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Advancing People's Health through Nursing Research

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- Workplace Wellness Program for Nurses: A Logic Model Approach
- Examining the Emerging Ideas of Connection within Nursing Practice and Education
- An experience of focus groups fieldwork among novice nurses in the Eastern Visayas Region, Philippines
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It is on record that when a young aspirant asked Faraday the secret of his success as a scientific investigator, he replied, ***'The secret is comprised in three words - Work, Finish, Publish.'***

- Michael Faraday (1791-1867) in
J. R. Gladstone, Michael Faraday (1872), 122

Erratum: The correct ISSN No. of the PJN is 0048-3818 NOT 0048-3318.

PHILIPPINE NURSES ASSOCIATION, INC.

VISION
By 2030, PNA is the primary professional association advancing the welfare and development of globally competent Filipino nurses.

MISSION
Championing the global competence, welfare, and positive and professional image of the Filipino nurse.

CORE VALUES
- Love of God and Country
- Caring
- Quality and Excellence
- Integrity
- Collaboration

Philippine Nurses Association, Inc.
PHILIPPINE JOURNAL OF NURSING

EDITORIAL

People's Health and Nursing Research

Research is a professional responsibility. We are duty-bound to contribute to the body of knowledge and strengthen the evidence base of our profession. We are accountable to society for safe and quality services, adhering to standards of care. The revised position statement of the American Association of Nursing Colleges in 2006 reveals that, *Nursing research worldwide is committed to rigorous scientific inquiry that provides a significant body of knowledge to advance nursing practice, shape health policy, and impact the health of people in all countries. The vision for nursing research is driven by the profession's mandate to society to optimize the health and well-being of populations*. This is shared by the International Council of Nurses in a similar statement in 1999 and by the Philippine Nurses Association as reflected in this journal issue's theme: Advancing People's Health Through Nursing Research.

Nursing research worldwide is committed to rigorous scientific inquiry that provides a significant body of knowledge to advance nursing practice, shape health policy, and impact the health of people in all countries. The vision for nursing research is driven by the profession's mandate to society to optimize the health and wellbeing of populations

Why Research? Often, we are quick to answer, "to discover new knowledge or to refine/validate existing knowledge", sometimes we say, "to test or develop theories." We rarely link these reasons to advance people's health or the advancement of quality and excellent health care, or to provide evidence for nursing practice. Nursing research provides a scientific basis for the health of the people.

Potempa & Tilden (2004) argue that for nursing to be at the forefront of knowledge generation and address societal issues and health care, nursing research must be relevant to health and illness situations, scientifically rigorous, and readily translatable into practice and health policy. This issue attempts to translate this perspective in the works of our colleagues.

Lellamo's *Workplace Wellness Program for Nurses: A Logic Model Approach* proposed a nurses' workplace wellness program focusing on physical activity facilities and nutrition education/weight management. Also, De leon's et al.'s *Pressure Ulcer Prevention in Acute Care using the Pressure Ulcer Bundle of Care* determined the effectiveness of the pressure ulcer bundle of care (PUB) in preventing pressure ulcers among patients in acute care using pre and post-test quasi-experimental design.

The health of the people is now characterized with debilitating, long-term illnesses that gradually erode patients' quality of life. As nurses, we need to understand their causes and role in disease progression is critical to improving health and finding better therapies. Florendo's *The Diabetes Camp Experience of Adolescents with Type 1 Diabetes* presents themes that describe the camp experience of adolescents with type 1 diabetes, its impact and recommendations.

In advancing people's health, research on developing and testing more efficient educational processes, identifying new ways to incorporate technology to enhance learning, and discovering more effective approaches to promoting lifelong learning merits attention. Lane and Serafica's *Examining the Emerging Ideas of Connection within Nursing Practice and Education* claims that "while connection is a common term and fundamental to the role of the nurse/patient relationship, the defining attributes of connect have dynamically changed, and therefore require new understanding". They proposed strategies that would enhance the nursing educator and student connection. On the other hand, Urgel & Borabo's *The Needs and Capabilities of Older Adults Bases for Nursing Curriculum Enhancement* posits that the needs and capabilities of the older adults should be determined to provide quality care and to make sure that they enjoy a quality life. This study aimed to determine the needs and capabilities of the older adults to serve as the basis for the enhancement of the BSN program in Gerontology Nursing that will help undergraduate nurses provide quality care for the older adults.

In advancing people's health, nursing research uses multiple philosophical and theory-based approaches as well as diverse methodologies. Nurse researchers continue to hone their knowledge, skills and attitudes to finding even more effective approaches. Pagatpatan, Ramirez & Perez' article, *An experience of focus groups fieldwork among novice nurses in the Eastern Visayas Region, Philippines* provides experiential ways to enhance the quality of data to improve trustworthiness of findings. Facilitation and note taking in FG discussions as well as transcribing and translating are important skills that a nurse researcher must master. Along the improvement of researching is Mazzotta's *Methodology and Methods: Why the Confusion amongst Novice Researchers*. This article is an example of advancing the knowledge, skills and attitude of a novice in the field of research. Novice researcher, Mazzotta, shares her realizations "…to challenge my thinking and myself if I am to embrace a fluid approach in order to appreciate diverse standpoints".

This issue also presents past and current nurse leaders and researchers who have advanced people's health in varying capacities, in their own time. Daplas' *Remembering the Lady with the Lamp* takes us to a journey in London, where she was able to visit the Florence Nightingale Museum. The paper highlights the legacy, the life and works of the woman we owe our roots to. Dr. Daplas shares her insights on Florence Nightingale as a person, as a nurse and as a leader. Reboroso, on the other hand, profiles Dr. Teresita Irigo-Barcelo, this year's Professional Regulation Commission's (PRC) Outstanding Professional Nurse, as a committed educator, researcher, advocate, a legendary leader, an exceptional achiever.

People's health and nursing research are intertwined. Let us continue to make great strides toward a better future.

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ERLINDA CASTRO-PALAGANAS, PhD, RN
Editor-in-Chief

President's Message

Consistently through the past issues of the Philippine Journal of Nursing, the Editorial Board have always been carefully planning and selecting relevant and knowledge-based scientific articles that continued to attract wide readership not only among nurses but also other health and medical professionals here and across the Asia and Pacific region, as well as countries around the globe. This is evident with contributors coming from the US, Thailand and Indonesia.

This issue is especially focused on "Advancing People's Health through Nursing Research", a theme that is so timely when people across nations are confronted with emerging diseases and conditions that put them at risk for illnesses that were not encountered during the past decade. Globalization and regionalization of health services have brought along new diseases and technologies that warrant new knowledge and capabilities aimed to prevent and control the spread of these diseases. This is where research and evidence-based guidelines can be best utilized.

The Philippine Nurses Association continues to support research initiatives. Research is recognized as an approach to achieving our life purpose to promote professional growth towards the attainment of highest standards of nursing. Thus, our constitution and by-laws, mandates the Department of Research to do the following: initiate, motivate and participate in research projects/studies related to nursing; disseminate research findings, conclusions and recommendations for the improvement of the profession; receive, keep and preserve records of research projects conducted by nurses; recommends due recognition of nurses who have conducted research studies in nursing; and identify strategies for the utilization of research findings as appropriate.

It can also be gleaned from our Roadmap 2030 that towards Service Excellence, we need to "push clear and research-based advocacies that promote nurses' welfare". Research thus is an important tool for us to be a responsive organization and be recognized as the primary professional organization in advancing the holistic welfare of Filipino nurses. If we are to take pride of our members to be globally competitive in providing quality and excellent care, research production and consumption form part of our professional responsibility.

Through these robust articles, nurses in the field can be armed with knowledge; thus translating evidence in advancing the health of the people and better quality of work life for our nurses, and ultimately build a better, healthier nation!

MILA DELIA M. LLANES, PhD, RN
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Philippine Nurses Association, Inc.
PHILIPPINE JOURNAL OF NURSING

RESEARCH ARTICLE

Workplace Wellness Program for Nurses: A Logic Model Approach

Efrelyn A. Iellamo, RN, MAN[1]

Abstract

Background: The present situation in the clinical practices in most hospitals in the Philippines presents great challenges and expectations for nurses to accomplish. Working in very busy large hospitals is considered tedious task. Even the most experienced nurses are confronted with complicated assignments that may threaten their wellness. It is in this context that the researcher conducted this study to determine (a) the nurses' rating of the availability of an existing hospital's basic health promotion program for nurses, (b) the nurses' perceptions of administrative support for the health promotion program, and (c) the nurses' appraisal of the scope of workplace wellness promotion in hospital units.

Methodology: A descriptive-correlational method was used. The sample consisted of131 of 194 staff nurses from a large city government hospital. Data were collected using the Workplace Wellness Questionnaire and interviews. Ranking, weighted mean, and Pearson coefficient were used to analyze data.

Results: The respondents rated the availability of basic health promotion with its overall mean score of 2.61 implying that the respondents perceived that the health promotion program is supported to some extent. With regard to the administrative support, the respondents perceived that administration was generally supportive of existing hospital health promotion program. However, they responded that they rarely experienced an optimum level of wellness. Statistical evidence supported that there is an existing relationship between the extent of workplace wellness and the availability of it and support of the administration.

Conclusion: Weak areas in the workplace were prioritized in the wellness program for nurses. These areas were: physical activity facilities and access to facilities outside of work hours, nutrition education/weight management, written policies and fitness programs, allocated budget, employee participation and health screening. Since the respondents experienced a low level of wellness, a nurses' workplace wellness program was formulated and proposed.

Introduction

The researcher, being aware of the working conditions of staff nurses in city government-managed hospitals, observed that even the most experienced nurses are confronted with

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complicated tasks that threatened their wellness. The prevalence of absenteeism is high due to sickness and other problems that are(wellness) health-related. Some nurses complain about their working conditions, and there were those who are dissatisfied with their work as nurses. These observations prompted the researcher to conduct this study. A workplace health promotion program is essential to increasing nurses' health awareness and to decreasing cases of absenteeism and sick leaves. The work areas must provide various opportunities for nurses to express themselves creatively when they are on the verge of giving up so that they may have a healthy and productive well-being and disposition that will redirect their overall thinking and actions (Swinford & Webster, 1989). They should be taught to have a way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated in order to live more fully within the human and natural community with which wellness is the driving force (Sweeney & Witmer, 1991, in Myers, 2003). All these opportunities can be provided by the work environment with the assumption that there should be congruence in the seven wellness aspects of individuals being nurtured and developed by the workplace. One way to design innovative institutional programs like wellness in the workplace is through the use of program logic model. In its simplest form, this diagrammatic representation analyzes work into four categories or steps: inputs, activities, outputs, and outcomes. Kirkpatrick (1998) contended that these steps represent the logical flow from inputs covering resources such as money, employees, and equipment to work activities, programs or processes, to the immediate outputs of the work that are delivered to customers, to the outcomes or results that are the long-term consequences of delivering such outputs. According to the development guide by the W.K. Kellogg Foundation (2004), the Program Logic Model provides a picture of how an organization does its work according to the theory and assumptions underlying a program. The model can enhance the participatory role and usefulness of evaluation. Also, the model provides direction by emphasizing the ability to identify outcomes and anticipate ways to measure the outcomes. The Program Logic Model is a strong tool for communicating with diverse people.

Based on these premises, the researcher conducted the study to determine the clinical nurses' appraisal of the wellness promotion in each ward or unit, and the significant relationships. It was anticipated that results would provide the necessary baseline data for the proposed Wellness in the Workplace Program for the Nurses. The goal is to enable nurses to continue to live up to their ideals of the nursing profession in terms of excellence in service they provide to their clients.

Witmer and Sweeney (1992) presented a holistic model for wellness and prevention across the lifespan which is based on psychological theory and empirical research on characteristics of healthy persons. Specifically, the authors incorporated cross-disciplinary research and theoretical concepts from a variety of disciplines that supported certain human characteristics as related to health, longevity, and quality of life. Cherry, R. (2006) stated that wellness is generally used to indicate a healthy balance of the mind, body and spirit that results in an overall feeling of well-being. Shurts and Myers (2008) found positive relationships between healthy life styles and the life tasks in the Wheel of Wellness, and Connolly and Myers (2003) found positive associations between job satisfaction, mattering and the life tasks. According to Bates (2013), Employee Wellness Programs are organized programs designed to support and assist staff members in establishing healthier lifestyles. Wellness Programs can include things like; increasing employee awareness on health topics, providing behavior change initiatives, and/or establishing corporate policies that support health-related goals and objectives. Programs and policies that promote increased physical activity, tobacco use prevention and cessation, and healthy food selection are a few examples. From a management perspective, wellness programs have the potential

to decrease absenteeism, reduce medical claims costs, and improve employee productivity, recruitment, and retention. Many employers credit the implementation of institutionalized fitness programs for productivity gains in areas such as reduced errors, improved efficiency, and improved decision making Sullivan (2009).

Another important factor to consider in the preparation of a wellness program is the identification of the signs of workplace stress and burnout. This was disclosed by Cruz (1994) who commented that mood and sleep disturbances, upset stomach and headache, and disturbed relationships with family, friends, and colleagues are examples of wellness related problems. The options depend on the goals and desired outcomes of the wellness program. If the goal is to help employees change behavior, reduce risk factors, or save healthcare dollars then the wellness program would be designed to accomplish those outcomes and a budget would be necessary to support that design. Amery (2005) conducted a study on the wellness perception among nurses working in selected US hospitals (particularly in Oncology Departments) and found that the respondents perceived themselves well in the 5 dimensions of wellness developed by Myers (2003). Jadada (2009) suggested that designing a wellness program should start from an understanding of the causes of workplace maladies. Job strain results from the interaction of the worker and the conditions of work. Views differ on the importance of worker characteristics versus working conditions as the primary cause of job stress. The differing viewpoints suggest there are different ways to prevent stress at work. According to one school of thought, differences in individual characteristics such as personality and coping skills are most important in predicting whether certain job conditions will result to disorders - in other words, what is stressful for one person may not be a problem for another.

The Program Logic Model

One useful tool to help administrators plan an effective program is the logic model. Logic models identify program outcomes, processes in which clients are to engage, and the organization structure for delivering activities. Well-conceived logic models are based on relevant disciplinary research and developed in consultation with users of the developed program (Israel, 2009).

The Program Logic Model (W.K. Kellogg 2004) is a systematic and visual way to present relationships among the resources needed to operate a program, the planned activities, and the changes or results the researcher hopes to achieve. The model presents a picture of how an organization does its work according to the theory and assumptions underlying a program. It can enhance the participatory role and usefulness of evaluation. The model supports identification of outcomes and anticipation of ways to measure outcomes.

Components of the model

Arrows are used to link the sequence of events necessary for the program to be effective. In addition to the diagram, logic models can include a narrative that explains the relationships between these components. Fully-specified logic models also identify the external factors that can hinder the efforts of program staff or help them achieve the program's objectives. The model may also indicate factors which affect recruiting participants into the program. A well-reasoned logic model draws upon disciplinary knowledge bases to establish the likely outcomes of program activities and factors which can help or hinder a program's success. The logic model components are presented in http://www.uwex.edu/2009. A sequence of actions that describe what the program is and will do and how investments link to results is shown. The five core components in this depiction of the Program Logic Model include:

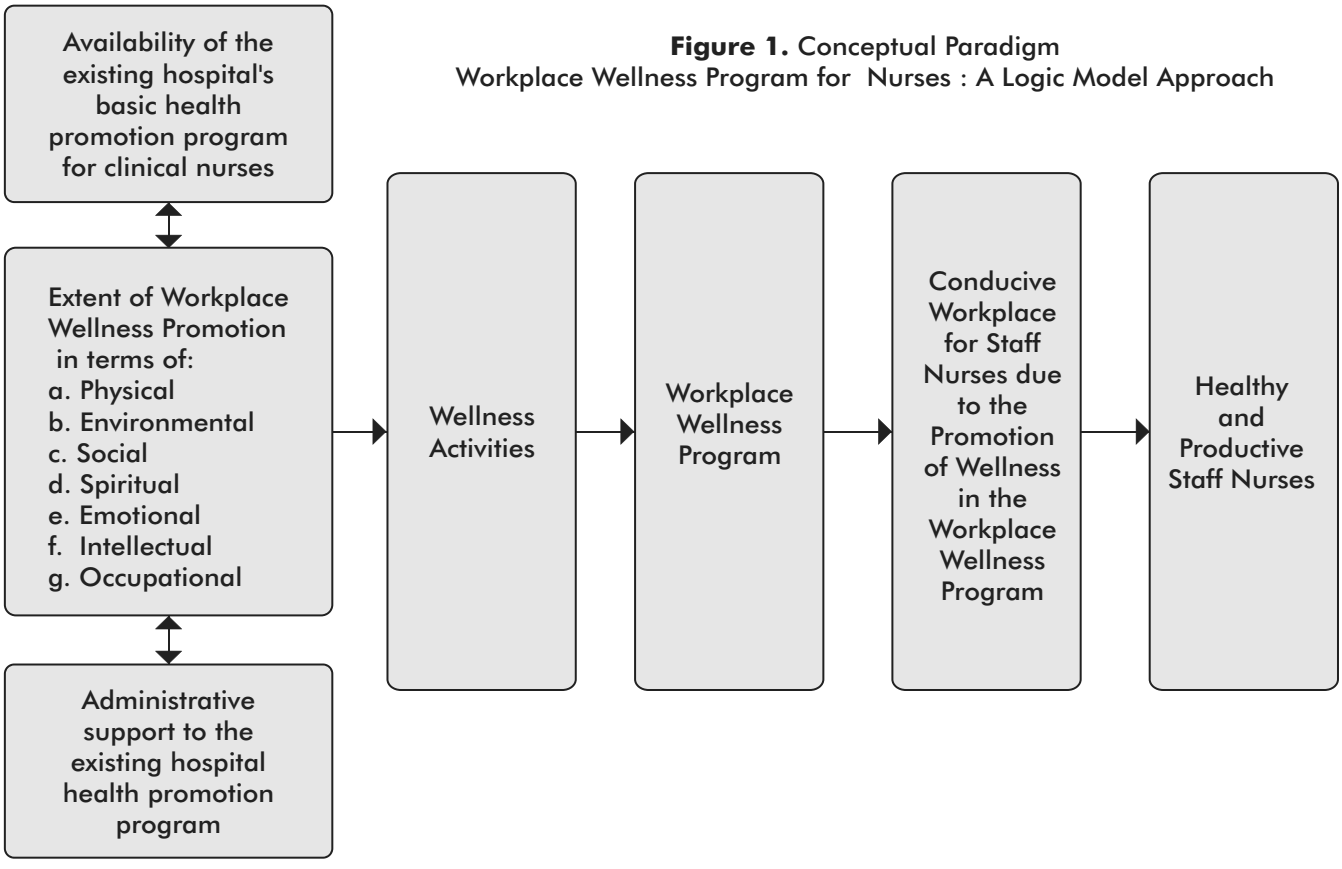

Figure 1. Conceptual Paradigm
Workplace Wellness Program for Nurses : A Logic Model Approach

- INPUTS: resources, contributions, investments that go into the program
- ACTIVITIES: the processes, tools, events, technology, and actions that are an intentional part of the program implementation. These interventions are used to bring about the intended program changes or result
- OUTPUTS: activities, services, events and products that reach people who participate or who are targeted
- OUTCOMES: results or changes for individuals, groups, communities, organizations, communities, or systems
- IMPACTS: the fundamental intended or unintended change occurring in organizations, communities or systems as a result of program activities within 7 to 10 years.

Factors that can affect the quality of a program

Factors that can affect the quality of a program are: the needs of clientele; content and sequence of activities; availability of resources; and coordination among employees, administrators, and stakeholders. In essence, an effective program gets the right information to appropriate clients in a way that they can understand and apply.

Methodology

This study employed the descriptive-correlational method of research. Zulueta and Costales Jr. (2004) defined this method of research, as a fact-finding study with adequate and accurate interpretation of the findings. This method describes "what is" with emphasis on what actually existed such as current conditions, practices, situations or any phenomena without any control or

manipulation of the variables under scrutiny. Since the present study was concerned with the availability of the existing hospital's basic health promotion program for staff nurses, perceived administrative support to the existing hospital health promotion program, extent of workplace wellness promotion in the hospital wards and units and significant relationships between these areas (as rated by the nurse-respondents), the descriptive method of research is the most appropriate method to use.

This study was conducted in a 300 bed government administered city hospital in the Philippines. The hospital is a non-profit tertiary, general and training hospital. As the hospital is operated and is maintained through taxes paid by city residents, its primary concern is the admission and treatment of patients who are bona-fide residents of the city. Furthermore, the hospital is responsible for the provision of an integrated community health program and the promotion of scientific excellence through research activities.

