changes in physical appearance and functional abilities
- Major life changes (e.g. retirement and functional abilities)
- The cost of health care

3.3 Stress Response

Is the compensatory reaction the body makes to the disturbance caused by the stressor. Physiologic response to stress comprises three phases: The fight-or-Flight response is the first phase, in which the sympathetic nervous system is active, increasing heart rate, respiration and blood pressure. In the second phase, the organism adapts to the source of the stress. The third and final phase is exhaustion also called general adaptation syndrome.

Psychological Responses To Stress

There are psychological responses to stress people react differently to stress. Stress responses are holistic; that means we respond and adapt to stress psychologically as well as physiologically. Psychological responses are both emotional and cognitive and they include feelings, thoughts and behaviors. Examples of psychological responses are cognitive, emotional and behavioral responses during adaptation failure etc.

1. **Cognitive Responses**
   - Difficulty in concentrating
   - Poor judgment
   - Forgetfulness
   - Decreased problem solving ability
   - Difficulty in learning
2. **Emotional Responses**
   - Anger
   - Anxiety
   - Depression
   - Fear
   - Feelings of inadequacy
   - Lack of motivation
3. **Behavioral Responses**
   - Crying, emotional outbursts
   - Dependence
   - Poor job performance
   - Substance use and abuse
   - Illnesses
   - Rebellion, acting out

The listed above are the psychological responses to stress of an individual. We have discussed stress and causes of stress which is called **Stressor**, now let's talk about how we can adapt to stress.

3.4 Stress Management

Stress management encompasses techniques intended to equip a person with effective coping mechanism for dealing with psychological stress. Stress management can be defined as interventions designed to reduce the impact of stressors in the work place. A set of techniques and programs intended to help people deal more effectively with stress in their lives by analyzing the specific stressors and taking positive actions to minimize their effects. Examples include Progressive muscular relaxation, guided imaginary, biofeedback, breathing techniques and active problem- solving.

Adaptation

Is the changes that take place as a result of stress and coping. Adaptation is generally considered a person's capacity to flourish and survive even with adversity. Adaptation is when a person is in a threatening situation, immediate response occur. Those responses are often involuntary, are called **Coping response**. The changes that take place as a result of the response to the stressor is **"Adaptation".**

General adaptation syndrome (GAS) is selye's name for the group of non-specific responses that all people share in the face of stressor. This syndrome is grouped into 3 stages which are:

1. Stage I: Alarm Reaction
2. Stage II: Stage of adaptation
3. Stage III: Stage of exhaustion

The stages of general adaptation syndrome (GAS) is in different session, we have discussed about stress and adaptation, designed them. Now in health sectors, how does stress affect nurses?

Factors Affecting Staff Nurses in Healthcare Setting

1. Long hours worked, work overload and pressure dealing with death and dying
2. The effect of these on personal lives- concern about technical knowledge and skills
3. Lack of control over work and lack of participation in decision making
4. Poor social support- conflict with other staff
5. Unclear management and work role and poor management style – lack of staff support and resources
6. Personal – concern about treatment and patient care.

Stress Management in Nursing

For the nurses to be able to be healthy without breaking down, they need to manage the stressor. There are steps to managing stress;

1. Identifying if you are stressed
2. Identify the stressor
3. Identify the reason for the stress
4. Select an appropriate stress management
5. Evaluate

4.0 Conclusion

The concept of stress is important because it provides a way of understanding the person as a being who responds in totality (mind, body and spirit) to a variety of changes that take place in daily life.

5.0 Summary

This study section explained the concept of stress, some stressors were identified. Furthermore, the body response to stress and stress management were discussed.

6.0 Tutor-Marked Assignment

1. Stress is …… to physical, mental and social disturbance

2. Stages of stress are: alarm, …….. and ……

Answer

1. response

2. Resistance and exhaustion

7.0 References/ Further Reading

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STUDY SECTION 2: GENDER ISSUES

CONTENTS

1.0 Introduction

Gender issues affect both sex, but more among women. These issues and the different type of violence against women will be explained in details in this section.

2.0 Learning Outcomes

At the end of this reading section, the student will be able to:

1. Explain the concept of gender issues
2. define gender violence
3. State the responsibilities of nurses in gender issues

3.0 Main Content

3.1 Concepts of Gender Issues

What is Gender?

Is the characteristics that a society or culture delineates as masculine or feminine. Gender role as a ‘man’ or a ‘woman’ in society can be quite different cross culturally.

What is Sex?

Sex is either of the two main categories (male and female) into which humans and most other living things are divided on the basis of their reproductive functions.

What is Issue?