The participants in this study were the regular permanent clinical nurses, one hundred thirty one (131)out of the total of one hundred ninety four (194) regular permanent clinical nurses assigned in the different units of the hospital. The researcher determined the sample size using the Slovin's formula Ariola (2006). The researcher utilized the lottery technique, where by all the names of the respondents per unit were placed in separate boxes and these were drawn, until the desired number was achieved. Fifty (50) participants were from Special Units, 14 were from OPD/Infirmary, 12 were from Medicine Department, 5 were from ENT Department, 9 were from Pediatric Department, 23 were from OB/DR, 13 were from Surgery Department, and 5 were from Central Supply and Nursing Administration. By employing the descriptive-correlational method of research, data were collected by utilizing the prepared Workplace Wellness Questionnaire and through the interview conducted. Ranking, weighted mean, and Pearson coefficient were used to present and interpret the data.

On the availability of the existing basic health promotion program, it was found out that generally, the respondents rated that the hospital has an available sustenance for the workplace wellness of the nurses. With regard to the administrative advocacy, the respondents perceived that they are generally supportive on activities with regard to it. However, the respondents evaluated that they rarely experienced an optimum level of wellness. The study found out that there is a significant relationship between these variables.

Statistical evidence supported that there is an existing relationship between the extent of workplace wellness and the availability of it and support of the administration. Moreover, since the respondents were rarely experienced high level of wellness, a nurses' workplace wellness program was formulated.

Results and Discussion

Table 1 presents the composite mean summary of the staff nurses' rating of the availability of the hospital's existing basic health promotion program. Response to cardiac events and emergency is rated at the top of the fourteen areas with the mean of 3.20, followed by written policies on tobacco use and healthcare coverage with respective mean scores of 3.18 and 3.06. The lowest mean score was for physical activity facilities and access to physical activity facilities outside of work hours with the mean of 2.00. These data may mean that, although health promotion is being practiced in the hospital, it seems that not all aspects of a well prepared wellness program are in place, as can be inferred from the responses. It is, however, important to note that cardiac-related incidence emergency handling, prohibition of tobacco use and healthcare coverage are rated high since the workplace is the hospital; and this is the very purpose of their work - to save lives or control sickness.

Table 1. Composite Mean Summary of the Respondents' Rating on the Availability of Existing Hospital's Basic Health Promotion

Areas Rated	Mean	I	Rank
1. Worksite Wellness Program Policy and Worksite Wellness Plan	2.62	A	5
2. Health Committee Representation	2.66	A	4
3. Written Policies on Physical Activity and Fitness Programs	2.48	PA	12
4. Breaks or Rest Periods	2.51	A	8
5. Physical Activity Facilities and Access to Physical Activity Facilities Outside of Work Hours	2.03	PA	14
6. Written Policies on Nutrition	2.59	A	6
7. Written Policies on Tobacco Use	3.19	A	2
8. Response to Cardiac Events and Emergency	3.20	A	1
9. Healthcare Coverage	3.06	A	3
10. Health Screening	2.49	PA	9
11. Nutrition Education/Weight Management Programs	2.15	PA	13
12. Employee Participation	2.48	PA	10
13. Education and Awareness Campaigns	2.52	A	7
14. Allocated Budget for Health Program	2.42	PA	11
Overall Mean	2.60	Available	

Legend:

Weight	Score Range	Interpretation (I)
5	4.51-5.00	VMA=Very Much Available
4	3.51-4.50	MA=Much Available
3	2.51-3.50	A=Available
2	1.51-2.50	PA=Partially Available
1	1.00-1.50	NA=Not Available

Table 2. Composite Mean Rating on Perceived Administrative Support to Existing Hospital Health Promotion Program

Indicators	Mean	I	Rank
1. Accessibility	3.18	S	1
2. Practicality and Suitability	2.63	S	3
3. Comprehensive Scope and Coverage	2.51	S	4
4. Focus on Employee's Welfare	2.44	LS	7.5
5. Employee Involvement	2.55	S	5
6. Sensitivity to Employee's Needs	2.47	LS	6
7. Quality of Service	2.46	LS	7.5
8. Continued Monitoring	2.41	LS	9
9. Cost, Equity, and Affordability	2.86	S	2
Overall Mean	2.61	Supported	

Table 2 displays the composite mean rating on perceived administrative support for the existing hospital health promotion program. Generally, the obtained means ranged from the 2.41 to 3.17. The data suggest that the respondents perceived that the hospital administration does not fully support

Legend:

Weight	Score Range	Interpretation (I)
5	4.51-5.00	FS=Fully Supported
4	3.51-4.50	MS=Much Supported
3	2.51-3.50	S=Supported
2	1.51-2.50	LS=Less Supported
1	1.00-1.50	NS=Not Supported

the existing hospital health promotion program. Generally, with its overall mean score of 2.61, the respondents perceived that the health promotion program is supported to some extent. In summary, all the interview data support the findings of this study concerning the area investigated. These findings should be considered by the administration when adopting a program that would promote, improve, and maintain employee health. The findings are parallel to those of authorities on the development of a workplace wellness programs. According to Henderson (2008), in any endeavor that aspires to maintain and sustain a particular project or program, full participation of every member, employee, and even the key player is a necessity. The key players are the most significant since they have the ability to decide on major operations.

Sweeney and Witmer (1991) argued that the seven dimensions of wellness should be developed and honed in every person especially the nurse-worker since, according to Venzon (2003) nurses are at all times prone to sickness with their exposure to various diseases within the hospital premises. Table 3 shows a Composite Mean Summary of the Respondents' Appraisal of the Extent of Workplace Wellness Promotion according to the seven dimensions of wellness in the hospital units. Informal conversation with the nurses revealed an interesting idea. Although the wellness promotion at this hospital is not that evident, they are fully aware of the benefits of having a functional workplace wellness program. They said they would like the hospital to implement one in order that avoid excess absenteeism and low performance. They also wanted to project the traditional image that Filipino nurses, whatever odds and shortcomings the workplace exposed them to, possess tender loving care qualities in the conduct of their nursing jobs. The study findings have implications for the administration and may challenge the key decision makers to consider having a concrete, comprehensive wellness program that could cover all the seven dimensions of well being and health and assure that nurses from this hospital will become models of optimum wellness in the nursing-caring services in this country and in the international arena.

Table 3. Composite Mean Summary of the Respondents' Appraisal of the Extent of Workplace Wellness Promotion in the Hospital Units

Indicators	Mean	I	Rank
Physical	2.5	AE	4
Environmental	2.16	LE	7
Social	2.53	AE	3
Spiritual	2.61	AE	2
Emotional	2.28	LE	6
Intellectual	2.60	AE	1
Occupational	2.36	LE	5
Overall Mean	2.43	Low Extent	

Legend:

Weight	Score Range	Interpretation (I)
5	4.51-5.00	VHE=Very High Extent
4	3.51-4.50	HE=High Extent
3	2.51-3.50	AE=Average Extent
2	1.51-2.50	LE=Low Extent
1	1.00-1.50	NE=No Extent

Table 4 is the composite summary of significant relationships between the availability of the hospital's basic health promotion program and extent of wellness promotion. On the other hand, Table 5 is the composite summary of significant relationships between administrative support to the existing hospital health promotion program and extent of wellness. The proposed workplace wellness program for nurses is designed based on the weak areas, six (6) partially available areas in the existing basic health promotion program, four (4) less supported areas of administrative support to the existing program, and on all the areas of workplace wellness promotion that are described as rarely promoted and sometimes promoted.

Table 4. Composite Mean Summary of Significant Relationships between the Availability of Existing Hospital's Basic Health Promotion Program and Extent of Wellness Promotion

Availability of Existing Hospital's Basic Health Promotion Program	Extent of Workplace Wellness Promotion						
	Physical	Environmental	Social	Spiritual	Emotional	Intellectual	Occupational
Physical Activity Facilities and Access to Physical Activity Outside of Work Hours	S	S	S	S	S	S	S
Nutrition Education/Weight Management Program	S	S	N. S.	S	S	S	S
Written Policies on Physical Activity and Fitness Program	S	S	S	S	S	S	S
Allocated Budget for Health Program	S	S	N. S.	S	S	S	S
Employee Participation	S	S	N. S.	S	S	S	S
Health Screening	S	S	N. S.	S	S	S	S

Legend: S=Significant NS=Not Significant

Table 5. Composite Mean Summary of Significant Relationships between Administrative Support to the Existing Hospital Health Promotion Program and Extent of Wellness

Administrative Support to the Existing Hospital Health Promotion Program	Extent of Workplace Wellness Promotion						
	Physical	Environmental	Social	Spiritual	Emotional	Intellectual	Occupational
Continued Monitoring	S	S	S	S	S	S	S
Focus on Employee's Welfare	S	S	S	S	S	S	S
Quality Service	S	S	S	S	S	S	S
Sensitivity to Employee's Needs	S	S	S	S	S	S	S

Legend: S=Significant NS=Not Significant

The existing health promotion program was given a rating of availability in the areas of response to cardiac events and emergency; written policies on tobacco use; healthcare coverage; health committee representation; worksite wellness program policy and worksite wellness plan; written policies on nutrition; education and awareness campaigns; and breaks or rest periods. However the nurses rated health screening; employee participation; allocated budget for health program research; written policies on physical activity and fitness programs; nutrition education/weight management programs; and physical activity facilities and access to physical activity facilities outside of work hours as partially available. As a whole, the hospital has available basic health promotion. The administrative support to the existing program was perceived to be available in areas of accessibility; practicality and suitability; employee involvement; and comprehensive scope and coverage. However, quality of service; focus on employees' welfare and sensitivity to employee's need; continued monitoring and cost, equity, and affordability were perceived to be less supported. The scope of workplace wellness promotion in the hospital units for intellectual; spiritual; and social wellness was sometimes promoted, while physical; occupational; emotional; and environmental wellness were rarely promoted.

Conclusion and Further Research

To counter the increasing cases of absenteeism and sick leaves in a workplace like hospital, a workplace wellness and health promotion program is essential. For nurses, it will help them increase their health awareness and it will provide various avenues and options for nurses to express their creativity so that they may have a healthy and productive well-being and disposition that will redirect their overall thinking and actions instead of feeling and thinking about the exhaustion and frustrations. This study is conducted to determine whether health and wellness among nurses is promoted in a government hospital in the Philippines. Specifically, the study investigated the nurses' rating on the availability of the hospital's existing program, their perceptions of administrative support of the program, and their appraisal of the scope of workplace wellness promotion in the hospital units. The data for nurses' rating on availability of hospital's existing program presented beforehandindicatesthat, generally, health promotion is being practiced in the hospital, but not all aspects of a well prepared wellness program are in place. On the other hand, data for perceived administrative support for the existing hospital health promotion program suggest that the respondents perceived that the hospital administration does not fully support the existing hospital health promotion program. Generally, the respondents perceived that the health promotion program is supported to some extent and the findings are parallel to those of authorities on the development of a workplace wellness programs.

As a whole, the hospital has available basic health promotion. The administrative support to the existing program was perceived to be available in areas of accessibility; practicality and suitability; employee involvement; and comprehensive scope and coverage. However, quality of service; focus on employees' welfare and sensitivity to employee's need; continued monitoring and cost, equity, and affordability were perceived to be less supported. The scope of workplace wellness promotion in the hospital units for intellectual; spiritual; and social wellness was sometimes promoted, while physical; occupational; emotional; and environmental wellness were rarely promoted.

As a whole, workplace wellness promotion in the hospital was a limited. The proposed workplace wellness program for nurses was prepared based on the findings regarding weak areas: six (6) partially available areas in the existing program, four (4) less supported areas of administrative support for the existing program, and on all the areas of workplace wellness promotion that are described as rarely promoted and sometimes promoted.

The researcher therefore recommended to conduct further study considering other sample and population. Since there are significant findings revealed in this study, it is also

recommended to present the findings of the study and the proposed workplace wellness program to the government-managed hospital. It may be considered by the said institution which they may incorporate in their existing workplace-related programs. It is also recommended to further test program's validity and applicability. Overall, this may be presented to national institutions concerned with this kind of issue, like Department of Health (DOH). DOH should consider implementing the program in other government-run and private hospitals in the country to guarantee the promotion and development of wellness among Filipino nurses. More in-depth analyses should be done to include other variables that the present research did not cover.

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RESEARCH ARTICLE

Examining the Emerging Ideas of Connection within Nursing Practice and Education

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Abstract

Aim: The purposes are to (a) examine the emerging concepts of connection within nursing practice and education; (b) evaluate current measures of connections within nursing practice and education; and c) identify strategies for enhancing connections between nursing educators and students and for nurses and patients.

Background: Nursing and other disciplines rely on connections, although the term has evolved significantly in recent years due to changes of perceptions and expectations within other disciplines and within society. The lack of an empirical tool and defined attributes has constrained research and knowledge development. The initial exploration provided the first step in understanding the context and meaning of the word connect within the nursing profession. Three specific components were identified in this initial exploration within the nursing perspective: (a) respect, (b) trust, and (c) mutuality. Although the foundation of nursing care is based on the relationship and connections between the nurse and the patient, it is further identified in the first article that the need to further investigate the emerging ideas of connection within nursing practice and education.
Methods: A detailed literature review was used to explore the phenomena of connection. The review of the literature was performed through searches of CINAHL, EBSCO, and PubMed utilizing resources from the disciplines of transportation, business, technology, and nursing. Criteria for inclusion were (a) peer–reviewed articles; (b) articles published in English; and c) articles published between 2000 and 2014. Search terms included: connect, connection, connected, connectedness, and nursing. The search yielded a total of 114 articles; 33 were selected for inclusion. Definitions and related attributes were organized and classified based on relevance and frequency within the literature.

Results: The attributes that were consistently found in the literature within the nurse to patient connection were: (a) interactions between the person and the object of connection; (b) an inherent need to be part of a social system; (c) use of communication in verbal, written, non-verbal, physical or virtual format; (d) the occurrence of meaningfulness, trust, mutuality and respect; (e) polychronicity; and (f) technology based emphasis. Instruments that measure connections and connectedness provide valuable insight into the concept. However, they do not adequately address the concept of connection as it relates to nursing practice and education with current technological advances and expectations.

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Conclusions: While connection is a common term and fundamental to the role of the nurse/patient relationship, the defining attributes of connect have dynamically changed, and therefore require new understanding. It is critical to restructure the nurse to patient connection and to redefine the term within nursing practice and education with the inclusion of the multifaceted technological advances that define our current generations. Strategies that would enhance the nursing educator and student connection include: a) creation of additional nursing educational based Apps and Apps that focus on self-instruction tutorials and remediation techniques for non-successful students; b) integration of technological learning modalities into nursing curricula in both undergraduate and graduate programs; c) reduction of use of textbooks and inclusion of technology based learning; d) development of learning communities inside and outside of the classroom; e) creation of virtual resource support with simultaneous communication and valuable nursing information; f) and increased use of virtual environment and virtual communication.

Key words: *Connection, connect, connectedness, nurse, nursing, technology, polychronicity, relationship, interaction, concept*

Introduction

Connection is a term that is prevalent in today's society and cultures everywhere. Within the international framework of the concept of connection and its relationship to nursing outcomes, decreased attention has been given to the emerging definitions and changes within the concept of connection as it applies to technology and societal views within the nursing paradigm. As children, connections are seen through games and puzzles while teaching sequences or other facts. Through the transition from youth to adulthood, the concept of connection transforms in meaning, building societal value and forming relationships that foster social support (Lane & Serafica, 2014). In addition, the value placed on connections by society has transformed with the emergence of current innovations. The history of the meanings of connection coupled with the current values of connection has become an essential component of nursing and other disciplines.

The concept of connection has been explored by Lane and Serafica (2014) initially by examining the concepts' meaning within multiple disciplines: business, transportation, nursing and technology. This examination was considered vital for further development within a nursing framework due to the changes related to generational differences, technological connectivity and rapid transformations within healthcare delivery. Additionally, the concept of connection has the potential to add valuable support for the theoretical underpinnings and paradigm shift of value-added care models, interprofessional education and collaboration, transformation of healthcare delivery models, telemedicine and electronic medical records and database systems (Lane & Serafica, 2014).

Significance

The initial article by Lane and Serafica (2014) provided the first step through concept exploration in understanding the context and meaning of the word connect within the nursing profession and other disciplines. Three specific components were identified in this initial exploration within the nursing perspective: (a) respect, (b) trust, and (c) mutuality. Additionally, Lane and Serafica (2014) identified that connection is an imperative part of today's society. However, the emerging trends within nursing have not clearly defined the transformation of connection within the discipline. Although the foundation of nursing care is based on the relationship and connections between the nurse and the patient, it is further identified in the first article that the need to investigate and analyze the emerging ideas of connection within nursing practice and education in order to fully benefit the nurse, patient, faculty, and student in a more comprehensive approach. By addressing these components, strategies for enhancing connections can be implemented to improve outcomes.

Aims

The purpose of this second article is to examine, analyze, integrate, and synthesize the emerging ideas of connection and to evaluate current measures of connections within nursing practice and education through an integrative review of literature. Moreover, the authors will further examine the concept within nursing practice and education to facilitate application of emerging ideas of nursing connections. Additionally, we will identify strategies for enhancing connections between a) nurses and patients and b) nursing educators and nursing students.

Background

According to Noddings (2002), the concept of caring, which is fundamental to the nurse role, is directly tied to connection and involves the connection between the individual providing care and the cared-for. This relationship requires a degree of reciprocity, in which both the individual providing care and the cared-for both contribute as well as gain from the encounter in different ways. Additionally, Noddings identifies that three elements are required for the caring encounter: (a) Person A cares for Person B, in an encounter that Person A's consciousness is characterized by attention and motivational displacement, (b) Person A performs some act in accordance with the attention and motivational displacement, and (c) Person B recognizes that Person A cares for Person B. Connections have been identified in the literature as imperative in the nurse to patient role encompassing both short and long term encounters, which specifically are useful as a bridge to close the gap created by technology through the promotion of wholeness and integrity (Johnson, 2006). Meaningful connections have been deemed central to the nurse to patient caring experience (Johnson, pg. 135). Peplau (1965) also supported the value of connections through her Theory of Interpersonal Relations, which is centrally based on the human connection between the nurse and patient.

Defined by the Merriam-Webster Dictionary (2014), connection can mean, "something that joins or connects two or more things", "the act of connecting two or more things or the state of being connected", "a situation in which two or more things have the same cause, origin, goal, etc." (para 1). Similarly, connection is defined as "the act or state of connecting", "something that connects, joins, or relates; link or bond", "a relationship or association", "logical sequence in thought or expression; coherence", "the relation of a word or phrase to its context", "(often plural) an acquaintance, [especially] one who is influential or has prestige", a relative, [especially] if distant and related by marriage", "an opportunity to transfer from one train, bus, aircraft, ship, etc, to another", "the vehicle, aircraft, etc, scheduled to provide such an opportunity", "a link, usually a wire or metallic strip, between two components in an electric circuit or system", and "a communications link between two points, [especially] by telephone" (Collins English Dictionary, 2013, para 1). Some slang uses of the term connection within the English language may have generational connotations such as an intermediary person, supplier or source for a drug relationship (Collins English Dictionary, 2013) or a virtual gaming connection such as the Xbox Kinect (pronounced connect) (Microsoft, 2013).

Based on the identified foundations of the nurse to patient connection from the literature (Lane & Serafica, 2014), the definitions used to formulate the analysis for the concept of connection included "something that joins or connects two or more things", "the act of connecting two or more things or the state of being connected", "a situation in which two or more things have the same cause, origin, goal" (Merriam-Webster Dictionary, 2014, para 1). For the purpose of this analysis, other definitions were deemed not applicable to this specific application of connection in the nurse to patient connection and therefore were not included. Due to the multitude of definitions and the variety of dynamic characteristics of connection, it is crucial to evaluate the issues that surround connections in the nurse to patient role. These shifting perceptions of connections within health and healthcare, directly impact the role of the nurse and the consumer product within the healthcare industry.

Methodology

A detailed literature review was used to explore the emerging phenomena of the concept of connection and to determine common themes. The review of the literature was performed through searches of CINAHL, EBSCO, and PubMed utilizing resources from the disciplines of transportation, business, technology, and nursing. Criteria for inclusion were (a) peer–reviewed articles, (b) articles published in English, and c) articles published between 2000 and 2014. Search terms included: connect, connection, connected, connectedness, and nursing. The search yielded a total of 114 articles; 33 were selected for inclusion. Definitions and related attributes were organized and classified based on relevance and frequency within the literature.

Connection is not a recent concept. While nursing has not fully developed the concept to in an operational definition, nursing and other disciplines have used connections for years. In Lane and Serafica's (2014) concept exploration, they determined that the concept of connect has other meanings rooted in the disciplines of business, technology, and transportation, which influence how the term is defined in nursing and today's society. However, within these other disciplines, there are four categories of connection that exist in the literature: 1) physical, 2) technological, 3) business, and 4) cognitive. The findings of the detailed literature review are described below and specifically applied to nursing practice and nursing education.

Physical. For most disciplines, such as transportation, the concept has evolved over time. For many decades, connections were needed to bridge one person to another in a physical realm. Throughout time, the level of connection has evolved with inventions. From the invention of the wheel to the current space exploration program, connections have increased and progressed through the ages providing more opportunity for physical connections (Lane & Serafica, 2014). Society has hungered for faster and more efficient connections. For modern society, connections are a current expectation (Fotsch, 2007; Meadow, 2002). Through trade, war and exploration, the need for increased travel connections have been documented in history with the emphasis moving from the possibilities of connections to the speed and access (Lane & Serafica, 2014).

Within nursing, physical connectedness with family members has been identified as an emerging theme when measuring spirituality of older adults (Narayanasamy et al., 2004). Additionally, relationship building and connections between patients and the healthcare team members have been deemed an integral part of a quality improvement falls prevention program and concurrently named the CONNECT intervention (Anderson et al., 2012; Colon-Emeric et al., 2013). Moreover, Young et al. (2010) found improved clinical outcomes for patients with colorectal cancer utilizing the relationship building and direct connections between staff and patients through implementation of CONNECT via telephone interviews. Nursing practice has transformed over the years with the addition of more responsibility and scope of practice, taking time away from the patient's bedside and reducing the actual physical connection between the nurse and the patient. Despite this radical change, the nurse-patient caring connection remains is one of the foundational components of the nursing discipline. Similarly, the healthcare experience for patients is not opportune for the establishment of the nurse-patient connection due to the decreased length of hospital stays and increased acuity of the patient, creating additional tasks and responsibilities for the nurse and reducing the amount of direct care time between the patient and the nurse.

Technological. Comparable to the physical realms of connections, advances in technology including mobile devices, wireless internet, increased capacity computers, digital cameras, video streaming and more efficient networks are just some of examples of the swift pace of change for societal connections. These technological changes are results of demands for the need of rapid access to information as well as the connection to people. While societal demands have created value and worth related to connections, the focus has continued to shift from connection to speed. Cable lines, dial up internet,

and satellites are semi-recent inventions that produced large amounts of revenue and were showcased as premier items. Despite their contemporary nature, new and faster approaches have quickly replaced these developments (Lane & Serafica, 2014).

Technology competency begins in early education, and transforms children's expectations of connection. Children's exposure to the large quantities of technology connections may alter their ability to connect personally to others and interfere in their ability to develop interpersonal relationships throughout their life. With the large range of ages in the workforce, generational differences have emerged regarding technological connections. As Generation Z enters the workforce, there may be a potential of high level of technological connectedness with lower social and interactive connection skills. Within nursing practice, electronic health and telemedicine are quickly becoming an expectation of consumers and electronic medical records are the baseline standard in informatics. Based on these changes, nursing informatics is a critical component of most nursing curricula.

Richardson and Benbunan-Fich (2011) have researched the construct of work-related connectivity. Findings of the research included a blurred vision of work and non-work time due to the emergence of mobile devices that promote higher levels of connectivity at increased intervals. Within this study, antecedents for increased connectivity within work constraints in the 21st century included enhanced technological availability, behavioral intention to use technology, perceptions of availability, polychronicity, personal innovativeness with information technology, and role integration preference. Polychronicity as an antecedent for connectivity has additionally been supported by Bluedom (2007). Examples of emerging connections that require polychronicity are found in nursing practice such as connections with electronic medical records and databases, existence of virtual care centers and telemedicine, intrahospital mobile device connections, and increased responsibilities of healthcare providers due to changing healthcare environments. In nursing education, polychronicity is demonstrated through multiple avenues of classroom learning, hybrid courses, and mobile device applications for courses and for learning opportunities. Most nurse educators are changing communication styles to accommodate the need for polychronicity and availability by opening avenues of communication to include texting, messaging, and virtual office hours. Due to emergence of technology and the growing expectation of immediate response, communication within nursing has drastically changed altering the concept of connections.

Furthermore, in nursing academics, web based components and technological connections are often included in the course, while some courses are completely online allowing for flexibility in scheduling; this environment may create educational disparities for those who are not technologically competent. For face-to-face education, human-patient simulation has revolutionized nursing education and has been identified as an effective teaching strategy for developing connections with patients (Storr, 2010). Additionally, technological advances such as Facebook have been identified as a positive connection instrument in the process of nursing research for participant recruitment strategies (Amerson, 2011). Likewise, connections developed during e-mentoring between students and experienced public health nurses were deemed as viable strategies to enhance the learning and sharing environment (Miller, Devaney, Kelly, & Kuehn, 2008). Outside of nursing academics, nursing mentorships between retired or senior nurse mentors and new nurses have shown to be effective connections related to education and retention within the workplace (McDonald, Mohan, Jackson, Vickers, & Wilkes, 2010).

In general, technology has revolutionized the concept of connection based on the current demands of society and has changed the meaning within the discipline of nursing. With the vast and prolific nature of technological connection, it is clear that the understood definition of connection related to nursing should be reevaluated.

Business. The discipline of business also focuses on connection as a key concept and is applicable to the understanding of the concept of connect within nursing practice and education. Connection theories and limbic resonance foster relationships among ideas and people, respectively (Pearce, 2003; Puccio, Murdock, & Mance, 2007) and connections have been described as adding value to organizations throughout the business perspective (Gobillot, 2007). Through areas such as complexity science and healthcare, organizational leadership has been investigated further to formulate that relaxed connections or lack of connections between the management and the bedside nurses may signify patient safety concerns (Anderson, Corazzini, & McDaniel, 2004) or other negative outcomes (Kerfoot, 2011). Additionally, authors have described that diverse backgrounds among employees with positive connections to patients are vital in healthcare (Anderson et al., 2004; Colon-Emeric et al., 2013; Nadzam, 2007). Complexity science proposes that connections, such as trust and non-linear interactions affect the quality of care in healthcare and turnover for licensed practical nurses and nursing assistants (Anderson et al., 2005; Anderson et al., 2004). Trust and communication are the common themes for connectivity in business, as well as nursing (Keane, 2007). Similarly, Tarlier (2004) proposed that trust, mutuality, and respect are key measures of relationships, interdependence, and interconnectedness within the business perspective.

Cognitive. In addition to the categories of physical, technological, and business, connections have also been described as cognitive in nature. The cognitive portion of the brain has been directly linked to connectedness (Hallowell, 2011; Kerfoot, 2011; Slap, 2010). For example, Kerfoot describes that being connected and safe within one's environment, creates a response within the brain that leads to peak performance and involvement. Additionally, it has been shown that a loss of connections between management and bedside nursing along with negative cultures within the workplace lead to higher rates of depression and less optimal results (Kerfoot, 2011). Cognitive connections can occur in many realms. For example, cognitive connections between meals and types of food have been found to be beneficial in nutritional status, transition to nursing homes, and quality of life (Evans, Crogan, & Shultz, 2005).

Cognitive connections can also be linked back to technological advances. Currently, the internet has provided alternative ways to initiate relationships through dating compatibility, chat rooms, and virtual interactions. While some have viewed these changes positively, others have seen negative outcomes of cognitive and emotional connections that result in virtual affairs to others outside of the marriage which have caused conflict in the personal connections that were already established. Apart from these changes, there have also been negative outcomes of internet connections including the more recent phenomenon of catfishing, where false connections are made between two individuals and which one of the individuals has created a fabricated or stolen identity (Saedi, 2014).

Similarly, society has more access to knowledge and a greater access to people. The internet has provided information, support, and discussion for nurses and others creating a shift in the knowledge comprehension of patients (Braccia, 2006; Teel & Shaw, 2005). On the contrary, some information on the internet may be falsified, and may cause negative outcomes if used incorrectly. Many nursing resources such as standards, clinical documentation, networking, tele-medicine, focus groups, academic career support, and idea exchange are available on the internet to enhance the discipline's connection among those within nursing if accurate. Additionally, there is an increased risk of prescribed interventions which could lead to a decrease in critical thinking abilities (Braccia, 2007; Lin, Lin, Jiang, & Lee, 2007; Parse, 2004).

In nursing practice, school nurses have shown that using electronic journal clubs increased the connection among specialty nurses and enhanced the use of Evidence-Based practice within the workplace (Sortedahl, 2012). Furthermore, connections made between parents and school nurses through intervention programs have been shown as effective models for changing adolescent behavior (Suydum, & Garcia, 2010). In long term

care, connections have been demonstrated as positive intervention though the use of storytelling (Heliker, 2009; Heliker & Nguyen, 2010). Heliker and Nguyen identified that shared values, affective closeness, shared pleasurable activities, and reciprocity were significantly higher for relationships between nurse aides using storytelling and residents as compared to nurse aides who only used a specific set of communication skills. Storytelling has also been used an effective tool for educators to connection with diverse populations of students from various cultural and ethnic backgrounds in an effort to promote student success and retention within nursing programs (Rivera-Goba & Campinha-Bacote, 2008).

The value of emotional and cognitive connections and disconnection between the nurse and the patient have been described as a vital part of the nursing process allowing for healing and social support for optimal health outcomes within nursing practice (Schnek, 2006). Schnek also describes that connections between the nurse and the patient should serve as a motivation for providing the highest quality health care to our patients. Kutaka (2002) examined the lived experience of nurses' connections within the context of healing. Themes that emerged from this qualitative study included: connection as a process, the nurse as exemplar, personal transformation and connection as healing. Kutaka found that connection begins with the selection of a patient and involves cognitive, emotional and personal processes and spontaneous reactions. Participants within the study described the connection experience as a bubble of energy with physiological changes in the environment which included calmness, peace and warmth. Consequences of the connection for the nurse to patient relationship included a gained perspective of clarity and purpose in life. In a concept analysis of nurse to patient connection within a healing paradigm, the attributes of connection included: intimacy, focused attention on the patient, spiritual transcendence, energy, and relating spirit-to-spirit (Kutaka). This analysis does not adequately define a broader sense of the term connection in the nurse to patient relationship due to the narrowed focus on healing and the inclusion of literature support from past decades. Due to the continuous changes within healthcare delivery, nursing practice, nursing education and technological influence, this concept analysis must be revisited.

On the theoretical levels, connection has been identified by Parse in the theory of human becoming. Parse is quoted as stating that connection-separation "relates to the ways persons create patterns of connecting and separating with people and projects. Connecting-separation is about the paradox communion–aloneness and the ways people separate from some to join with others" (Tomey & Alligood, 2002, p. 532). Connectedness was also used as a theme in the theory of generative quality of life for the elderly. In this model, the term connected "refers to a state of synchronous, harmonious, and interactive presence" while not being constrained by time or space (Register & Herman, 2006, p. 343). Six aspects of connectedness are defined by this model: metaphysically connected, spiritually connected, biologically connected, connected to others, environmentally connected, and connected to society (Register & Herman, 2006). This model of connectedness described quality of life scores for individuals, but it is possible that this model could be adapted for nursing in other areas.

Similarly, women's ways of knowing include connected knowing and learning, and allow for things such as intuition, a fundamental element of the art of nursing (Clinchy, 1996, p. 205). Clinchy states that through examination, "connected knowing with the other and connected knowing with the self are reciprocal rather than oppositional processes: neither partner disappears into the other; each makes and keeps the other present" (p. 232). Without examining connected knowing, we cannot truly produce congruency between the nurse and patient connection (Lane & Serafica, 2014).

Likewise, nursing research has continued to use connection in middle range theory and qualitative research. Specifically, the formulation of theoretical premises related to Latina nursing

educators and pediatric nursing models examined connection as a critical component (Canales & Bowers, 2001; Coetzee, 2004). Connections were found to influence perception of educators, and to enhance learning opportunities related to pediatric care (Canales & Bowers, 2001; Coetzee, 2004). In long term care, connections has been defined in food preference and memories, as well as a need for closeness of relatives and significant others related to spirituality of older adults identifying the increased need for assessment per groups of people, as well as individually (Evans, Crogan, & Shultz, 2005; Narayanasamy et al., 2004).

Findings

Despite the research and current knowledge around the concept connect; there are still areas of the concept that needs further exploration. Throughout the literature connections have clearly been identified as critical encounters between the nurse and patient interactions and fundamental to the philosophical underpinnings of the role of the nurse. Some of the attributes that were consistently found in the literature within the nurse to patient connection were: (a) interactions between the person and the object of connection, (b) an inherent need to be part of a social system, (c) use of communication in verbal, written, non-verbal, physical or virtual format, (d) the occurrence of meaningfulness, trust, mutuality and respect, (e) polychronicity, and (f) technology based emphasis.

When examining connection in a broader sense, it is transparent that the expectations of connections have transitioned and are continuing to emerge as technology and our world evolves. The societal views of connections have quickly transformed focus from simply the ability to connect, into an emphasis on speed and efficiency of the connection itself. These changes have influenced healthcare practice and the role of the nurse including the foundational nurse-patient connection. These views are especially clear within nursing and other healthcare related disciplines. However, within nursing the emergence of polychronicity within the workforce environment may have initiated reformation of the perceptions of connections between the nurse and patient. The focus may be shifting from the quality of the connection into the quantity, speed, and efficiency of the connections only. While it is clear that the value of the connection between the nurse and patient is exceedingly relevant in the profession, the attention given to the connection may be losing importance in the eyes of the nurse, during which the focus has turned to increased and multiple roles as the care provider and the blending of various views, values and perceptions related to connection.

Society's philosophies of connection have changed radically within the past decade changing the consumer forefront for healthcare. Digital technological advances have developed into the standard way of living for most Americans directly affecting information accessibility, socialization and communication. It has been customary to receive information or knowledge within seconds due to technological advances. These expectations have directly prompted the movement towards electronic medical records and telemedicine. Continued progression towards faster and more efficient health information will continue to drive the healthcare market and revolutionize the role of the nurse and patient connection within the digital workforce. Within the prevalence of social media and changing connection expectations of society, nurses and/or patients may extend the connection outside of the professional environment; guidelines to assist nurses to make appropriate decisions regarding social media connections have been established (National Council of State Boards of Nursing, 2011). While some negative results of the increased social media presence have been documented, the role of social media and its effect on the nurse to patient connection is unclear. Generational differences may also shape the value and nature of connections within the nurse to patient role. These changes within connections of the nurse to patient role will have direct influence on healthcare educational programs that prepare our future workforce.

This same trend of instant, fast and efficient connections may also influence the type and style of communication connections between healthcare providers and patients, theoretically reducing the

traditional model of nurse to patient connections and fostering alternate connections for the nurse and patient. While the emerging trends of societal views of connections are evident, these types of connections have not been well researched nor have quantifiable methods of evaluation.

Empirical Measurements. Within nursing, it has become difficult to accurately measure and operationalize the concept of connection due to the evolving nature of connections and associated expectations. There is a lack of understanding and clarity in the shift of connections within the nursing discipline. The development of connectedness scales were established in the literature, however all findings were outside of the nursing discipline. The critical analysis of the literature resulted in identification of connectedness through several tools that may be used to measure the concept of connection and could be adapted for use within nursing practice and education. Bekker and van Assen (2010) have used connectedness to assess gender linked autonomy in terms of self-awareness, sensitivity to others, and capacity for managing new situations. Social connectedness and social assurance scales were also constructed to measure belongingness based on Kohut's self- psychology theory (Lee & Robbins, 1995, 1998). The Hemmingway Measure of Adolescent Connectedness scale was developed to measure adolescent connections to school, family, friends, romantic partners, and self (Karcher, 2013; Karcher & Lee, 2002; McWhirter & McWhirter, 2008).

While these tools may provide valuable insight into the concept of connectedness, they do not address the concept as it relates to nursing practice and education and do not address the shift in the concept itself. While there are several empirical measures of connectedness outside of nursing, none of these instruments measure connections in a global approach that meets the needs of patients within the healthcare system or identifies the changing meanings of connection. Further review of these instruments is recommended in the development of a tool that specifically measures patients' connectedness within the context of nursing and healthcare. In addition, it is recommended that a connections measure related to nursing education be developed for assessment and use with students to enhance student learning and to optimize the connections between the educator and student.

Discussion

Connection should be measured and defined individually to assure therapeutic connections and to establish congruency between the nurse and patient and/or the nursing educator and the student nurse. Without individual assessment, it is probable that the nurse and patient and/or the nursing educator and the student nurse will have varying views based on each person's experiences, biases, and motivations. Additionally, there may be generational differences in the expectations of connections. Efforts should be made related to identification of gaps in connections and to redefine how to establish a relevant and appropriate connection in today's nursing environment. By establishing connections and the gaps in current nursing practice and education, we can refocus connections to optimize quality care, patient-centered outcomes within practice and to create more effective learning environments for nursing students. A significant transformation is needed to restructure the nurse to patient connection through education of current and future nurses to redefine the term and adapt the multifaceted technological advances that define the current generations.

Through the examination of other tools used to quantify related concepts, an empirical measure of connection may be developed for nursing practice and education. This tool not only will be useful in nursing, but potentially could be designed for interdisciplinary measurement. Within the development of this tool, specific research is needed to determine if perceptions of connections vary among generations, cultures, and healthcare disciplines. Due to the emerging technologies over the past decades, many generations' perceptions of connections may be impacted by the instant connections associated with text messing, video gaming, internet, and social media that have been an integral part of their daily activities. This change related to connection within society may

impact the value of face-to-face connections such as holding someone's hand, crying with a patient, or providing personal touch and emotions that written words, texts, or emoticons may not be able to fully portray.

Ironically, the expectation of the ability to connection and the innovative construction of connection have created levels of isolation within society by decreasing face-to-face contact and in the case of nursing, replacing personal touch (Lane & Serafica, 2014). Through the discipline of nursing, it is evident that personal connections are still valued, but have been overshadowed by the changing societal expectations and distorted by the presence of emerging technology. These changes in the concept of connection need to be studied further to determine the consequences of societal demands related to connectivity in the realm of technology. With the strong surge towards evidence based practice, it is imperative to maintain the personal connections while infusing technological connections, otherwise, the art of nursing is lost. Based on the results of the research, the following questions are posed: Does the evolving nature of connections change our nursing profession and practice? If efficiency and speed are the focus on connections, how do we maintain the art of nursing? Further research is needed to determine the answers.

With the broadening of societal connection views of geographical proximities, it can be ascertained that the perception of connections will continue to evolve. Continued evaluation of connections is needed to determine the sustainability and progress of connections among healthcare providers and networks, between healthcare providers and patients, and educators and students. In light of healthcare reform, there is a robust movement of increased care outside of the hospital setting and the proliferation of online education. For patients, the connections to healthcare providers have been expedited through patient portals to allow for direct connections to secure electronic messages, medical records, billing, and scheduling of appointments. These types of accessibility allow for patient and healthcare provider engagement and increased compliance and quality of healthcare communication. Due to the changes in healthcare, these expedited connections are only the beginning changes of expectations within healthcare connections from both the provider and the patient and the student nurse. It can be expected based on the historical background of the proliferation of technology and that these changes will only continue to multiply.

The meaning of connection may vary among cultures and within different global arenas. Through qualitative research, nursing could seek to determine the meaning of connection for specific groups and establish if disparities related to connectedness exist among race, age, or other clusters of people with similar characteristics. Assessment is needed to identify the needs and priorities for the patient or groups, and the connections that can influence goal related success and decision-making behaviors for those persons.

Additionally, the influence of polychronicity within the nursing practice and nursing education may impact the values and levels of connections within the nurse to patient and nurse educator to student roles. Due to the increased expectations for multiple connections to be occurring at one time, it is uncertain if the level and quality of the connections that are occurring are achieving the desired outcomes. Within the nurse to patient connection, variables that may impact polychronicity may include acuity of patients, nurse-to-patient ratios, staffing within the organization, electronic medical records, and other nurse related assignments and responsibilities. For nursing education, variables that may impact polychronicity include academic faculty workload, faculty to student classroom ratios, expectations regarding scholarship, service and teaching, and other educator related assignments and responsibilities. Comparative studies evaluating connections and the quality of outcomes of these connections may provide insight into the effectiveness. Without this information it is difficult to ascertain whether these shifting perceptions of connections within health and healthcare delivery impact patient satisfaction and consumer demand within the healthcare market which may impact financial and economic outcomes within the era of

healthcare reform. Additionally, these changes in connections will directly impact the preparation of our current and future nursing workforce.

Limitations. This evaluation was inclusive of global publications; however, the majority of the articles included in the literature review were within the constraints of the United States. Inclusion of non-English published articles would greatly provide insight into connection in a more global approach.