Is an important topic or problem for debate for discussion. Now we know the definitions of Gender and issues, let us join it together.

What is Gender Issues?

Gender issues is not same as women’s issue. Understanding gender mean understanding the behavior opportunities and constraint that affect both men as well as women.

What is Gender Inequality: it refer to unequal treatment or perceptions of individuals based on their gender. It arises from difference in socially constructed gender roles.

What is Gender Equality: is also known as sex equality or equality of the genders. It's the view that everyone should receive equal treatment and not be discriminated against based on their gender.

Equity and Bias (Where it Matters)

- **Equality:** is the state of being equal especially in status, right or opportunities
- **Equity:** is the quality of being fair and impartial
- **Bias:** is prejudice for or against one person or group especially in a way considered to be unfair. There are difference between equality and equity

Equity and equality are two strategies we can use in an effort to produce fairness. Equity is giving everyone what they need to be successful. Equality aims to promote fairness, but it can only work if everyone starts from the same place and needs the same help. Another issue of gender is **Gender violence.**

3.2 Gender Violence

Is a behavior involving physical force intended to hurt, damage or kill someone or something. Any act or gender – based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

The nature and extent of specific types of gender base violence vary across cultures, countries and religions. Examples include; rape, social exploitation and forced prostitution, domestic violence, trafficking, forced or early marriage; and harmful traditional practices, such as female genital mutilation and honor killing.

Choking violence, crimes against women. Every minute and seconds a woman are violated such as:

- Rape (every 29 minutes a girl or woman faces such act)
- Molestation; every 15 minutes
- Sexual harassment: every 53 minutes
- Murder: every 16 minutes
- Cruelty Act: every 9 minutes
- Dowry death: every 77 minutes.

The source of this information is National crime Records Bureau, 2005.

Women are not dying because of the disease we cannot treat; they are dying because society have yet to make a decision that their life are worth saving.

Gender Discrimination Throughout a Woman's Life

	Phase	**Type**
1	Prenatal	Prenatal sex selection, female feticide, battering during pregnancy
2	Infancy	Infanticide, emotional and physical abuse, differential access or deprive to food, nutrition and medical care
3	Childhood	Genital mutilation, incest and sexual abuse, child prostitution, differential access or deprive to food, nutrition and medical care
4	Adolescence	Dating violence, sexual abuse in work place, forced prostitution, rape, sexual harassment, forced pregnancy, trafficking, forced abortion, early marriage
5	Reproductive	Abuse by intimate partner, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual harassment, forced pregnancy, trafficking, forced abortion, bigamy, polygamy
6	Old age`	Abuse of widows, elder abuse

Types of Gender Violence

A. Domestic violence
B. Sexual violence
C. Human trafficking and forced prostitution
D. Others

- Honor killings
- Dowry violence
- Acid throwing
- Forced marriage
- Stalking
- Mistreatment of widows
- Accusations of witchcraft

Domestic Violence:

It is defined as the physical or mental torture given by a member of the family to another member of the same family. It is the most common form of gender based violence

Types of Domestic violence

1. **Physical abuse:** Causing pain physically which includes slapping, beating, arm- twisting, stabbing, strangling.
2. **Sexual abuse:** forced to fulfilling sexual desire of men include rape, coerced sex through threats, unwanted sexual act, incest, marital rape.
3. **Psychological abuse:** include threatening behavior, harassment, threats of abandonment, confinement, verbal abuse and other mental torture
4. **Emotional abuse:** Public embarrassment, humiliation, fear, shame, isolation.
5. **Economic abuse:** denial funds, exploitation controlling access to healthcare, food, basic necessities.

Sexual Violence: is defined as a sexual act committed against someone without that person's freely given consent. It could be done by acquaintances or strangers. Sexual violence is divided into the following types: it includes:

- **Sexual exploitation and abuse**
  It is the second abuse of children and youth through the exchange of sex or sexual acts for drugs, food, shelter, protection, and other basics of life. Sexual exploitation includes involving children and youth in creating pornography and sexually explicit websites. Incest, child abuse, pornography.

Sexual harassment/sexual assault: It the making of unwanted sexual advances or obscene remarks

Gender Discrimination

It is the unjust or prejudiced treatment of different categories of people, especially nurse on the grounds of race, age or sex. Discrimination affects both men and women. It is apparent in work situations where one gender is given preferential treatment or one gender receives less pay or job responsibilities because of gender bias and unfair strategies.