Implications for Nursing Practice. Within the context of nursing practice, the foundation of nursing lies with the nurse-patient relationship. Without the establishment of connections between the nurse and the patient, the health outcomes of the interaction may not achieve optimal results. The patient and nurse expectations of the connection need further exploration. In addition, the following question is critical in the preparation of nurses and the current role of the nurse: Has the role of the nurse-patient connection changed with both the healthcare providers' and patients' perspectives or is there a division between the expectations of the nurse and the patient? What do these changes mean to our role as nurses? Therefore, connection is a critical part of any nurse-patient interaction and should be highly valued by the discipline of nursing and other interdisciplinary team members.

Connections promote collaboration between the nurse and other healthcare providers in order to expand and integrate high quality care and safety for the patient. Connections may enhance the ability of the nurse to appropriately respond to planned and unanticipated situations within nursing practice. Additionally, establishing a connection provides increased opportunities for health education and collaboration with plan of care between the nurse and the patient. Furthermore, patient family members or significant others may benefit from the connections that occurs during the nurse-patient relationship by enhancing knowledge, confidence, communication and dynamics. Specifically, with the movement of technology and healthcare towards telemedicine and other related technology based health models, connections are a concept that must be addressed in order to maintain or redefine the meaning for optimal health outcomes and established congruent expectations are needed for the patient, nurse and other healthcare team members. In-hospital virtual communities would offer resource support and enhanced connections to nurses in direct patient care roles. Offering 24 hour virtual access to a nurse or other healthcare team members may address connection needs for patients. Another potential strategy might include offering electronic mail or text communication for triage care. Many of these technological based strategies are already being offered by comprehensive healthcare organizations that service a wide array of people and geographic locations.

Implications for Nursing Education. Preparing future nurses to practice requires a commitment of all nursing educators to recognize the inherent significance of connections in the practice of nursing and the value of teaching connections and most effective ways to connect in today's society to achieve high quality patient outcomes. Educational strategies and student evaluation must include a focus on connections among nurse and patient interactions and must be modeled throughout the nursing educational process both didactically and clinical-based. Additionally, connections are extremely relevant between the nurse educator and student role. Students must begin early in their educational opportunities to recognize the importance of connections to school and faculty to establish professional growth. Nursing educators should also demonstrate connections in their own practice and make students aware of the benefits of connections within life-long learning.

Nursing education may provide opportunities to model meaningful connections and to establish therapeutic relationships between the nurse educator and the student. Doing so enhances opportunities to recognize early problems and assist with retention and remediation of nursing students. By more thoroughly understanding the evolving nature of connections within the nurse to patient role, educators can adapt educational

opportunities to mimic the expectations of connections and provide significant learning experiences. More research is needed to determine if the conceptual meaning of connections vary from the nurse to patient role when compared to the nurse educator to student role.

Strategies to enhance nursing connections between the educator and the student include consistent use and creation of nursing based Apps. Focusing on Apps that include self-instruction tutorials and remediation techniques may be useful for students in nursing programs. Furthermore, the creation of Apps that help students become more familiar with therapeutic communication and other connection strategies may offer insight for student nurses or new graduate nurses to build communication and connection skills. Nursing educators must integrate technology learning modalities into the classroom and nursing curricula in both undergraduate and graduate programs. Concurrently, the increased use of technology based learning and decreased use of textbooks will help to address generational differences in learning and may enhance connections between the educator and the student nurse. The development of learning communities offers other opportunities to reinforce or establish connections between the educator and the student. By implementing these types of resources, the students can learn connections through virtual resource support allowing for simultaneous communication and valuable nursing knowledge. These learning communities could be established inside or outside the classroom. Specifically these communities would be beneficial within educational platforms such as Moodle or Blackboard, on social networks sites, through gaming systems, or even in Second Life through avatars. Increasing the use of virtual environments may assist in facilitating the students' learning needs at their educational level while offering alternate ways to teach connections within nursing. Second Life offers the opportunity to experience connections in a variety of situations introducing other factors such as cultural diversities, language differences, other barriers, and biases that students may struggle with when developing connections with patients.

Conclusion

In conclusion, this integrative review and synthesis of the concept of connection has determined specific defining attributes and evaluated the emerging ideas of connection within the literature focusing on the influence on nursing practice. Specifically, four themes within the literature were found: a) physical, b) technological, c) business, and d) cognitive within the disciplines' perspectives of connect defined by Lane and Serafica (2014). Current empirical measures of connection were reviewed in relation to patient connections within the nursing discipline but found to be limited and narrow in scope. New empirical measures reflecting the current societal perceptions of connections are needed. The emerging nature of connections was not clearly addressed in the empirical measurements and the consequences of the emerging expectations of connections were not found in the literature. The findings of this analysis demonstrated that the fundamental values of a personal connection are still demonstrated within the attributes of the concept diminishing the ambiguity associated with the concept connection. However, this analysis also identified that the evolving perceptions of connections related to technology and polychronicity are not fully understood within the discipline of nursing. By clarifying this concept, the first step in facilitating further research investigation regarding the polychronicity and technological impact on personal connections has been completed. Future research is integral to evolvement of the nurse to patient and educator to student connections. There are many strategies to assist in facilitating the movement towards technology based connections in the academic nursing educator role. Additionally, the strategies mentioned can also be directly applied to the role of the nurse through implementation in hospitals and organizations through staff development educational programs. Healthcare must embrace the changing facade of the nurse to patient connection and determine best to how maintain the fundamental role of the nurse but also address current technological needs of efficiency, speed, and polychronicity.

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RESEARCH ARTICLE

An experience of focus groups fieldwork among novice nurses in the Eastern Visayas Region, Philippines



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Abstract

Focus group (FG) as a method of research is becoming popular in nursing. However, limited practical examples on the processes and skills required for its implementation in the Philippines to address the complexity of this method may prevent novice nurses to pursue more FG-based researches. For nurses and other health researchers who intend to use the FG, facilitation and note taking in FG discussions as well as transcribing and translating are important skills to master. Ways to enhance the quality of data should also be devised to improve trustworthiness of findings such as pre-testing of tools, conduct of debriefing sessions and, validation of translations and other data sources. Through appropriate methodological processes and examples, FG research is valuable in exploring and understanding nursing and health-related issues. This article showcases the experience of nine novice Philippine nurse researchers in their aim to achieve high quality FG study on access to maternal health services conducted in the Eastern Visayas region of the Philippines.

Keywords: *Focus groups, nurses, research skills, Philippines*

Introduction

Internationally, focus groups or FGs are increasingly becoming popular in nursing research since the 1980s (Happell, 2007). It has been used in nursing to explore patient safety (Lyngstad, Melby, Grimsmo, & Hellesø, 2013; Nicklin & McVeety, 2002), investigate health policy (Lawn et al., 2014; Meagher-Stewart et al., 2010) and understand e-learning practices (Bloomfield & Jones, 2013; Moule, Ward, & Lockyer, 2010). However, a systematic search of FG research in nursing in the Philippines within the major databases (Scopus, Proquest, Web of Science, CINHAL and Medline) yielded only limited articles. One potential explanation of this scarcity is that

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examples in relation to the technical skills and approaches required for this type of research are inadequately described in the literature. Documentation of Philippine experiences to serve as practical guides in conducting FG research are lacking, possibly influencing novice nurse researchers to be less appreciative of FG as an important and beneficial research method in the country.

The recent experience of nine young nurses from the Philippines' Eastern Visayas region shows that nurses, with appropriate training and guidance, are able to successfully implement FG research. This particular FG research aimed to assess women's access to prenatal, delivery and postpartum services in the region, a study spearheaded by the Ateneo Center for Health Evidence, Action and Leadership (A-HEALS) of the Ateneo de Manila University. This article presents the process of training, data gathering and data quality assurance that the nurses underwent to serve as a practical example of successful FG research implementation among nurses in the Philippines.

Promoting FG as a qualitative approach for nursing research

Nursing education in the Philippines emphasizes the importance of acquiring data in providing quality nursing care. For instance, in providing postpartum services, nurses are taught to check patients' temperature and observe color changes in lochial discharge that may indicate possible infection. In research, this type of information is classified as quantitative data and is always measurable and observable. In the country, many nurses tend to focus on this type of data and this can be attributed to the continuing dominance of quantitative thinking in research. Despite its relevance, however, this type of data has its limitations and today, there is an assertion for a stronger movement towards a more pluralistic approach in nursing research, as affirmed by Cutcliffe and Ward (2014).

This suggests that aside from measurable data, nurses are encouraged to develop better appreciation of information that are qualitative in nature such as understanding mothers' feelings after childbirth or reasons that influence her to visit a health care provider. One method of qualitative research is the conduct of FGs, which allows deepening and understanding of the context of measurable data at hand from a specific group of people. This process of gathering and processing of qualitative data through FGs can be challenging as it involves interacting with a group and requires attention to the individual responses as well as the exchanges among participants. However, it also provides a rich opportunity for in-depth appreciation of factors that may explain a particular issue or phenomenon and is truly a valuable research approach.

Focus groups in brief

A focus group is a special type of group in terms of purpose, size, composition, and procedures (Krueger & Casey, 2015). This research method gathers a certain number of participants, preferably around 6 to 10, to obtain their knowledge, perspectives, opinions, feelings and experiences regarding a specific issue or topic. Focus groups, using predetermined guide questions, follow a procedure that promotes interaction among participants and this interaction is considered the unique feature that distinguishes it from other qualitative research methods. Morgan (2010) argues that interaction in FGs is essential in producing high quality data. It is important as one participant's comment may provide other participants the opportunity to reflect and better understand the issue at hand. This allows them to elaborate their perspectives and experiences as they share to the group, providing even deeper insight. Interaction may also influence participants to modify or change their perspectives as other's sharing may serve as confirmation or disagreement to the data provided or their own opinion. Data presented by each FG participant is considered valid and there are no right or wrong answers especially when discussing personal perspectives and experiences.

Focus groups are considered particularly useful when the topic under investigation is complex and concurrent use of additional data collection method

is necessary to ensure validity. This approach is also applicable when the existing knowledge of a subject is inadequate and elaboration of pertinent issues or the development of new supposition is necessary to help develop or improve a data collection tool (Powel and Single, 1996; Jayasekara, 2012). On the other hand, FG is inappropriate when the issues at hand are sensitive and highly confidential (Krueger & Casey, 2001), in which the interactive processes could be compromised. In this case, individual interviews are more appropriate in gathering the necessary information.

The Eastern Visayas FG research on access to maternal health services

Focus group research was conducted by A-HEALS to provide deeper understanding to the results of a recently conducted household survey on access to maternal health services in the Eastern Visayas region. Quantitative results from the survey revealed questions that could not be answered by figures or other measurable data. Hence, the FG research sought to supplement and complement quantitative findings by providing the "why" to explain the reasons behind observations as well as to clarify the context in which the study was done. One example is the finding that less than half of women in the region had access to postpartum care services. The reasons for this cannot be derived from the survey's numerical data and thus, necessitated a qualitative approach to explain the issue further. This article, however, does not focus on the content of the research but on FG as a method used in discovering the answers to these questions.

Four researchers from A-HEALS comprised the investigating team. Each acted as an area supervisor, and led a data gathering team in the conduct of FGs with women, village health workers (locally called barangay health workers or BHWs), and registered midwives in the Eastern Visayas region. Nine young nurses from the region comprised the data gathering teams and played a central role in moderating the FG sessions, transcribing discussions and translating the data to English.

A total of sixteen (16) audio-recorded FGs were facilitated by nurses, conducted in the local dialects, particularly Waray and Visaya. A standard pre-tested FG guide was used by all four teams and each discussion was accomplished by asking directed questions as well as applying activity-based strategies (Colucci, 2007) using pictures, ranking and rating to enhance the elicitation of responses from the participants.

The main source of data generated was the transcripts of the 16 FGs, along with their subsequent English translations. For each FG, nurses also produced *field notes* that included the shorthand responses of the participants and salient observable data relevant to the participant responses. In addition, *debriefing sessions* (Mack et al., 2005), an essential FG research activity emphasized in this study, were conducted after each FG to synthesize salient ideas, identify problems encountered during the FG and determine recommendations for succeeding discussions. These sources of additional data are expounded below.

Specific tasks of the young nurses in the Eastern Visayas FG research

In this FG research, the nine novice nurses were immersed in the data collection process. Despite limited knowledge in the practice of FG research, the experience was an enriching experience for all of them.

These young nurses are local residents of the Eastern Visayas region. This important consideration maximized their familiarity with the locality they were assigned to and proved advantageous in the overall conduct of the research. Identification of FG potential respondents was easy as the nurses had prior knowledge about the target participants and their household location. Being conversant in the local dialect also facilitated clearer understanding of issues discussed during the FGs and contributed to establishing trust between the nurses and the participants. Likewise, familiarity of the local

culture and location of facilities also facilitated coordination with the local health offices and village officials.

Preparing the nurses for FG data collection

The nurses' preparation began with a training-workshop to introduce the FG method and develop essential skills for qualitative research. Training of these young nurses in the conduct of research and timely guidance was essential to achieve a more rigorous research process. To aid the appreciation of their specific tasks, these young nurses were trained on the principles of the qualitative paradigm, principles of FG research, designing and moderating focus groups, effective communication, observing non-verbal cues and group dynamics.

The training-workshop was conducted with all nurses in attendance for three (3) consecutive days in February 2015. Inputs were given by the main resource person Dr. Erlinda Palaganas, a nurse researcher and a regarded country expert in the use of FG method.

For each team, two essential roles in the conduct of FGs were identified namely, moderator and note-taker. The nurses had to select from these based on which best fit their interest, skills and personal strengths. Several practice FG sessions were then conducted during the training to increase the nurses' familiarity and comfort with the method as well as to gain expertise in their assigned specialized task. These practice sessions were overseen by the resource person and A-HEALS area supervisors where immediate feedback was provided after each session to recognize effective practices and areas for improvement. Two of the practice sessions involved actual BHWs and mothers from a nearby village and served as pre-test groups for the FG guide. The opportunity to pre-test the guide, the subsequent processing and feedback better equipped the nurses in anticipating and handling possible scenarios in the conduct of FGs. One-on-one mentoring was made available for individuals who had specific concerns regarding the conduct of the FG.

Arranging and preparing the focus groups

The recruitment of participants took place one week before the actual FG sessions. Informed consent was acquired using a standard form, approved by the ethics review board of the Ateneo School of Medicine and Public Health. The form was discussed by the nurses with the participants before each FG session, allowing adequate time to discuss any questions raised regarding the study. Most consent forms were given several days prior to the FG, some were given immediately before the discussion began. One day prior to the scheduled FG session, each participant was followed up by a nurse researcher and reminded of the session either through a home visit or text message. At times, nurses would provide an orientation to the participants prior to the actual FG session to introduce themselves and begin building rapport. All FGs were well attended and each lasted for at least one (1) hour.

Each data gathering team arrived at the FG venue at least 45 minutes prior to the scheduled session. This provided ample time to prepare the venue, particularly the layout of tables and chairs used, as well as to address possible distractions such as noise in the vicinity and warm temperature inside the venue. For the first few FGs, participants arrived at the venue in trickles, delaying the start of the discussion. These late participants missed some early parts of the discussion including the orientation and house rules relevant to the session. One helpful realization regarding this concern is the need to remind and emphasize to participants the importance of arriving at the venue early so the session can start on time and all may receive proper briefing. Hence, this was done for subsequent FG sessions. Another modification was the provision of a detailed orientation during recruitment to level off expectations of participants and to save time during the actual FG.

The venue of the FG session significantly influenced the conduct of the discussion. As a case in point, a FG with midwives that was held within their health clinic had several interruptions from other

employees on work-related concerns. Likewise, a FG with women participants held at the local government hall influenced them to be hesitant to talk about the lack of government support for maternal services. This guided the team to ensure that subsequent sessions were not held in participants' areas of work and were conducted in a neutral venue where opinions could be expressed freely without fear of being heard and judged by others. The decision to hold the succeeding FGs in places with fewer distractions and limitations was helpful in focusing the attention of the participants and gathering meaningful data.

Moderating the focus group discussions

Moderating discussions is critical in FG research, as it requires mental discipline, preparation and group interaction skills (Krueger & Casey, 2015). One important factor that was helpful in facilitating the sessions was that the FG moderators were native speakers of either the Waray or Visaya dialects. This allowed the moderator to establish rapport, aiding the participants to be more relaxed and spontaneous. Apart from their familiarity of the local language, the ability to recognize possible power play among the participants helped these nurses to moderate the discussion with ease, thus, providing opportunity for all participants to share experiences adequately. Krueger and Casey (2015) opined that the moderator's role is to level off participants who are dominant and less dominant thereby allowing them to reflect on various arguments without pressure. The use of facilitating skills such as listening, reflecting and synthesizing were also crucial in ensuring that all participants were engaged in the discussion.

Interaction as an important component of FG (Morgan, 1996) may become limited when participants are very much acquainted with each other and have the same experiences in the same setting. It is not common that people share experiences with others when they know that their experiences are the same. The moderator's role in asking other participants about personal experiences or opinions has been shown to encourage interactions within the group. Another possible way to encourage interaction is the modification of the FG composition such as having a mixture of participants from adjacent villages or municipalities but this may require additional fieldwork expenses.

In rural communities, mothers commonly brought toddlers and babies to the FG. At times, a mother's attention to the discussion became limited especially when the baby expressed needs or became irritable. For this concern, it was helpful to allow family members to come along to the FG venue as the children's caregiver while the discussion was on-going. Another alternative was to request, if possible, that children remain at home if the mother was not breastfeeding. Inability to resolve this issue may result in the unproductive participation of the mother or even absence from the actual FG session.

Activity-based strategies used in the discussion were helpful in achieving the goals of the FG research. These included the use of pictures illustrating factors that influence access to maternal health services as well as evaluation of health services and service providers. One effective activity was the use of a rating scale with pictures to understand levels of satisfaction of maternal health services provided. Instead of using numbers in the scale, pictures of faces showing a progression of expressions from anger (low satisfaction) to delight (very high satisfaction) was shown, thus helping participants express their satisfaction rating better. This strategy provided the researchers a clear understanding of the participant's perception of the quality of service provided by health care workers. There were times, however, when activity-based strategies were not useful and asking straightforward questions were more appropriate. This was true when investigating mothers' reasons for choosing between home delivery and facility delivery. Questions were asked plainly and participants answered them directly and adequately.

Note-taking and recording

For each FG, nurses produced *field notes* that included participants' shorthand responses and

salient observable data such as facial expressions, body language and other non-verbal cues. Wolfinger (2002) argues that there is a relationship between the background or tacit knowledge of the note-taker and the quality of field notes. For the study, the note-taker's background knowledge about the geographical location of women in relation to the health facilities, the prevalence of home deliveries or the extent of postpartum visits and other information were essential in providing details for writing the field notes. Background information gathered from the previously conducted household survey were reviewed prior to each FG, ensuring that nurses understood the context of each discussion. In addition, their academic training as nurses provided sufficient context in understanding the maternal care concepts and terminologies relevant to the study.

A *field notes* guide was provided for each team, which highlighted vital components of the FG discussion such as answers to questions, layout of the FG venue and arrangement of participants as well as other observable non-verbal cues. While getting the gist of the responses for each question from the FG guide, the nurses' previous experience during the training also allowed them to identify and elaborate important details to include in expanding the field notes. It is necessary to write the field notes during the actual FG or shortly afterwards to ensure data validity and inclusion of all pertinent details. However, Mulhall (2003) suggests that when the purpose of the research is to capture broad patterns, it is possible to write field notes after a longer period from the fieldwork. During the actual FG discussion, the note-taker worked collaboratively with the moderator who was usually seated among the participants. It was ensured that the note-taker and moderator had eye contact with each other to allow non-verbal communication such as to signal the need to provide cues, to ask follow-up questions or to gesture the amount of time left in the discussion. In one instance, one team had three nurses, instead of the usual two. The additional member was helpful in preparing needed materials for the activity-based strategies as well as following-up important points missed by the moderator in the course of the discussion.

Moreover, all the 16 FGs were recorded using two or more units of audio recorders. The use of additional recorders was necessary to overcome possible problems that relate to the audibility of recordings and other fortuitous events such as loss of or damage to equipment. The research team realized that in the actual conduct of the FGD, apart from ensuring a quiet physical environment, having less space between participants and use of a smaller table or having no table at all were significant factors that improve audio recording. This is particularly important when the 'microphone range' of the audio recorder is limited.

Transcription of audio recording

It is ideal that the transcriber of the discussion's recording should come from those who were involved in the actual FG data gathering. In most instances, the note-taker led the transcription process. Transcriptions did not only include a verbatim account of the session but also captured important information such as silent agreement, obvious body language, and indication of group mood or contradictory agreements. This information can be manifested through notations such as emotional contents (e.g. 'soft laugh', 'sounding tearful', 'nodding', 'tapping the table') and conversation fillers (e.g. 'hum', 'ahm', 'ahh'). According to MacLean, Meyer, and Estable (2004) including such notations enhances the understanding of the data as well as interpreting the motivation behind the interaction. For instance, when asked to comment about political support for maternal services in their community, some participants responded with a long silence, rolling of eyes and tapping on the table before responding to the question. This may be an indication of the presence of a problem in relation to this issue. This important account cannot be captured if the transcriber was not involved in the actual FG, thus limiting the interpretation of the data. The issue of recall and the ability to incorporate relevant non-verbal cues could be addressed and realized when the transcriber comes from the data collection team.

Translation from the local dialects to English

The FG transcripts in the local dialect were subsequently translated into English text. As translation involves interpretation of meanings in which the translator interprets the language in the local dialect and transfer it to the target language (van Nes, Abma, Jonsson, & Deeg, 2010), careful processing is necessary to ensure validity of the translation. Although the moderator was commonly designated to do the translation, this process was also a collective effort of the team. The note-taker provided some support in translating some concepts in the local dialect to a more understandable English text by discussing with the moderator difficult concepts in the local dialect and coming up with better translation alternatives. Although the area supervisor is not conversant of the local dialect, they also supported the translation process by commenting on the English construction of the text. In some instances, area supervisors of the other teams also contributed to improving the translation. In addition, validation of the initial translations was also conducted and will be discussed further in the succeeding section.

Enhancing trustworthiness of data

Although qualitative data is not measurable in numbers, accuracy and quality are still factors that need to be assured. Ensuring trustworthiness of data was of primary importance and the investigating team guaranteed this through several approaches.

Firstly, the FG guide was pre-tested by the nurses and the area supervisors. The guide included items in relation to the results of the household survey that identified factors that facilitate and obstruct women's access to prenatal, delivery and postpartum services. Pre-testing was initially administered among the nine nurses and later to two groups of women and one group of BHWs. The objectives of this process were to determine if the questions were unambiguous and to evaluate the appropriateness of the activity-based strategies employed. It was important to ascertain if the strategies and questions were indeed helpful in eliciting desired responses from the respondents. Deliberation of each pre-test result was conducted and subsequent revision of the tool was done before the pretesting of the next set of participants. Eventually, the investigating team finalized the data collection tool based on the significant points raised in the four pretested groups.

Secondly, to ensure the quality of data, a *debriefing session* was conducted every after FG discussion, totalling to 16 debriefing sessions. The main purposes of these sessions were to evaluate if the objectives of each FG was met, to analyse salient ideas that surfaced, to identify problems encountered and to determine recommendations for succeeding discussions. Sessions were guided by a standard form and were audio recorded. For each session, the team facilitated a review of the events during the FG, consolidated observations of the nurses and their supervisors, reflected on findings from the discussion and synthesized conclusions and initial analysis. Although in many instances strengths and weaknesses in relation to the conduct of FGs were context specific, there were important points that were applicable to the succeeding FGs by providing some recommendations on how future sessions were to be conducted with due consideration to the contexts.

Throughout the conduct of the FGs, nurses had regular communication with their area supervisors. The presence of the supervisors during the entire period of data gathering allowed provision of timely guidance to the nurses especially during the debriefing sessions. Notes from the debriefing sessions were also shared among the four data gathering teams to identify common patterns across the FGs and served as an approach to determine emerging salient data. This helped the team to note repeatedly surfacing ideas or concepts in relation to the research questions, thus providing basis to the achievement of 'saturation point' (Munhall, 2012; Streubert Speziale & Carpenter, 2003, Glaser & Strauss, 1967).

The third significant strategy to ascertain data quality was the validation of the translated FG transcripts. Selected validators were invited to provide feedback on the translation done by the

nurses to determine if the meaning of the local dialect was appropriately captured in the translated text. These validators are language educators and regarded experts from the major colleges and universities in the Eastern Visayas region who are conversant in both the local language and English. They were required to provide comments and alternative reformulation of the translation, as deemed necessary. This process resulted in the further refinement of the initial translation and identified inconsistences were appropriately revised by the nurses based on the validator's comments. Validation of two secondary sources of data, the debriefing session report and the expanded field notes, were also reviewed by volunteer students. In particular, these students, identified consistencies between the salient points presented in these two materials. Although back-translation is sometimes done to determine accuracy of the translated text, validation by the socio-linguistic competent language validators, as uniquely applied in this study, could be a practical alternative in achieving quality data. Translation and validation are time-intensive processes and additional cost for these tasks should be taken into consideration in the conceptualization of FG research.

Conclusions

This experience of young nurses provided some insights on practical methodological considerations in the conduct of focus groups fieldwork. Focus group as an important research approach in nursing and other health related studies could produce trustworthy results when required research skills are detailed and effectively learned. Techniques to ensure trustworthiness of FG data can be employed in the various stages of the fieldwork process such as the pretesting of tools, conduct of debriefing sessions and validation of English translation. Appropriate training, complemented by timely and consistent guidance by area supervisors was crucial in priming the young nurse researchers in entering the complex process of FG fieldwork.

Moreover, familiarity of the nurse researchers with the local setting is an important asset in carrying-out FG research. As evident in this experience, it facilitated many benefits from the recruitment of participants, moderating of the FG discussions, local coordination with village partners as well as transportation and communication in the area.

By highlighting and mastering the essential FG skills, this research approach can serve as a useful and valuable tool in understanding and exploring various nursing and other health-related issues, and should be promoted to younger nurse researchers in the Philippines.

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RESEARCH ARTICLE

The Diabetes Camp Experience of Adolescents with Type 1 Diabetes

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Abstract

Diabetes (DM) camps were established as an intervention for children with Type 1 diabetes to promote self-care and coping with the rigors of its management. Previous studies found camps to be significant to children with chronic illness but needs continued exploration. Using phenomenology, this study aimed to contribute to the effort of determining the impact of DM camps on adolescents with Type 1 diabetes. Data was gathered from 7 purposively selected participants and 1 FGD. Analysis was done to deduce essence of the experience and 9 themes emerged from the accounts of the participants. This includes: missing home, camp acclimation, discovering control of diabetes, life changing experience, acceptance of having diabetes, boosting self-efficacy, developing camaraderie. I am like any other kid and camp as refuge. The themes describe the camp experience of adolescents with type 1 diabetes, its impact and recommendations for possible enhancement of camp programs. Learning about diabetes and its management were among the experiences gained. As adolescents they went through the course of discovering themselves, building relationships and attaining some sense of independence.

Keywords: *Diabetes camp, adolescent, Type 1 diabetes, camp experience, phenomenology*

Introduction

Diabetes (DM) camps were established as an intervention for children with Type 1 diabetes. It was conceived to promote self-care and coping with the rigors of the management of this condition. In the Philippines, existing literature on diabetes camps generally centered on the description of its programs and activities (Healthy Advocacy, 2013). The studies about camp experiences, on how it contributes to the quality of life and changes it brought to the campers were mostly done in the United States and Australia. Cheung, et al, (2006) found social support to be valuable while Békési, et.al, (2011) reported that children and adolescents with cancer, diabetes and juvenile idiopathic arthritis gained health related quality of life and enhancement of their self-perception. Ramsing (2006) likewise found camps to help in DM management and build self-esteem. Hunter, et.al, (2006) pointed out that camps are significant to children experiencing chronic diseases but had not been given due attention. Winsett, et.al,(2010) recommended continued exploration of the influence of diabetes camps and

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the need to identify the benefits of camp attendance to attain self-efficacy.

This study aimed to contribute to the understanding of the diabetes camp experience of adolescents with type 1 diabetes particularly in the Philippine setting. Adolescence is a critical period of growth and development. The physiologic, psychological and behavioural changes that occur as part of this period presents added demands on the adolescent and a chronic condition like diabetes can profoundly affect. Looking into the experience of adolescents who attend diabetes camps shed light to the question of what is the diabetes camp experience for an adolescent with type 1 diabetes.

Exploration of the lived experience in diabetes camp particularly among Filipino adolescents provided a clear perspective of the phenomenon. It gave valuable information to promote understanding of the experience and its impact. The attainment of the purpose of the diabetes camp can be seen in the result and used as a basis to enhance camp programs.

Methodology

The qualitative research approach was utilized in the study specifically phenomenology. It is the study of "the individual's life world, as experience rather than as conceptualized, or theorized. Phenomenology aims for a deeper understanding of the nature or the meaning of everyday experiences (Munhall, P. 2012). The approach brings out the experience and perceptions from the perspective of the person. It looks at how an individual is looking at things and thus allows a deep, clear and veracious description of an experience to be obtained (Husserl, 1982 as cited by White, 2009; Behnke, 2011).

This was made possible by purposively selecting key informants or participants based on specific characteristics. First is that they have type 1 diabetes and have attended a diabetes camp. They are adolescents and have attended the diabetes camp when they were aged 13 to 19 years old. However their age during the time of the interview was variable. This allowed information of the experience to be gathered from different perspective. The participants also did not have any communication disabilities and were willing to share their diabetes camp experience. There were 7 individual participants and 8 in the focus group discussion who contributed to the completeness of the data collected. Table 1 shows the profile of the participants in terms of age and gender.

Table 1: *Participant Information*

Interview			Focus Group Discussion		
Participant(P)	Gender	Age (years)	Participant (F)	Gender	Age (years)
P1	F	25	F1	F	15
P2	M	16	F2	F	16
P3	F	19	F3	F	17
P4	F	16	F4	M	13
P5	F	17	F5	M	14
P6	F	15	F6	F	14
P7	F	14	F7	F	16
			F8	F	15

Data collection commenced after acquiring permit to conduct the research from the Ethics Review Board and approval to implement the study from the diabetes camp director. For the participants, an informed consent was obtained from the parents of adolescent and from adult participants prior to the interview. The young participants were likewise asked for an informed assent and their right to refuse even if their parent agreed was emphasized.

The face to face interview was used in gathering rich information about the phenomenon. An interview guide consisting of open ended questions helped in conducting the interview and focus group discussion. The interaction with the participants was captured with a digital audio recorder. Field notes were also be used to document the data gathering process. This helped separate the participants' ideas from my own. Prior to the implementation of the study, I wrote my personal thoughts and reflections on the focus of my research.

The interviews were conducted in accordance to the choice, safety and convenience of the participants. Six took place in their home and one in the counselling room of an outpatient health care facility where they seek consultation. The schedule of the interview was by appointment. A focus group discussion (FGD) was conducted after the interviews to triangulate the data gathering method. According to Wilkinson (2003) FGD helps to further deepen understanding of the experience by stimulating memories, disclosures and discussions.

Transcription of the interaction with the participants was done soon after each interview. This enabled the identification of gaps in the information gathered. Completion or filling up of missing pieces was obtained in the succeeding interview of the participant. An improvement in the conduct of the next interview was made possible by this process. Data collection was continued until no new information was obtained or until the point of saturation was reached. The copy of the transcription was also shown to the participants to determine if it captured the description of their diabetes camp experience.

Responses of the participants in Tagalog were translated into English and retranslated back to Tagalog to ensure the essence of the statements is not lost.

Analysis of data was done concurrently with data collection. The statements of the participants in the transcription were read and re-read to capture the essence of the description of their experience. Codes were used to group statements conveying particular thoughts and ideas. Emergent themes were identified and then discussed. The process of analysis was conducted by three researchers. I did the analysis with two other trained diabetes nurse educators who are adept in doing qualitative research. They did the analysis individually and then conferred with each other regarding the results. Points of difference were discussed until agreement or consensus was reached. The result of the analysis was shown to the participants to confirm if it is their lived experience in a diabetes camp that was described.

Ethical Consideration

The principles of Ethics guided the conduct of this study. Utmost consideration of the welfare of the participants was a priority as well as the assurance of the absence of risk and harm.

The only possible harm, though perceived as negligible, can emanate from the collection of data. It may have caused some inconvenience because of the time they gave for the interview session and anxiety of being interviewed about their personal experience. The questions that were asked may also have caused some mental strain and recall of feelings or emotions felt during the camp. It may have made them feel embarrassed, uncomfortable or even upset because they shared something personal. Although the research presented minor risks, this however was given utmost attention.They were informed of the foreseen risks. Also their rights were protected and treated with respect at all times. Their privacy was ensured and all information they disclosed was used for research purposes only. The participants' anonymity was maintained with the use of codes. It was emphasized that they can decide which information to provide and they can also withdraw anytime (Philippine Health Research Ethics Board Ad Hoc Committee (2006).

The data was kept in file in a personal computer accessed using a password known only to the researcher. A back up CD copy was stored under lock and key. The files will be deleted and all hard copy shredded 6 months after the completion of the final paper.

Establishing Trustworthiness

The goal of this research work was to accurately describe the experience of the participants. As a diabetes nurse educator, I have served as a camp volunteer and facilitator since 1998. This has given me the opportunity to observe and develop trusting relationship with those who have attended the diabetes camps. However, to minimize my personal ideas, I reflected on my personal thoughts about the focus of this study and kept a field journal for noting my points of view.

The process helped identify biases I may have and to limit its effect. Triangulation was also employed in the process. There was variability in the profile of the participants and consideration of the similarities as well as the differences in the collected data. The transcription of the interview was likewise shown to the participant to determine accuracy and completeness of the information.

Analysis of data was done by three researchers. They did the analysis individually and points of difference were discussed until this was settled. The result of the analysis was shown to the participants to confirm if it is their lived experience in a diabetes camp that is described.

Findings

The result of the processing of the data gathered from the interview of 7 participants and 1 focus group discussion is the researchers' understanding of the experience. Table 2 presents the 9 themes that emerged from the processing of the data collected from the participants. These evolved from the different categories and subthemes deduced from the specific statements gathered during the interviews and focus group discussion conducted. Processing of the interview results, which were started after each interview, was done separately from of the FGD data. Similar categories and subthemes surfaced from the analysis done. Statements from the interview and focus group were place together under the same

Table 2. *Themes of the diabetes camp experience of adolescents with type 1 diabetes.*

Themes	Subthemes	Categories
Missing Home	Homesickness	Being away from family Homesickness
Camp Acclimation	Initial adjustment	Adjustments needed Getting to know others
	Fitting-in Dealing with camp limitations	Fitting - in Limitations of camp resources
Discovering Control of Diabetes	Learning about DM and its management	Basic diabetes management Understanding diabetes Answered questions
	Learning from sharing and with fun	Learning from sharing Learning while having fun Incidental Learning
Life Changing Experience	Dawning of Realizations	Others like me Eye opener Dm not a hindrance Change in perception Pursue dreams Seeing DM differently Finding support from others
	Disciplining oneself	Changes in handling oneself Desire to be in control Being able to mingle Disciplining oneself Doing self-care Developing independence
Acceptance of Having Diabetes	Acceptance while learning Acceptance with knowledge	Acceptance while learning Acceptance with knowledge
Boosting Self-Efficacy	Receiving recognition	Receiving recognition
	Gaining confidence	Gaining courage Reflecting on learning Being proud of oneself
Developing Camaraderie	Cherishing moments together	Missing absent friends Seeing old and new friends Cherishing moments together
	Beyond the illness	Beyond the illness
I am like any Other Kid	I feel normal	Feel normal I am not different
Camp as a Refuge	Extending togetherness	Camp duration too short Enjoying oneself Experiencing excitement
	One big family	Felt like family Be with people who understands Memories worthkeeping Escape from reality

themes which are: missing home, camp acclimation, discovering control of diabetes, life-changing experience, acceptance of diabetes, boosting self-efficacy, developing camaraderie, I am like any other kid and camp as a refuge.

Nine themes emerged from the processing of the data collected from the participants. These evolved from the different categories and subthemes deduced from the specific statements gathered during the interviews and focus group discussion conducted. The themes are: missing home, camp acclimation, discovering control of diabetes, acceptance of diabetes, boosting self-efficacy, life-changing experience, developing camaraderie, I am like any other kid and camp as refuge.

Key Themes

Theme 1: Missing Home. One of the themes identified by the participants was the experience on the initial days at the camp. This was missing home. Children may have some anxiety when they leave home for an extended period of time. The unfamiliar camp environment, the new faces, and desire for the "old and familiar" may led to the feeling of homesickness. Among the statements that express this theme include:

> "…Siempre po kapag nasa dorm kung minsan, medyo na ho-homesick po kasi nakaka miss din po pagmalayo ka sa pamilya mo…nakaka miss po talaga…"
> *(…There are times when I am in the dorm that I feel a little bit homesick because when you are far from your family, you miss them…you really miss them…)*

Being away from home for the first time and from the people they care led to their expressed feelings of missing home. This, however, does not seem to be evident in most of the participants.

Theme 2: Camp Acclimation. The initial exposure to the camp is reflected in the themes camp acclimation and missing home. As individuals they went through facing something new. Camp acclimation is the experience of initial adjustment to the camp environment. It was a time period when there were new campers to get to know, the need to fit-in and camp facility limitations to deal with. Initial adjustment was indicated by:

> " Kasi bago so syempre hindi alam kung ano ang gagawin ko doon and yung first time ko po kasi wala akong kakilala wala pang kaibigan kaya parang feeling ko innocente pa ako…bagong place na gagalawan ko".
> *(…Being new there*[camp] *so I really did not know what I would do and being there for the first time I did not know anyone, I did not have friends yet so I sort of felt lost in this new place where I am at…)*

Another subtheme that emerged was dealing with camp limitations. Verbalizations include:

> " Magkaroon pa nang maraming electric fan kasi super init po lalo na ang camp eh summer nagaganap…siguro po yung mahirap nasa una lang po, yung pag –aadjust po because of the water, kasi sa gabi nawawalan ng tubig."
> *(Have more electric fans because it's so hot, more so because the camp is held during summer…perhaps the difficulty is only at the start, you need to adjust because of the water, because there is no water at night…)*

They also experienced fitting- in :

> "Pag nasa camp may nangunguna, parang mga sosyal yun… tapos ikaw parang tahimik ka lang. Parang meron silang grupo na hindi ka "in"…mayroon silang kung sino lang ang kasama, yung feeling ko".
> *(At the camp, some stands out, seems to be feeling important…then here you are just being quiet. I felt that there is a group where you do not feel you belong… they have selected members only.)*

Their experience upon arrival at the camp commenced with the need to acclimate themselves. There was a period of adjustment to the social and physical environment. This may be an expected occurrence for anyone who is situated in a new place which was experienced by these young individuals. Leaving the comfort of home to

go and live in another place no matter how short it may be, they brought their own ways with them. The camp made them experience different feelings and reactions. Nervousness and sense of uncertainty was felt.

Theme 3: Discovering control of Diabetes. According to the American Diabetes Association (2012), camp environment provides opportunities for the acquisition of skills in managing diabetes in a constructive atmosphere. It allows them to come together, share their experiences and learn. In a similar light, discovering control of diabetes was part of the knowhow gained by the participants. Attending the camp facilitated their learning of basic diabetes management. This was a common expression among all participants.

There was learning about diabetes and its management:

> "Ang daming nabigay… mas na intindihan ko ang diabetes, mas naintindihan ko kung bakit kailangan mag inject mag prick."
> *(There were many things given…I got to understand diabetes better and why I need to inject and prick.)*

> "Natututo akong mag-inject, mag carbo counting, treat hypo and hyperglycemia at pano maiwasan ito. Dahil po sa natutunan ko sa camp… yun mga dapat gawin para iwasan complication…"
> *(I learned how to inject, do carbo counting, treat hypo and hyperglycemia and how to avoid them. Because of the learnings at the camp… the things that needs to be done to prevent complications…)*

And learning came was with fun and some were from sharing. Among the responses that were given includes:

> "I was able to meet a lot of different people. You get to know their different perspective about Diabetes, how they manage it, and a lot more"

> "It's the games, because it's like hitting two birds with one stone. You're having fun at the same time learning in a very interesting way".

> "Yung time na parang maglalabas ng mga salolobin yung mga campers. Kasi mas na o open yung eyes mo sa experiences ng ibang tao tapos na re-realize mo na ah we have the same experience or ay mas iba …grabe pala na experience ni ate…kaya gayun so naintindihan mo na okey na pala yung ginagawa ko kaysa sa ginagawa nila "
> *(The time when the campers disclose their inner thoughts/feelings because it helps open your eyes through the experiences of others and you realize you went through the same experience or how different one's experience is… or how bad the experience of an older camper was… you get to know that you are doing fine compared to how the others are…)*

Gaining knowledge and understanding of what diabetes is specifically type 1 are among the factors important in its management. The participants' claimed learning the importance of monitoring, how to inject, to do self-monitoring of blood glucose and carbohydrate counting. They gained understanding of the disease from sharing of fellow campers and diabetes educators. The learning process had been enjoyable and fun filled. The camp served as a venue for young individuals afflicted with the condition to acquire the knowledge and skills basic for diabetes related self-care.