3.3 Roles and Responsibilities of Nurse in Gender Issue

According to the international council of nurse (ICN) code of ethics for nurses, the nurse is expected to provide care for all patient with respect for his/her human dignity and uniqueness as an individual regardless of race, creed, gender, socio- economic status or the nature of illness.

i. The nurse is responsible for safeguarding the patient's right to privacy by honoring the confidentiality of information related to the patient

ii. Nurse should advocate for legislature reform and enforcement of laws for the promotion and the protection of women's right to reproductive health choices and informal consent, including promotion of women's awareness of laws, regulations and policies that affect their rights and responsibilities in family life.
iii. Nurse should promote zero tolerance of all forms of violence against women and works for the eradication of traditional practices that are harmful to women's reproductive and sexual health such as rituals associated with puberty.
iv. Nurses can hold workshops for health providers on recognizing the effects of gender- based violence on women's health and on how to detest and prevent abuse and assist victims.
v. Nurses also can help to ensure emergency contraception is available for victim of sexual violence.

4.0 Conclusion

Both gender faces all these violations. But, nurses should carefully assess the vulnerable group and protect their interest.

5.0 Summary

Gender issues and the different types were identified and explained in this study section. Moreover, The responsibilities of nurses in gender issues were explained.

6.0 Tutor-Marked Assignment

1. …….is the state of being equal especially in status, right or opportunities

2. …….. is the quality of being fair and impartial.

3. Gender discrimination affects ……

4. The following are types of domestic violence EXCEPT

A. Physical Abuse

B. Sexual Abuse

C. Social Abuse

D. Emotional Abuse

Answer

1. Equality

2. Equity

3. Both men and women

4. C

7.0 References/ Further Reading

Bradbury-Jones, C. & Isham, L. (2021). Understanding Gender-Based Violence: An Essential Textbook for Nurses, Healthcare Professionals and Social Workers. Springer.

Segal, M. T. & Demos, V. (2014). Gendered Perspectives on Conflict and Violence. Part B. Emerald Group Publishing Limited.

STUDY SECTION 3: SEXUAL HEALTH

CONTENTS

1.0 Introduction

Sexual health requires a positive and respectful approach to sexuality and sexual relationship as well as the possibility of having pleasurable and safe sexual experiences, from of coercion, discrimination and violence. This section will explain the concept of sexual health, its components,

2.0 Learning Outcomes

At the end of reading this study section, the student will be able to:

1. Explain the concept of sexual health
2. identify challenges to good sexual health
3. highlight ways to promote good sexual health
4. explain positive sexual health behaviors.

3.0 Main Content

3.1 Sexual Health

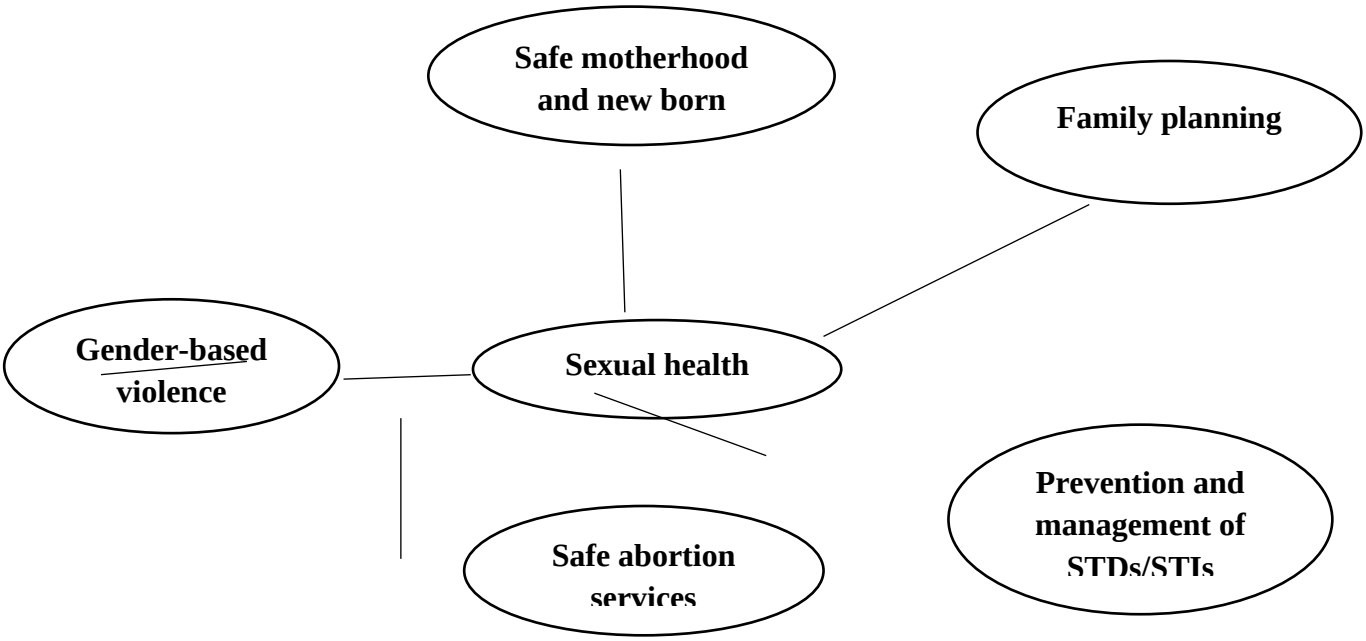
Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health is not just about sex. It includes different things such as;