Theme 4: Life-changing Experience. The experience was found to be life-changing. The theme emerged from two subthemes, dawning of realizations and disciplining themselves. The learning and insights gained or the discovery of control of diabetes led the participants to have certain realizations about things that affect their lives. One predominant response was the realization that there were other young people like them with diabetes.

> "…Yung camp ay isang eye opener. Binuksan nito ang aking kaalaman tungkol sa diabetes…"
> (*…The camp is an eye opener. It opened my knowledge about diabetes…)*

> "…Tapos na experience ko po na hindi ako nag-iisa, marami pala kami, marami po na may type 1 diabetes"

(I experienced that I was not alone, there are many of us with type 1 diabetes…)

"Attending camp taught me that you are not isolated just because you have diabetes, there are also children who suffer and younger than me".

They described changes in their everyday life because of their camp experience. One participant claims:

"Parang nabigyan ng second chance to complete my life kasi since nung nagka diabetes ako parang nabawasan ako ng konti sa buhay pero when I came here sa camp I feel so complete kasi may nalaman ako tungkol sa sakit ko".
(It was like being given a second chance to complete my life because it seemed that I lost a part of my life when I had diabetes but when I came to the camp I felt sense of completeness because I learned about my illness.)

"They found that diabetes care is not that difficult…Akala ko nung una mahirap magka diabetes pero dito ko naturan po ako, akala ko maraming bawal pero dito natutunan ko hindi pala".
(*…Initially I thought it was difficult to have diabetes but I was taught, I thought there were so many things not allowed but I learned that this was not true.)*

Someone stated:

"I managed to live a normal life just like other kids and I'm able to do stuffs that brings out the best in me."

Disciplining oneself was also among the subthemes found to be experienced by adolescents with type 1 diabetes. A participant mentioned:

"Natutunan kong maging independent, kasi nasanay akong kasama ko lagi mama ko na laging nagpapaalala at nagbibigay ng gamut ko…pero dahil sa camp natutunan ko na kahit umalis ako mag-isa, kaya ko na"
(…I learned to be independent because I am used to having my mother with me all the time and she constantly reminds and gives my medicines…but because of the camp, I learned that I could manage by myself.)

"Natutunan ko para maging independent.. alamin ang actions ko at bakit nangyayari sa akin".
(I learned to be independent…I should know my actions and why it is happening to me…)

The exposure of the participants to the camp environment where other young individuals like them were present provided them the chance to gain insights about themselves. The experience gave them a wider perspective about diabetes and its management. This experience altered how they saw themselves and their future. The camp atmosphere has made the participants see themselves and their situation from a much better perspective. The environment favoured the development of independence and allowed the campers to make choices and own their actions.

Theme 5: Acceptance of having diabetes. Another theme that emerged was acceptance of having diabetes. This was however not an experience shared by many of the participants. Its importance as a part of the camp experience however cannot be discounted.
Acceptance while learning

"…nakita ko doon na yung mas bata sa akin na medyo matagal ng na diagnose, na magaling at marunong nang magmonitor at mag-inject. Marami na rin silang alam sa diabetes… Dahil doon unti-unti kong na-aaccept ang aking diabetes"
(I saw children younger than me who were diagnosed for a longer period and were good and knowledgeable in monitoring and injecting. They also know a lot more about diabetes… because of this, I slowly accepted my having diabetes.)

"Every camp na na-attendan ko gave me different experiences and learning na nakatulong para ma-accept ko ang diabetes at mga challenges nito"

(Every camp that I attended gave me different experiences and learning that helped me to accept having diabetes and all its challenges.)

Acceptance with knowledge

"I became more knowledgeable about my care and was able to understand and accept it wholeheartedly".

"Noong natututo ako, naiba yung pamumuhay naming. Noon araw di ko pa matanggap na mayroon akong diabetes."
(When I learned, our life changed. In the past, I could not accept that I have diabetes.)

The experience of acceptance was gained because of the knowledge about diabetes and the management they learned to perform. Having a clear grasp of what is happening to oneself through the educational activities implemented in the camp favored the process of acceptance of one's situation.

Theme 6: Boosting Self-Efficacy. A boost in the participants' confidence was also felt during their exposure to the diabetes camp. This emanated from receiving recognition for achievements during camp activities.

Receiving recognition

"Every camp is memorable pero yung naging best camper ako yun po talaga nag-stand out. Wow may award pa lang ganito at sa akin ibinigay".
(Every camp is memorable but when I became the best camper, this was most memorable. Wow there is an award and it was given to me…)

"Yun din pong nag-'Darna" ako noong super heroes ang theme, kahit hiyang hiya, push pa rin. Nagsuot pa rin ako noon ng costume ko. Push pa rin. Nanalo po ako ng best costume noon".
(It was the time when the theme was superheroes and I was "Darna", even though I was so embarrassed I still went on. I wore the costume. I won the award for best costume…)

Gaining Confidence

"Natututo makipagkaibigan kasi po sa bahay po wala po makipagkaibigan sa sakin gaano."
(I learned to make friends because at home, very few wanted to befriend me.)

"As a camper, siguro yung camp siguro yun din ang nagbigay sa akin ng lakas ng loob na mag mounteneering…"
(As a camper, I guess it was the camp that gave me the courage to undertake mounteneering…)

"The camp was able to give me confidence and other values that I could use not only for a short time but for a long time. It taught me not to be shy or lower my self esteem because I'm a diabetic. Instead, I should be proud and strong because other normal people don't know what our struggles are."

Though not all the participants experienced a boost in their self-efficacy, this is another positive outcome of attending a diabetes camp. Confidence emanated from the encouragement, reflection of their learning and being proud of oneself because of what they go through as adolescents with diabetes is not easy. The recognitions they were given during camps attest to their capabilities.

Theme 7: Developing Camaraderie. It was a unanimous expression by all participants that it was the friendship that matters. They missed friends who could not attend the camp but were also excited to see old and new friends.

Cherishing moments together

"Yung relationship nila sa isa't isa…kasi kung may problem yung isa yung grupo yun pwede nilang tulungan yung hindi nakaka relate so para sabay-sabay umangat… sabay-sabay natututo."
(It is the relationship with each othe…if one would have a problem, one who could not relate, the group can help so every one would move up at the same time…they all learn together.)

"Yung last night po ng camp, yung bago umalis. I che-cherish mo po yung last hours na makakasama mo sila parang ang tagal ulit bago magsama-sama…nandoon yung time na nagku-kwentuhan na lang kami, nagsasalo-salo sa snacks na binili."
(It's the last night in the camp just before departure. You will cherish the last hours you spent with each other because it will take a while before we will be together again…there are times we would tell stories and share snacks we bought.)

" Campers' camaraderie … the bonding during teaching learning activity…the staff…."

Beyond the illness

"…Hindi lang po yun tungkol sa sakit kung di pati yung tao."
(It's not just about the illness but about the person.)

"…Later on para sa next camp hindi pala sila kasama… ay hindi pala siya kasama kasi hindi siya na-inform, tapos yung iba dahil namatay na yung mga ganon so yun yung medyo malungkot… ay hindi sila nakasama sayang naman yung experience na dati tayo yung magkakasama tapos ngayon …ah wala pala… yun po yung nakakalungkot."
(In the next camp, others will not be there… so he/she is did not join because they were not informed or some died already which is rather sad… so they will miss the experience… before we were together now … now no more… that is what makes it saddening.)

The camp experience was beyond illness, it is about people. What pervades the camp experience was more than the anticipation of seeing fellow campers. It was the bond of friendship that has been developed among them. They cherished the moments of togetherness. It went beyond the campers but included the staff as well. A lasting closeness developed in just a few days of being with each other.

Theme 8: I am Like Any Other Kid. The feeling of being different or like an "odd ball" can be deduced from the statements of some participants. However what stands out is the feeling of being normal or just the other adolescents. The subthemes I feel normal and I am not different speaks of how their camp experience contributed to their thoughts and feelings.

I feel normal

"Nagkakatuwaan lang kahit may sakit tayong lahat. We feel normal with each other, di parang nandon sa ating mga bahay, we feel na parang were trying to… nagpapanggap lang tayong maging normal… ".
(We are having fun even if we are all sick. We feel normal with each other unlike at home, we feel like we're trying to pretend to be normal…)

"Tapos yun din para kaming normal na mga batang naglalaro naghaharutan"
(We, too are like normal children playing and fooling around.)

"Naramdam ko na normal lang ako. Hindi ko naiisip na diabetic ako pag nasa labas ako. Pag- kakain at mag i- inject ko na lang ma-iisip na may diabetes nga pala ako."
(I feel I am normal. I do not think about having diabetes when I'm outside. It is only when I eat and inject that I am reminded that I have diabetes.)

I am not different

"Hindi kami unique parang katulad din kami ng iba, ng ibang batang walang sakit… na normal… katulad din kami nila. Ang pagkaka-iba lang siguro may iba lang kaming ginagawa, may extra activity na ginagawa na hindi nila ginagawa".
(We are not unique, we are just like every child who is not sick… who is normal… we are like them. The difference perhaps is that there are other things that we need to do, we have extra activities that they do not do.)

"Doing all these activities empowered me to believe that I am not different to normal individuals without diabetes. In fact, it gives me a proud feeling na despite my diabetes I can do almost everything like a normal person or even better."

"Hindi mo kailangang isipin na iba ka.... Doon talaga sa experience nakuha ko Ito sa experience sa camp"…
(You should not think you are different… it was really the experience I got from the camp.)

The adolescents in this study felt a sense of difference as a result of having diabetes. The management regimen of diabetes made them feel as if they were odd or different from the rest. The feeling that they desire to be just like any other kid is strongly felt in the camp. All of their fellow campers have diabetes and they all have to adhere to the same regimen which is a normal part of their everyday life within the camp. According to them, the additional things that an adolescent with diabetes does do not make him or her different from the rest. At the camp they felt they are normal.

Theme 9: Camp as a refuge. Though there was no direct statement about the camp being a refuge for these adolescents with type 1 diabetes, their description of the camp experience speaks of this theme. The camp served not only as a venue for learning about diabetes and its management but became a home for them. The experience they had during camp made almost all participants felt the camp duration to be too short. It was an expression of the desire to continue or prolong what is share amongst them with in the camp.

Extending togetherness

"Yung araw mas matagal po sana yung camp kasi po pag 5 days parang bitin…parang nakakamiss bitin po yung pagsasama-sama namin. Parang hindi pa masyadong kilala ang isa't isa kung kailan pa malapit na ang uwian saka palang niyo nagiging close…so mas ma-mimiss ko po".
(To extend the camp duration because 5 days is not enough…we will miss our being together. It seems that we still do not know each other well enough and it's when we are about time to go home that we become close.. so the more I will miss it.)

"Yung number of days nga ng camp, dapat ma extend pa para mas enjoy…para mas makilala pa namin isa't isa kasi parang bitin pag 3 – 4 days lang". "Nakaramdam po ng lungkot kasi sandal lang ang pasasama"
(The number of camp days should be extended so more time to enjoy…to get to know each other better because 3 to 4 days is not enough. We feel sad because of the short time we are together.)

"Have more camp days for more bonding, more activities. The longer the better and age limit be extended."

One big family with memories worth keeping

"It feels like a home actually. At first it was awkward but then when you learn to open yourself to other people and share their feelings by then it was like a family."

"I guess it's about the relationship made between the DEs (Diabetes Educators) and us because they are more like big brother/sister for us and they treat us like their younger siblings, they give advices, jokes and share their hobbies and talent"

"At saka po sa camp pakiramdam na parang isa kayong pamilya na nagtutulong-tulong".
(Also in the camp we feel we are like one family who help each other)

"…also it made me realize that I'm not the only one who is travelling in this journey. the camp support us diabetics. We are not alone in this unique journey".

"Memorable experience kasi sa mga campers and activities" and "memorable yung mga ano… moments at mga tinuturo nila"

(Memorable experience because of the campers and activities and the things they teach us.)

"Nakakalimutan naming mayroon pala kaming lahat ng diabetes…pag nandoon ako nakakalimutan ko lahat. I forget everything and what I remember is what happens sa camp".
(We forget that we all have diabetes… when I'm there I forget everything and what I remember is what happens in the camp)

The desire for the extension of being together and the feeling of belonging to one big family was experienced. Several participants saw the people they were with in the camp as siblings. They felt support and complete understanding. The games became the source of joy while anticipation of what the camp holds for them gave the participants a sense of excitement. There were also memories worth keeping about the camp. The memories stemmed from various situations. There were different activities and people that made it worthy of remembering for them.

Discussion

The diabetes camp experience was an episode in their life the participants desired to prolong and go through repeatedly. The reason seems to be beyond learning about diabetes and how to be in control. Although there was initial adjustment, this did not last. Apparently a few days is needed for young people to adjust being away from home and in a camp. Muchnick (2012) stated they are eventually able to cope with the help of camp staff and support systems coping require some effort but in a supportive camp environment adjustment will not be difficult.

Winfree, Williams, & Powell (2002) emphasized "for more than 150 years, summer camps have been shown to be a supportive and beneficial environment for youth, especially for children and adolescents facing a variety of medical conditions".

The camaraderie, the bond of friendship and the caring environment together with the feeling of being like everyone else is a very pleasant sensation. The advantages of the diabetes camp to children with diabetes are cited such as gaining confidence and establishing friendships (Von Wartburg, 2007). A sense of belonging was felt within the diabetes camp. This seems to be the experience they want to hold on to. The diabetes camp became their refuge, a place of respite from the stress of the outside world where they felt they were seen as an odd ball. This seems to imply the need for measures to further strengthen the self-perception of adolescents with type 1 diabetes about themselves and to determine the role of the diabetes camp. It would be difficult to change views of other people. The change should be from within them. To see and accept themselves as they are. They need a strong self- perception as they live with other people who may not understand them.

Of significance also was the acceptance of having diabetes occurring during camp. It occurred in two ways. One is through understanding of the disease while the other way was seeing others like them with diabetes. It is reasonable to assume according to the American Diabetes Association (2012) that adolescents have benefited not only from the camp experience but also for being in an environment where the norm is to have diabetes. Exposure to a diabetes camp facilitated acceptance of having diabetes. The study of Misuraca, et al done back in 1996 was the only study found that had results that suggest that summer camps have an important bearing on achieving acceptance of the disease. Cushner-Weinstein, et.al, (2007) in their study on camp benefits stated that "camps give children and adolescents the resources to change their feelings about their condition and the opportunity improve their quality of life". This may suggest the need to expose adolescents with Type 1 diabetes soon after diagnosis to hasten possible acceptance of their condition favoring self-adjustment needed.

Personal development specific to diabetes related self-care was also achieved. These adolescents do not only have inherent challenges of development but also need to manage diabetes (Hill & Sibthorp, 2006). Sense of independence on the rigors of diabetes management and self-efficacy were among the positive outcomes gained from the experience at the camp. A significant

improvement in knowledge and self-management of the disease was noted at the end of the camps in the study by Semiz, et.al.,(2000). They were given the opportunity to assume care for themselves and make decisions. Bialeschki, et al (2007) stated that most children perceive the camp experience to be enjoyable but together with the pleasurable aspect of camp, findings of studies reveal additional developmental outcomes to be positive which includes skill building among others. It requires an environment that allows choice, perspective taking, and rationale provision (Sheldon, Williams, & Joiner 2003). Summer camps serve as alternative setting of Diabetes Self-Management Education (DSME) for children and adolescents with Type I Diabetes Mellitus (T1DM). DSME is the cornerstone of care for all individuals with diabetes who desire to realize successful health related outcome (Tumini, Anzellotti, Chiarelli, 2003). It allows these youth to learn, grow and handle their illness (Ramsing & Sibthrop, 2006). Muchnick (2012) further stated that "campers experience the companionship of other children and acquire skills that improve self-confidence, increase self-reliance, enhance the ability to cooperate with others, and, hopefully, a greater awareness of life that is larger than one's self. Hopefully, the acquisition and refinement of such skills will contribute in positive and significant ways to the child's adjustment and will carry over into his/her adult years". The need for camp staff to be equipped to contribute to the development of adolescents holistically as individuals as they promote learning about diabetes and its management should be considered.

Conclusion and Recommendations: Existing literature have found camps to be significant to children with chronic disease but not given attention and continued exploration of its influence and benefits was recommended. In contribution to the furtherance of the effort, this study aimed to contribute to the understanding of the diabetes camp experience of adolescents with type 1 diabetes in the Philippines and thus provide a clear perspective of the phenomenon.

The participants in the study were able to provide opulent amount of information of their stay in a diabetes camp. The findings led to the conclusion that the experience is beyond what the camp was conceptualized to provide adolescents with type 1 diabetes. Learning about diabetes and its management were among the experiences gained but there was more than this. The adolescent lived through a life changing experience and found the camp to be their refuge. As adolescents they went through the course of discovering themselves, building relationships and attaining some sense of independence.

Gaining insight on what this young people went through can help guide camps to focus on how they can provide better support to adolescents in the implementation of camp programs.

In the light of the result of this study, the researcher presents the following recommendations for the enhancement of the camp experience of adolescents with type 1 diabetes.

1. Training of camp staff and facilitators on child development and counseling to enable them to conceptualize programs that will not only promote knowledge and skills development on diabetes but for the holistic development of the individual.
2. Determination of how the camp can address to the enhancement of self-perception as adolescents with chronic illness.
3. An assessment of the camp's social and physical environment to identify areas of improvement to further the quality camp experience.
4. A study on the acceptance of having type1 diabetes specifically the role of the camp in the process.
5. Further exploration of the experience be done among campers attending camps in Visayas and Mindanao to gain a more comprehensive perspective of diabetes camp experience in the Philippines.

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RESEARCH ARTICLE

The Needs and Capabilities of Older Adults Bases for Nursing Curriculum Enhancement

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Abstract

The needs and capabilities of the older adults should be determined to provide quality care and to make sure that they enjoy a quality life. This study aimed to determine the needs and capabilities of the older adults to serve as the basis for the enhancement of the BSN program in Gerontology Nursing that will help undergraduate nurses provide quality care for the older adults. The study employed descriptive research design to determine the needs and capabilities of 928 older adults in 14 cities in Metro Manila. Documentary analysis and a researcher-made questionnaire composed of the descriptions of older adults' needs and capabilities were used. Mean and standard deviation were used to describe the needs and capabilities of older adults. T-test and ANOVA were used to determine difference between the needs and their capabilities and when compared according to gender, civil status, number of children and educational attainment. Results showed that expenditure, health, services and housing needs are "much needed", by older adults and they have "good" capabilities. There is a significant difference in the needs and capabilities of older adults (p=<.01) and when compared to gender, civil status, number of children and educational attainment. The older adult's needs and capabilities are important in the assessment process and must be included in the curriculum. The capabilities of older adults must be maintained to a higher degree to ensure meeting older adult's present and future needs. The gaps identified in the gerontology nursing curriculum must be the bases for curricular enhancement.

Key words: *Capabilities, curriculum enhancement, needs, older adults*

Introduction

The 21st century has brought about the advancement in medical science and technology at a rapid pace, thus, the growth in knowledge and technologies have been so profound. Along with these changes, health care delivery system are challenged resulting in less

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ability to provide safe, quality, equitable, effective and efficient patient care. Research on the quality of care revealed that a health care system frequently results in poor praxis- a system that falls short in its ability to translate knowledge into practice and to apply new technology safely and appropriately (IOM, 2001). The 21st century brought about also changes in patient demographics. Today, the world is experiencing one of the greatest demographic movements and cultural shifts in history. The population most affected by these changes is the adult age. Chronic conditions among the aging population are now the leading causes of illness, disability and death thus necessitating a clinical education responsive to this shifting demographics and desires, changing health system expectations and evolving practice requirements. It is for this reason that something has to be done in order to fortify and further revise the existing BSN curricular program with regard to Gerontology Nursing Care in order to strengthen competencies of undergraduate nurses to provide quality care responsive to the immediate needs and capabilities of older adults.

Various articles on Gerontology Nursing were reviewed and considered to look deeper on the profile of the elders who have reached retirement age and needs and to determine abilities in terms of Expenditures, Health, Social Network, Services and Housing. There are nearly 40 different theories of aging in biologic, physiologic and a lot more in gerontology nursing (Kozier, 2007). A quantitative report by Middleton (2007) showed that the needs of the older adults are expenditure, health, social networks, services, housing and neighbourhood and income. The study suggested that older people in the future would have higher aspirations than the current generation, who experienced relatively lower levels of affluence during their working lives. There is also evidence that the prevalence of ill-health among older people is increasing over generations. Five domains of self and independent living should be evaluated (Skeltona et al., 2010). Capabilities of the older adults in these domains include personal needs and hygiene, condition of home environment, activities for independent living, medical self-care, and financial affairs. Kohlert (2010) stated since the world is an aging population it may be facing too small and unprepared healthcare workforce to address the needs of the elderly using new and quality technologies. Although there are a lot of research studies in the United States and Australia on needs and capabilities of older adults there this is a dearth of literature in the Philippines and other Southeast Asian countries.