- Sexuality
- Changes during puberty
- Relationships
- Sexually transmitted diseases (STDs) and Sexually transmitted infections (STIs)
- Family planning
- Contraception
- Pregnancy

Components/ Scope of Sexual Health

1. Family planning counseling, information, education, communication and services
2. Care of new born
3. Prevention and management of complications of abortions

4. Information, education, counseling on human sexuality
5. Safe motherhood: education and services for healthy pregnancy



These are the components of sexual health, there are rights to sexual health which includes the following:

- The right to privacy
- The right to equality and non- discrimination
- The rights to information, as well as education
- The rights to freedom of opinion and expression
- The right to an effective remedy for violations of fundamental human rights
- The right to the highest attainable standard of health (including sexual health) and social security.

3.2 Challenges to Sexual Health

There are rights in sexual health of an individual. So also there are challenges. The following are the challenges to sexual health:

1. Gender inequality (major challenges that brings the gap from access of services to the utilization of services)
2. Lack of awareness
3. Misconceptions about family planning services
4. Culture, tradition and taboos

5. Increased risk of HIV and other STIs
6. Ignorance to sexual health issues.

3.3 Ways to Promote Sexual Health Issues

1. Empowerment of women and involving women in various program
2. Availability of effective methods of family planning
3. Emphasizing on advocacy on the concept of sexual health
4. Promotion of research activities related to sexual health
5. Tackling the cultural barriers and taboos related to sexual health
6. Assuring highest level of quality of care and services.

3.4 Positive Sexual Health Behaviors

1. Healthy relationships are the key to good sexual health, respect yourself and your partner
2. Delay your first sexual experience until you are sure you are ready
3. Use condoms and lube every time. Lube makes condoms less likely to break and increase pleasure
4. Protect your family tree- untreated STIs can cause infertility.
5. Drinking alcohol can affect the decisions you make, including around sex
6. Limit numbers of sexual partners
7. Use reliable contraception unless you want a baby now.

Sexual health- related issues are wide – ranging and encompass sexual orientation and gender identity, sexual expression, relationships and pleasure. They also include negative consequences or conditions such as:

i. Infections with human immunodeficiency virus (HIV), sexual transmitted infection (STIs)
ii. Unintended pregnancy and abortion
iii. Sexual dysfunction
iv. Sexual violence
v. Harmful practice (such as female genital mutilation, FGM)

4.0 Conclusion

Positive sexual health is necessary for proper function of the physical, mental and social aspect of an individual. Healthy relationship appropriate for healthy sexual health. Therefore, teaching should not be only directed to sex, but other aspect such as family planning, family health education, safe motherhood and others.

5.0 Summary

This study section explained the concept of sexual health and challenges of good sexual health. Ways to promote good sexual health and positive sexual health behaviors were discussed.

6.0 Tutor-Marked Assignment

List 4 aspect of sexual health

Answer

1. Family planning,
2. prevention and management of the abortion,
3. safe mother,
4. care of the new born.

7.0 References/ Further Reading

Aggleton, P. & Parker, R. (2010). Routledge Handbook of Sexuality, Health and Rights. Routledge Taylor & Francis Group..

Melville, C. (2015). Sexual and Reproductive Health at a Glance. Wiley Blackwell

STUDY SECTION 4: PAIN MANAGEMENT

CONTENTS

1.0 Introduction

Pain is termed as an unpleasant response to an injury. This study will exp[lain the various types of pain, both pharmacological and non-pharmacological management of pain.

2.0 Learning Outcomes

At the end of reading this study section, the student will be able to:

1. define pain
2. explain pain management using medication and without medication.

3.0 Main Content

3.1 WHAT IS PAIN?

Pain is highly unpleasant physical sensation caused by illness or injury. It can also be defined as a signal in your nervous system that something may be wrong. It is an unpleasant feeling such as a prick tingle, sting, burn or ache. Pain may be sharp or dull.