The older adults' needs and capabilities must be addressed to ensure their successful aging. Good physical health, mental and social functioning activities and social engagement are essential to successful aging. One question posed by this study was how the perceived needs and capabilities of older adults were being addressed by the undergraduate nurses with regard to understanding of and proper health care in their health services. To state it more succinctly, the academe and its nursing educators cannot neglect national visions and development agenda, thus there is a need to link the gap between the needs as defined by older adults themselves. Thus, the present study aimed at determining the gap in the existing BSN curriculum with regard to Gerontology Nursing Care and the vision to fortify and make it relevant. Nursing Health Care education aims to create an understanding that change is inevitable and there is a need for more timely and scientific Nursing Curriculum change. Eventually, it is for this reason that this study looked into the specific needs and capabilities of the older adults leading to the proposed curricular enhancement in terms of Gerontology Health Care. The needs and capabilities of older adults were compared according to gender, civil status, number of children and educational attainment. This in effect will be very relevant to both the academe, who nurtures and produces future health care graduates and to the elders themselves, whose needs and capabilities should be properly handled and addressed. Finally, new provisions based on recommendations will be of great considerations for the betterment of Gerontology Health Care, the School the bureaucracy and NGOs whose advocacy is to provide relevant and proper health care services in the contemporary world.

Conceptual Framework

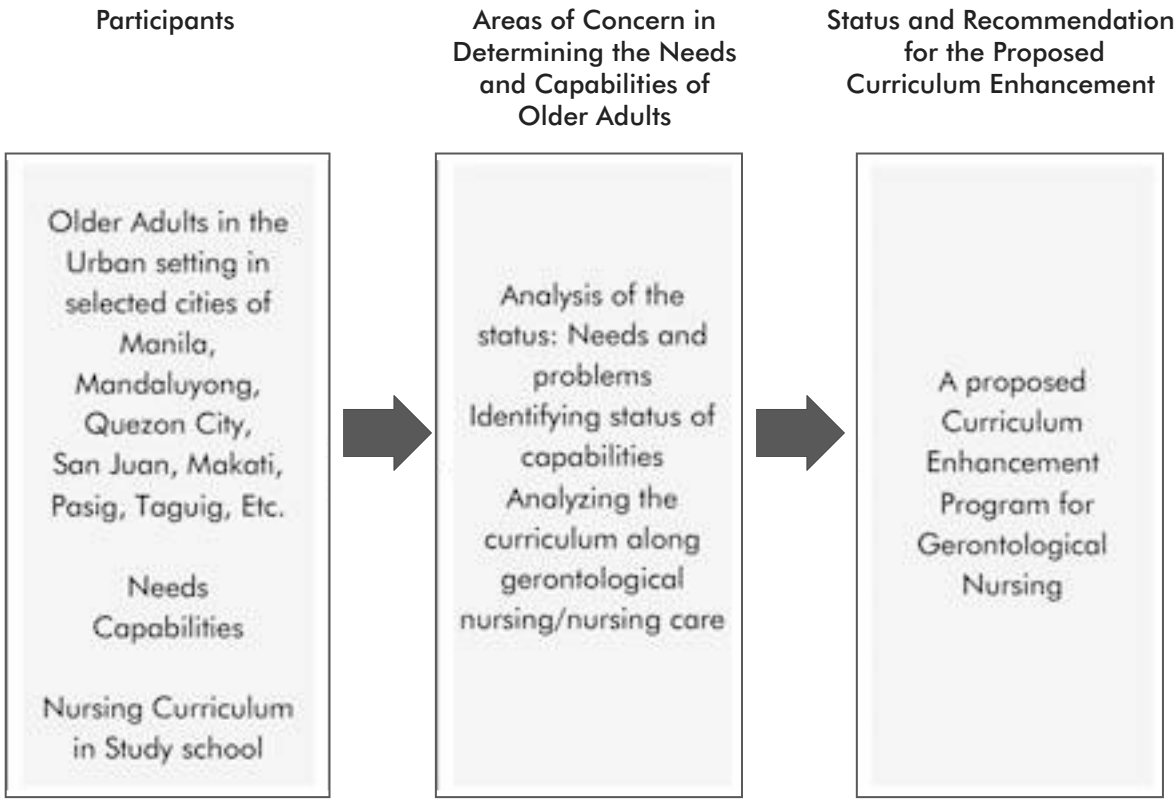

Figure 1
A Conceptual Model in Determining the Needs and Capabilities of Older Adults as a Basis for the Enhancement of Bachelor of Science in Nursing Program in Gerontology Nursing

Research Design

This study employed descriptive research design to determine the needs and capabilities of the older adults according to gender, civil; status, number of children and educational attainment as bases for a proposed curriculum enhancement for Gerontology Nursing.

Setting of the study

Fourteen (14) cities were selected as the setting of the research study. These included Manila, Mandaluyong, Quezon City, San Juan, Makati, Pasig, Taguig, Parañaque, Las Piñas, Pasay, Valenzuela, Malabon, Caloocan and Navotas.

Subjects of the study

Using purposive sampling technique older adults were purposively selected according to the following inclusion criteria: 60-67 years old, included in the "Baby Boomers" generation (born in years 1945-1964) living with their family in the community setting in urban areas and selected cities, physically and mentally healthy. Older adults of other generation were not included in the "Baby Boomers" generation as well as those living in the institutions for the elderly. Those with physical and mental disability were also excluded in the study.

Instrumentation

Documentary analysis and a researcher- made questionnaire were utilized in determining the older adults' needs and capabilities as well as the extent of their needs and capabilities that are responsive to life demands within their immediate surroundings. A documentary review of 2008 BSN curricula was taken from CEU, Manila School of Nursing office was conducted to study/analyse the

gerontology nursing curriculum components. Meanwhile, the researcher-made questionnaire was composed of 3 parts: Part 1 included the profile of the respondents in terms of age, gender and civil status, number of children, income and educational attainment. Part II consisted of the description of older adults' needs with response categories on a Likert scale are four, which ranges from (4) very much needed to (1) least needed. Part III included the description of older adult's capabilities. The response categories on a Likert scale ranging from (4) to a great extent to (1) not at all. The instrument underwent reliability testing. Cronbach's alpha coefficient of 0.89 for the needs of the older adults, and capabilities of the older adults were obtained suggesting that the items have relatively good internal consistency.

Data Collection

A letter of request was forwarded to the Municipal Health Officer of the 16 selected cities. The letter together with a copy of the proposed study was forwarded to the Ethical Board Committee of the respective Municipal Health Office for approval. Furthermore, informed consents were secured from the respondents of the study. Copies of questionnaires were distributed to the respondents, as well to determine the needs and capabilities of the older adults. The data gathered were arranged in a descriptive form and were treated statistically. Based on the findings of the study, the differences in older adults needs and capabilities as well as its' comparison according to gender, civil status, number of children and educational attainment, an enhanced Gerontology Nursing curriculum was developed to provide quality care to the older adults.

Statistical Treatments

In presenting the demographic profile of the respondents, percentage distribution was used. In describing the extent of older adult needs and capabilities, weighted mean scores and standard deviation were used. In determining the difference between the needs and capabilities of the older adults, T-test was used. For the comparison of the needs and capabilities of the respondents when grouped according to socio-demographic profile, Analysis of Variance (ANOVA) and t- test were used.

Results

Socio- Demographic Profile of the Older Adults

Majority of the older adults have four or more children, comprising 29.6 percent of the population. From the total population, 31.7 percent of the older adults have an income of 10,001- 20,000 pesos per month. Demographically speaking, baby boomer generation is at peak of its earning power. It can be deduced that they are still actively working and still have their fixed regular income. Most of older adults' especially the baby boomer generation, are still capable of working productively. Almost half of the older adults are skilled and formally educated, thus developed certain expertise that made them productive even in their senior years.

Table 1. *Socio-Demographic Profile of the Respondents*

Profile	Frequency	Percentage
Gender		
Male	579	62.40
Female	349	37.60
Civil Status		
Single	129	13.90
Married	483	52
Separated	103	11.11
Widow	213	23
Number of Children		
0	108	11.6
1	106	11.4
2	216	23.3
3	223	24
4 or more	275	29.6
Income		
No income	57	6.14
<5,000	258	27.8
5,001-10,000	198	21.3
10,001- 20,000	294	31.7
>20,000	121	13
Educational Attainment		
Elementary Graduate	164	17.67
High School Graduate	284	30.6
Vocational Graduate	129	13.9
College Graduate	308	33.2
Post College Graduate	43	4.6

Needs and Capabilities of Older Adults

The expenditure, health, services and housing needs are "much needed" while social network are perceived to be "moderately needed" by older adults. The perceived expenditure needs of the older adults are "good". Expenditure capabilities to purchase medicines and buy own car are "average" while the expenditure capabilities of the older adults to purchase foods, clothes, pay bills and acquire own house are "good". The older adults have "good" capabilities with "average," capabilities in housing but "good" capabilities in expenditure, health, social network and services (Table 2).

Comparison of the Needs and Capabilities of older Adults

Table 3 shows the mean difference between the older adults' perceived needs and their capabilities to meet them were subjected to t-test which yielded a significant (p=<.01) result in all of the five variables.

There is a significant difference in the expenditure needs and services' needs of the older adults when grouped according to gender. Male older adults have more expenditure and services needs compared to female. However, there is no significant difference observed in the health needs, social network needs and housing needs of the older adults when grouped according to gender.

Discussions

Older adults profile shows that most of the population is female and married. From the report of the Philippine census (2010) among the senior citizens, female (55.8 percent) outnumbered the male respondents (44.2 percent) and three in five elders are married. Older adults are still actively working and still have their fixed regular income.

Table 2. *Needs and Capabilities of the Older Adults*

Variables	Needs Mean	SD	Verbal Interpretation	Rank	Capabilities Mean	SD	Verbal Interpretation	Rank
1. Expenditure	2.91	.80	Much Needed	3	2.45	.80	Minimal extent	3
2. Health	2.80	.76	Much Needed	4	2.36	.81	Minimal extent	4
3. Social Network	2.48	.86	Moderately Needed	5	2.55	1.06	Somewhat	1.5
4. Services	3.44	.72	Much needed	1	2.55	1.06	Somewhat	1.5
5. Housing	3.18	.76	Much Needed	2	1.82	.83	Minimal extent	5
Overall mean	2.96	.78	Much needed		2.35	.912	Minimal extent	

Table 3. *Comparison in the Needs and Capabilities of the Older Adults*

Needs and Capabilities	Mean	SD	T value	Significance
Expenditure needs	2.46	.79	-16.25	p=.000<.01
Expenditure capabilities	2.92	.79		
Health needs	2.36	.81	-15.38	p=.000<.01
Health capabilities	2.79	.76		
Social network needs	2.15	.72	-12.17	p=.000<.01
Social network capabilities	2.51	.81		
Services needs	2.54	1.06	-23.72	p=.000<.01
Services capabilities	3.44	.73		
Housing needs	1.82	.82	-17.48	p=.000<.01
Housing capabilities	2.95	.81		

*p= <.01; = Significant

Older adults with 5,001- 10,000 with 5001-10,000 income have higher social network and housing needs, while those with 1001-20,000 income have higher expenditure and health needs. Eventually both older adults with 5,001-10,000 and 10,001-20,000 income have higher services' needs. Most of older adults especially the baby boomer generation are still capable of working productively, thus, they continue to be active providers of their family. In contrast to the result of the study, according to Natividad (2005) most older Filipino adults face financial insecurity due to low (or no) pension benefits and increasing health-related expenditures.

The expenditure needs of older adults are "much needed" and the highest score among the expenditures is food for it is essential and the main source to maintain healthy body nutrition. The findings are consistent with the assisted living facilities checklist for the baby boomers posited by Parsanko (2010), among these are: comfortable home-life, environment, medical expertise and resources and meals. Older adults perceived that their expenditure capabilities to spend basic necessities such as food, clothing and shelter are "to a large extent". Expenditure capabilities to purchase medicine is "average", while the expenditure capabilities of older adults to purchase foods, clothes, payables and acquire own house are "good". This means that older adults are willing and capable to spend their money on food, clothes, bills and house which are basic expenditures. This shows that no matter what age they are tend to spend much on food. Hayes and Finney (2013) in their study on the patterns of expenditure among older adults- emphasized that older adults have lower than average expenditures and spend less on non-essential such as recreation. The expenditures on food and non-alcoholic drink increase as one ages, however expenditure for housing, fuel and power doubles over the age range. It is also reported that the expenditure pattern of older persons in health steadily increases with age. It captures around 10 percent of the budget for those between 50-64 years old but increases to about 20 percent for those 85 years old and over (Hayes & Finney 2013, Sudipto, 2012).

With the changes the respondents experience on their health, they feel the need to improve their well-being. The older adult generation desire to live longer and be more active than the generation before them. Stephens et al., (2015) argue that the capability of older persons to achieve the valued functioning was of high importance regardless of physical health status. The health capabilities of older adults are all perceived to be "average". However, longevity increases the necessity to treat chronic problems and injuries (Skeltona, 2010). Since deterioration of functions results from the process of aging, it is logical and expected that the health needs related to physical fitness, mental fitness, social vitality, anticipation of future health problems, performance of functional activities such as being able to stoop, crouch, kneel without experiencing pain improved upper and lower body strength and balance range of motion and functional performance were perceived by the respondents as "much needed" if they were to continue to have productive lives. Medical care needs the support of the family and the lack of fulfilling this can cause senility, feelings of rejection, marginalization and expulsion by society (Dziechciaz, Guty, Wojtowicz, Filip 2012). Phelan & Larson (2002) claims that freedom from disability, independent functioning, life satisfaction, active engagement with life, longevity, positive adaptation, mastery/growth is necessary to age successfully. Also, Rowe & Kahn (1997) found that low probability of disease and disease-related disability; high cognitive and physical functional capacity; and active engagement with life are necessary for successful aging. In contrast, health capabilities of the respondents are perceived to be at "minimal extent". Understandably, elders reaching retirement age can no longer perform the way they do during their prime age. Therefore these minimal capabilities in given health activity situation are still indicators that they are physically fit. It is noteworthy to mention that the older adults still rank physical fitness as the highest health capability, an indicator of their being healthy and physically capable. It is in this light that Gerontology Nursing curriculum must be strengthened and fortified in areas of principles in the care of the older people in terms of wellness, health promotion, chronic illness, recovery and rehabilitation and quality of life.

The social network needs are perceived to be "moderately needed". Older adults engage in social networking for online interaction and socialization. It may have a great implication on developing the task of adjusting to or transcending the changes going on to maintain the feelings of well- being. Peck (1968) expanded the eight stage of Erickson's ego integrity versus despair into these stages; ego differentiation versus work role occupation and body transcendence versus body preoccupation (Ignatavicius & Workman, 2005). The latter stage (body transcendence versus body preoccupation) can be resolved by focusing on the satisfaction obtained from inter-personal interactions and psychosocial actions. The social networks capabilities are perceived to be "to a large extent" However, the capabilities to join senior citizen group and formation of own group in the community are "minimal extent". Along with old age is the need for contact with family and friends increases (Dziechciaz, et al. 2012). However, the results on health capabilities, with the mean score of 2.52 being "somewhat" is alarming. As posited earlier developing ego integrity which is the developmental task of an older adult (Erickson, 1963) and which was expanded by Peck (1968) can be resolved by focusing on the satisfactions obtained from interpersonal interactions and psychosocial actions. Thus, if the older adults were to develop ego integrations, their social network capabilities should increase again. This calls for government actions to enhance the active role they play in the society as productive, contributing members.

Understandably, free hospitalization and 20% discount in all establishments are ranked to be the top perceived service needs of the respondents since older adults are prone to illness and ailment because of old age and body deterioration. Among the privileges enjoyed by the older adults are 20 percent discount on medical and dental services, and diagnostic and laboratory fees including professional fees of attending doctors in all private hospitals and medical facilities; and grant of educational assistance to pursue post-secondary, tertiary, post-tertiary as well as vocational or technical education (RA 7462, 1992; RA 7876, 2010). The perceived services capabilities of the respondents are "to a large extent" As reflected, the services capabilities were measured in terms of the capability of the government and non-government institutions in providing services. It is good to know that both the bureaucracy and the private sector join hands in providing for the health services of the elders, as established by their response "to large extent" to their health and services' needs. However, it suggested a follow-up study should be made on how to improve or make better the services for and privileges of the senior citizens with regard to the realization to the total and integral senior citizen development towards the next 2nd half of this 21st century.

According to the 2000 Philippine Census, the most dominant living arrangement of older adults was living with a child. The study showed that half of the participants lived as extended family of their family. The limited living space, even shared with their children and grandchildren, were among the reasons why the participants preferred to have their own house. A house that has nursing facilities is perceived to be much needed by the respondents since most of the Filipino older adults live with the family (Kuan, 1993, Racelis et al., 2012). Filipino culture underscores the importance of *utang na loob* (debt of gratitude) that children and grandchildren will never allow their aging parents and close relatives to be neglected because older adults in the Philippines are expected to be cared for by their family. This is also reflected on the capabilities of the older adults. The respondents' housing capabilities are to a "minimal extent". The findings imply that most of the older adults have still a need to have their own houses. As perceived by the older adults housing is "much needed" for them. After reaching a retirement age from work, there is still a minimal need to acquire a house and live with the family and the desire to have a free housing for older adults from the government and NGO's. This indicates that not all the retired older adults were able to establish a house for their family in the entire duration of their employment time. A further study is suggested on the role of the government and non-government organizations in providing comfort to the life of the older adults.

Gaps Identified in Gerontology Nursing

Based on the results of the study, the researcher identified gaps in Gerontology Nursing. The existing curriculum in Gerontology nursing was examined and compared to the results of the study. Gaps were identified after comparing the existing needs and capabilities included in the curriculum and the results of the study. The assessment of health, expenditure and housing needs of older adults are not included in the care of older adults. Older adults' health, expenditure and housing needs are of great importance because if the health of older adults are compromised there will be an increased morbidity and mortality in the aging population. Older adults without housing will be displaced from home and be placed in institutions of home for the aged. Gender, civil status, number of children, income and educational attainment are also considered important variables in determining the needs and capabilities of older adults. All of these variables must be included in the present curriculum. For instance, the American Association of the College of Nursing recommended the Baccalaureate Competencies and Curriculum Guidelines for Nursing Care of Older Adults. The guidelines stipulate that nurses must intervene to assist older adults and their support network to achieve personal goals based on the analysis of the living environment and the availability of the community resources. They must utilize resources and program to promote functional, physical and mental wellness in older adults (AACN, 2010).

Proposed Curriculum Enhancement for Gerontology Nursing

The needs and capabilities of older adults are different and there was a gap between the existing gerontology nursing curriculum and the perceived needs of older adults. Based on the gaps identified in the study, a proposed curriculum in Gerontology Nursing is proposed. The proposal includes (1) assessment of barriers for older adults in receiving, understanding and giving information, (2) utilization of resources/programs to promote functional, physical and mental wellness in older adults, (3) collaboration with other health care professionals (doctors, physical therapist, nutritionist) to meet the basic needs of older adults, (4) safe and effective transitions across level of care, including acute community-based, and long term care (e.g. home, assisted living, hospice, nursing homes), (5) provisions of living environment for older adults (assisted living, homecare, hospice), (6) respect in the variations of care, the increased complexity and the increased use of healthcare resources inherent in caring for older adults, (7) the use of Evidence-based geriatric assessment instruments 8) The use of valid and reliable tools to guide nursing practice for older adults, (9) generational, family role changes, and cultural patterns that potentially impact communication with older adults, (10) livelihood programs to increase financial capability of older adults, (11) assessment of the living environment as it relates to functional, physical, cognitive and psychological and social needs of older adults.

Conclusions

The older adult's needs and capabilities are different when compared according to gender, civil status, number of children and educational attainment and it is important in the assessment process and must be included in the curriculum. The capabilities of older adults must be maintained highly to ensure that older adult's present and future needs are met. The gaps identified in the Gerontology Nursing curriculum must be the bases for curricular enhancement.