Types of Pain

We have two types of pain, they are;

1. **Acute Pain:** is a normal response to an injury or medical condition. It starts suddenly and it is usually short-lived.
   .
2. **Chronic Pain:** it continues beyond the time expected for healing. It generally lasts for longer than 3 months. Pain may be anything from a dull ache to a sharp stab and can range from mild to extreme. You may feel pain in on part of your body. It may be widespread.

Type of pain by intensity

- mild
- moderate
- severe

3.2 PAIN MANAGEMENT

Pain management is a medical approach that draws on disciplines in science and alternative healing to study the prevention, diagnosis and treatment of pain. A person's emotional wellbeing can impact the experience of pain. Understanding the cause and learning effective ways to cope with your pain can improve your quality of life. Key pain management strategies include:

- Pain medicines
- Physical therapies (such as heat or cold pack, massage, hydrotherapy and exercise)
- Psychological therapies (such as cognitive behavioral therapy, relaxation techniques and meditation)
- Mind and body techniques (such as acupuncture)
- Community support groups

3.3 MANAGING PAIN WITHOUT MEDICATIONS

Many non-medicine treatments are available to help you manage your pain. A combination of treatments and therapies is often more effective than just one. Some non-medicine options include:

- **Heat or Cold:** use ice packs immediately after an injury to reduce swelling. Heat packs are better for relieving chronic muscle or joint injuries.
- **Physical therapies:** such as walking, stretching, strengthening or aerobic exercises may help reduce pain, keep you mobile and improve your mood.
- **Massage:** this is another physical therapy; it is better suited to soft tissue injuries and should be avoided if the pain is in the joints.
- **Relaxation and stress management techniques** including meditation and yoga.
- **Cognitive behavior therapy (CBT)**
  This form of psychological therapy can help you learn to change how you think and in turn how you feel and behave about pain. This is a valuable strategy for learning to self-manage chronic pain.
- **Acupuncture:** is a component of traditional Chinese medicine. Acupuncture involves inserting thin needles into specific points on the skin. It aims to restore balance within the body and encourage it to heal by releasing natural pain- relieving compounds.

3.4 MANAGING PAIN WITH MEDICATION

Many people will use a pain medicine (analgesic) at some time in their lives. The main types of medicine are:

1. Paracetamol: is often recommended as the first medicine to relieve short term pain

2. Aspirin: for short term relief of fever and mild – to- moderate pain (such as period pain or headache)
3. Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen; these medicines relieve pain and reduce inflammation (redness and swelling)
4. Opioid medicines, such as codeine, morphine and oxycoclone- these medicines are reserved for severe or cancer pain
5. Local anaetheties (drops, sprays, cream or injections) used when nerves can be easily replaced.
6. Some antidepressants and anti-epilepsy medicines used for a specific type of pain called nerve pain.

   When taking medication choosing the right pain medicine is effective. The right choice of medicine for you will depend on

- The location, intensity, duration and type of pain
- Any activities that ease the pain or make it worse
- The impact your pain has in your lifestyle, such as how it affects your appetite or quality of sleep
- Your other medical conditions
- Other medicines you take

Always follow instruction for taking your medicines safely and effectively by doing so:

- Your pain more likely to be well managed
- You are less likely to need larger doses of medicine
- You can reduce your risk or side effect.

Medicines for chronic pain are best taken regularly. If your medicines are not working or causing problems such as side effect, consult your doctor or pharmacist. These more likely to occur if you are taking pain medicines for a longtime.

3.5 MANAGING PAIN THAT CANNOT BE EASILY RELIEVED

Sometimes pain will persist and cannot be easily relieved. It's natural to feel worried, sad or fearful when you are in pain. Here are some suggestions for how to handle persistent pain.

1. Don't increase your pain medicines without taking to your doctor or pharmacist first.
2. Increasing your dose may not help your pain and might cause you harm
3. Improve your physical fitness, eat healthy foods and make sure you get all the rest you need
4. Concentrate on finding fun and rewarding activities that don't make your pain worse
5. Focus on improving your day – to – day function rather than completely stopping the pain.

4.0 Conclusion

Though pain is highly subjective, proper assessment of pain is necessary. When all the steps in pain management are followed properly, there will be reduction in pain and patient will be able to live a functional live as possible.

5.0 Summary

In this study section, the concept of pain was discussed, pain management using medications and without medications were discussed.

6.0 Tutor-Marked Assignment

1. Pain the lasts less than 3 months is known as ……..

2. The classification of pain by duration can either be ……. and ……

3. which of the following is a medication for pain

A. Heat compress
B. Massage
C. Acupuncture
D. Opioid

Answer

1. Acute
2. Acute and chronic
3. D

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