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RESEARCH ARTICLE

Pressure Ulcer Prevention in Acute Care using the Pressure Ulcer Bundle of Care






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Abstract

A study was conducted to determine the effectiveness of the pressure ulcer bundle of care (PUB) in preventing pressure ulcers among patients in acute care. The pre and post-test quasi-experimental design was utilized to predict a model of preventing pressure ulcer in acute care setting. Thirty acute care patients with moderate risk for pressure ulcers were randomly selected to receive the following five PUB interventions: assessment of pressure ulcer risk, repositioning, head elevation, heel elevation, and frequent diet monitoring. Pressure ulcer risk was assessed using the Braden risk assessment scale before and after PUB interventions. This scale assesses important aspects of ulcer formation according to six subscales: sensory perception, moisture, mobility, physical activity, nutrition, and friction/shear. Profile of the patients according to age, sex, and length of hospital stay was described using frequency and percentage distribution. Bundle compliance, as measured by performance of the five interventions was described using mean scores and standard deviations. The t-test was used to determine the differences in pressure ulcer risk or occurrence between pre- and post-intervention phases. Multiple linear regression analysis was used to determine the relationship of Pressure Ulcer Risk Assessment Scores (PURAS) to the PUB, and to identify the predictor(s) of PURAS among the four interventions in the PUB. Statistical significance was considered at the .05 level. Pressure ulcer risk scores of patients improved significantly from "mild risk" to "not at risk" post-PUB ($p=<0.001$). Head elevation, heel elevation, and diet monitoring were found to be predictors of pressure ulcer risk scores after PUB interventions. Repositioning was not significantly associated with pressure ulcer risk scores of patients after PUB interventions. The three predictor model revealed the PUB interventions were able to account for 52% of the variance in pressure ulcer risk scores, which indicates a strong significant relationship between patients receiving PUB and their improvement in pressure ulcer risk. In conclusion, the pressure ulcer bundle of care intervention is effective in prevention of pressure ulcers in patients at risk. Nurses should adopt the provision of bundle of care intervention(s) to enhance patient safety and quality of care.

Key words: *Bundle of care, Pressure ulcer, Prevention, Acute care*

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Introduction

Bundle of care is the most common term used in the group of nursing intervention given to patients requiring care. The bundle of care has continuously become famous in providing quality patient care around the world. Evidenced based researches proved the effectiveness of the bundle of care. A bundle of care is a grouping of evidence-based practices that individually improve care, but when applied together, result in substantially greater improvement (Institute for Healthcare Improvement, 2012). Pressure ulcers are socio-economic and affects health of patients that has an important financial impact, with its prevention being less costly than its treatment. Pressure ulcer treatment ranks third among the most expensive health treatments, less expensive only than cancer treatment and heart surgery (IHI, 2012) Pressure ulcers (PUs) are serious and costly complication for many individuals with reduced mobility and sensation. Clinical observations and research have demonstrated staggering costs and human suffering because of PUs, including profound negative effect on general physical effect, socialization, financial status, body image and level of independence and control. The International Pressure Ulcer Prevalence Study from 2006 to 2009 demonstrated a change in PUs prevalence in the U.S. healthcare facility population. Overall, PUs prevalence was slightly lower in 2009 than in 2006. Pressure ulcers is reasonably preventable condition; it was assumed that pressure ulcers would generally not develop on patients receiving care according to current evidence guidelines. Unfortunately, although international guidelines for pressure ulcer prevention recommended a wide range of measures, the evidence for the effectiveness of many of these measures is fairly weak.

The European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) created guidelines that summarized evidence-based guidelines on pressure ulcer prevention and treatment. The goal of the international collaboration was to develop evidence-based recommendations for the prevention and treatment of pressure ulcers. The clinical guideline evidences showed weak evidences in the international and the national clinical guidelines. A systematic review was conducted to determine effectiveness of repositioning in preventing pressure ulcers. The study results revealed that there were limited evidences that suggest repositioning was effective in preventing pressure ulcers (Henzel et al, 2011). There were also studies conducted to predict validity and effectiveness of the Braden risk assessment scale and other assessment scale to predict pressure ulcers. Braden scale in clinical practice was highlighted as a very useful instrument to predict pressure ulcer development or occurrence. The use of this instrument permitted knowledge on patients' individual risks and the early establishment of preventive nursing actions in line with this risks (Latini, et al. 2011). The Pressure Ulcer Bundle (PUB) of care is considered effective at preventing pressure ulcers based on studies by Gray-Siracusak and Schrier (2012), Baldelli and Paciella (2008), and Gibbons, Shanks, Kleinhelter, and Jones (2006). Each nursing intervention was believed to contribute to the prevention of pressure ulcer.

However, the results of the studies indicated that health science do not yet have evidence for the efficacy of pressure ulcer bundle of care in preventing pressure ulcers. Further investigation and consideration of current Evidence-Based Practice (EBP) is vitally important in the development and implementation of prevention, treatment and rehabilitation strategies for PUs. Although international guidelines for pressure ulcer prevention recommend a wide range of measures, the evidence for the effectiveness of many of these measures is scarce.

To ensure that the measures recommended by international clinical guidelines lead to reduction in pressure ulcers in the national setting, it is critical to confirm if the pressure ulcer bundle of care measures is effective and implemented. Confirming the effectiveness of pressure ulcer bundle of care five interventions are appropriate in

preventing pressure ulcers. In this premise, it is necessary to conduct investigation. The study aimed to determine the effectiveness of the pressure ulcer bundle of care in preventing pressure ulcers among patients in acute care setting. The results of the study will suggest model to prevention of pressure ulcer in acute care setting.

Study Framework:

The study framework (Figure 1) utilized the five PUB interventions: assessment for pressure ulcer risk scores, repositioning, head and heel elevation, and frequent diet monitoring in pressure ulcer prevention. Utilizing pre and post research design the effectiveness of the PUB intervention was determined. Patient with "mild risk" to pressure ulcer was subjected to the five interventions to determine the effectiveness of the bundle of care or each of the nursing intervention to the prevention of pressure ulcer.

Method

Research Design

The study utilized the pre and post quasi-experimental research design to determine the effectiveness of the Pressure Ulcer Bundle (PUB) of care and predicts a model of preventing pressure ulcer in acute care setting.

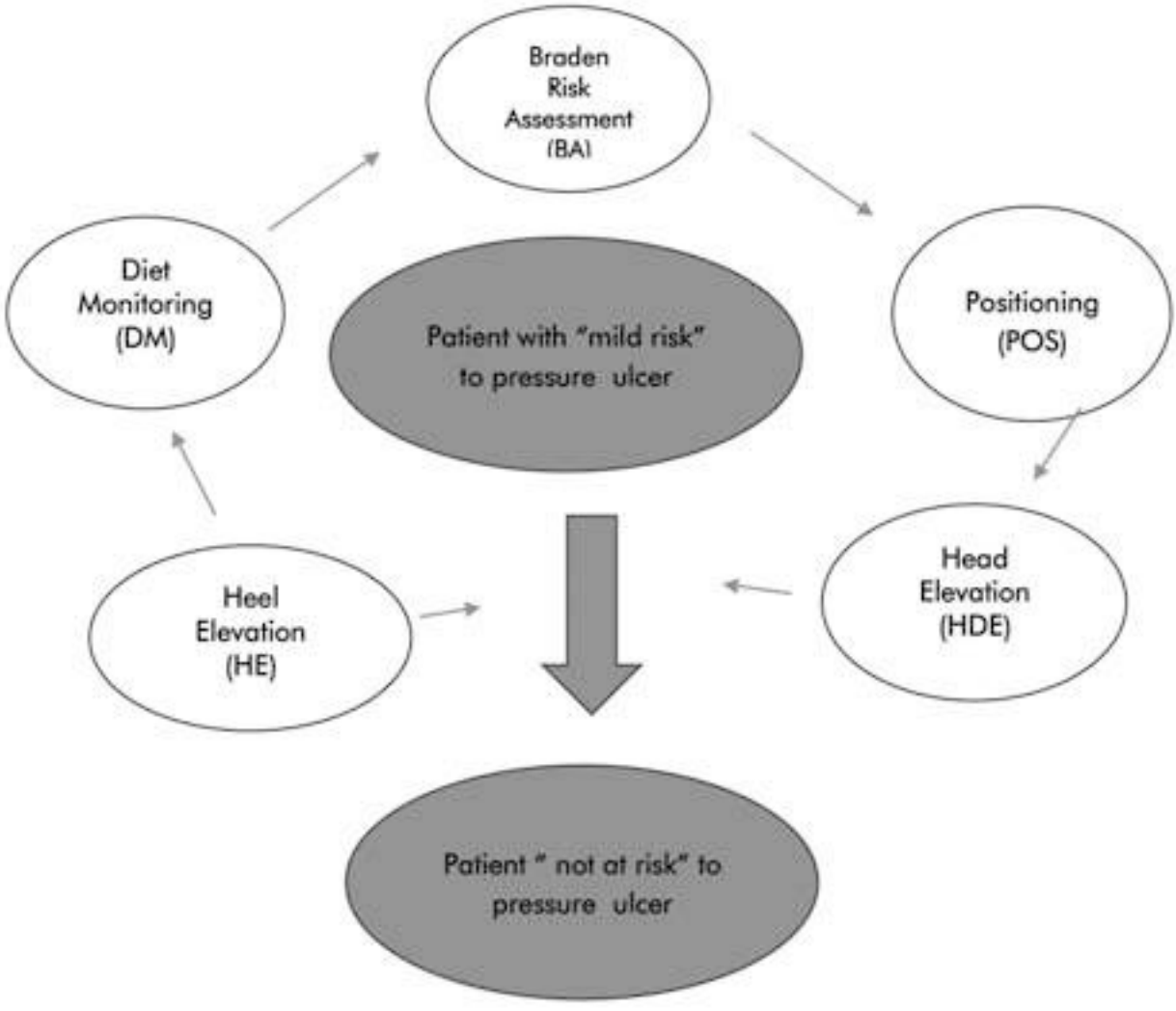

Figure 1. *Pressure Ulcer Prevention Using the Pressure Ulcer Bundle of care*

Participants

Thirty acute care patients confined in the Medicine ward of the Quirino Memorial Medical Center was randomly selected and consented to participate in the study. Selection criteria in the study were patients with debilitating disease, who were bed-bound (impaired mobility), and had been hospitalized for a minimum of 5–10 days. These 30 patients had no pressure ulcers at the time of first assessment, but were all considered to be "mild risk" for pressure ulcer development based upon their Braden risk assessment score at admission.

Ethical Clearance

Our research study complied with ethical rules for human subject research. The study was reviewed by the Centro Escolar University (CEU) Institutional Review Board (IRB) and Quirino Memorial Medical Center (QMMC) IRB. After receiving approval from both IRBs, medical record review was conducted at QMMC after obtaining written informed consent from the patients selected for study inclusion.

Data Collection

Patients' pressure ulcer risk scores were measured using the Braden risk assessment scale before and after the PUB interventions. The Braden risk assessment scale assesses important aspects of ulcer formation according to the following six parameters or subscales: sensory perception, moisture, mobility, physical activity, nutrition, and friction and shear. Each of these parameters was rated from 1 to 4, except friction and shear, which was rated on a scale of 1 to 3. Thus, the maximum score would be 23, and the minimum would be 6. The Braden risk classification is as follows: mild risk = 15–18; moderate risk = 13–14; high risk = 10–12; and very high risk < 9. Hence, the lower the score is, the more severe the risk for developing a pressure ulcer. The Braden risk assessment scale was adopted from studies by Serpa, Santos, Campanti, and Queros (2011); Cox (2012); and Tescher, Brander, Byrne, and Naessens (2012). The instrument has undergone repeated testing with varying reports of inter-rater reliability (Cowan, Stechmiller, Rowe, & Kairalla, 2012). Cowan et al. (2012) reported Braden Scale inter-rater reliability with Cronbach's alpha of 0.83 to 0.99, with specificity between 64% and 90% (with cutoff risk scores of 18 or less), and sensitivity ranging from 83% to 100%.

Bundle compliance for repositioning patients was assessed using a positioning checklist (POS), and rated as follows: 5 = very frequent intervals, 4 = frequent intervals, 3 = moderate intervals, 2 = less frequent intervals, and 1 = not at all. Bundle compliance for head and heel elevation were assessed using head elevation (HDE) and heel elevation (HE) checklists, with ratings of: 3 = frequent intervals, 2 = moderate intervals, and 1 = not at all. Bundle compliance for diet monitoring was assessed using a diet monitoring (DM) schedule checklist, with ratings of: 3 = frequent intervals, 2 = moderate intervals, and 1 = not at all. Three experts in nursing practice and education validated the four checklists (POS, HDE, HE, and DM). Cronbach alpha of 0.81 revealed that the four checklist are highly reliable for use in this study.

Procedure

The effectiveness of the PUB was evaluated by implementing five interventions in the pressure ulcer bundle of care. Data from medical record review determined the profile of the patient according to age, sex, and length of hospital stay. Patients were assessed for pressure ulcer risk, repositioned, received head and heel elevation at frequent intervals, and their diet was monitored frequently. Researchers were assigned to assess pressure ulcer risk of study patients. Pressure Ulcer Risk Assessment Scores (PURAS) of patients were obtained before and after PUB interventions; Braden risk assessments (BA) were performed on patients during the PUB intervention. The rest of the bundle of care (repositioning, elevating the head of the bed to 30 degrees, heel elevation, and diet monitoring) was performed by the nurse counterpart assigned to the study patient. The nurse counterparts were Registered Nurses, who participated in the study by performing the nursing interventions in the PUB. These nurses also validated the PURAS obtained by the researchers

by acting as rater B in the performance of pressure ulcer risk assessments. The nurse counterparts visited, performed, and monitored the patient for PUB compliance every day during the patient's hospital stay. The researcher monitored PUB compliance every other day of the patient's hospital stay.

The research study was divided into three phases. In the pre-intervention phase, nurses were oriented to the PUB interventions, screening patients for eligibility, and patient selection using the Braden risk assessment scale following study inclusion criteria. Patient PURAS were measured before the PUB interventions. The mean PURAS obtained by Rater A (researcher) and Rater B (nurse counterpart) was used to describe the PURAS of patients before PUB interventions. Changes from baseline data were used to determine effectiveness of the pressure ulcer bundle of care in preventing pressure ulcers.

In the intervention phase, patients received the five PUB interventions depicted in Figure 2 below followed by detailed descriptions of each.

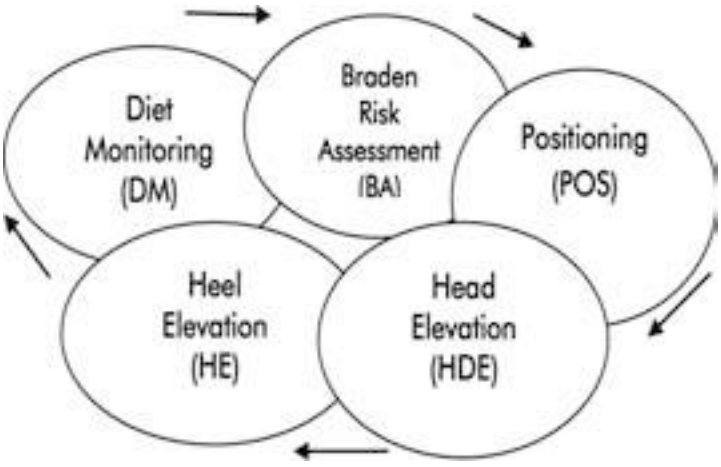

Figure 2. *Pressure Ulcer Bundle of Care*

Braden risk assessment (BA) denotes monitoring of patients for pressure ulcer using the Braden risk assessment scale. After obtaining baseline risk assessments during the pre-intervention phase, patients were assessed for pressure ulcers thrice during their hospital stay to determine risk of developing pressure ulcers. The researcher recorded the BA scores and interval frequency in the patient's BA record.

Positioning (POS) involved repositioning bed-bound patients every 2 hours. Nurse counterparts assigned to the care of patients were educated on repositioning techniques that included proper postural alignment, distribution of weight, balance and stability, and pressure redistribution. A written repositioning schedule was posted at the bedside for use as a guide in repositioning schedules. The nurse counterpart documented repositioning frequency and adoption of specific position in the patient's POS checklist. Lifting devices (e.g., trapeze or bed linen) were used to move patients rather than drag them during transfers and position changes. Hospital standards were followed regarding turning of patients (i.e., reposition every 2 hours as follows: 8 a.m.–10 a.m. flat on bed; 10 a.m.–12 p.m. right side; 12 p.m.–2 p.m. flat on bed; 2 p.m.–4 p.m. left side; 4 p.m.–6 p.m. flat on bed; 6 p.m.–8 p.m. right side; 8 p.m.–10 p.m. flat on bed). Nurses assigned to the care of the patient documented repositioning schedule with frequency and position used in the patient's POS checklist.

Head elevation (HDE) denotes elevation of the head of the patient's bed to 30 degrees. Nurse counterparts assigned to the care of patients were educated and performed HDE, and documented HDE frequency in the HDE checklist.

Heel elevation (HE) involved positioning the patient to redistribute pressure. Nurse counterparts assigned to the care of patients were instructed to have patients use a pillow as a footrest when in bed, thereby relieving pressure from the heels. Nurse counterparts documented frequency of HE in the patient's HE checklist. The researcher retrieved records of repositioning from the patient checklists (POS, HDE, and HE).

Diet Monitoring (DM) involved daily monitoring of diet for every patient at risk of pressure ulcers throughout their hospital stay. Nurse counterparts

assigned to the care of patients documented the frequency of diet monitoring in the patient's DM checklist. The researcher retrieved records of DM from the patient's DM checklist.

The post-intervention phase followed the intervention of the pressure ulcer bundle of care. Patient PURAS were measured after PUB interventions. The data were used in comparison with baseline data to determine the effectiveness of the PUB in preventing pressure ulcers. As was done during the pre-intervention phase, both the researcher and nurse counterpart measured PURAS after PUB interventions. The mean PURAS obtained by Rater A (researcher) and Rater B (nurse counterpart) were used to describe the PURAS of patients after PUB interventions. Patient PURAS before and after the PUB intervention were compared.

Internal validity of data was ensured using the following methods: 1) researchers visited patients and nurse counterparts in QMMC every alternate day during the whole duration of the intervention phase; 2) PURAS of patients before and after interventions, including the BA of patients during the PUB intervention, were measured during the patient's hospital stay by the researcher, with validation by the nurse counterpart; 3) mean PURAS of patients were used to present the PURAS before, during, and after PUB intervention by getting the average of the PURAS ; and 4) data captured in the BA record, POS checklist, HDE checklist, HE checklist, and DM checklist were utilized to provide validation of data collection and to ensured that data were recorded during the PUB intervention.

Data Analysis

Statistical Package for Social Science (SPSS) software version 19 was used for data processing and analysis of data. Profile of the patients according to age, sex, and length of hospital stay was described using frequency and percentage distribution. Bundle compliance, as measured by performance of the five interventions (BA, POS, HDE, HE, and DM) was described using mean scores and standard deviations. The t-test was used to determine the differences in pressure ulcer risk or occurrence between pre- and post-intervention phases. Multiple linear regression analysis was used to determine the relationship of PURAS to the PUB, and to identify the predictor(s) of PURAS among the four interventions in the PUB.

Results

The profile of study patients according to age, sex, and length of hospital stay are displayed in Table 1. The majority of patients was 51–60 years of age, male, and confined to QMMC for 5–10 days.

Table 1. *Patient Characteristics (N = 30)*

Variables	Frequency	Percentage
AGE		
19 and below	2	6.7
20–30	2	6.7
31–40	7	23.3
41–50	5	16.7
51–60	9	30.0
61–70	2	6.7
71 and above	3	10.0
SEX		
Male	20	66.7
Female	10	33.3
HOSPITAL STAY		
5–10 days	22	73.3
11–15 days	8	26.7

The Bundle of care element compliance is depicted in Table 2. The mean Braden assessment score of patients was 17.34, which is interpreted as mild risk. Patients were repositioned at very frequent intervals, as reflected by the rating of 4.85 out of 5 (POS checklist). The heads of patients' beds were elevated to 30 degrees at frequent intervals (every 8-hour shift or thrice a day), as reflected by the mean rating of 2.67 out of 3 (HDE checklist). Patients' heels were elevated at frequent intervals (every 8-hour shift or thrice a day), as reflected by

the mean rating of 2.66 out of 3 (HE checklist). Patients' diets were monitored at frequent intervals each day, as reflected by a mean rating of 2.67 out of 3 (DM checklist).

Table 1. *Patient Characteristics (N = 30)*

Variables	Mean ± SD	Verbal
Interpretation		
Braden assessment	17.34 ± 1.78	Mild risk
Positioning frequency	4.85 ± 0.15	Very frequent intervals
Head elevation	2.67 ± 0.88	Frequent Intervals
Heel elevation	2.66 ± 0.29	Frequent Intervals
Diet monitoring	2.67 ± 0.88	Frequent Intervals

Table 3 shows the PURAS of patients before and after intervention. As shown in Table 3, prior to the intervention study patients had slightly limited sensory perception (mean, 3.31; scale of 1–4); very moist skin (mean, 2.79; scale of 1–4); "bed fast" activity (mean, 1.73; scale of 1–4); very limited mobility (mean, 2.80; scale of 1–4); probably inadequate nutrition (mean, 2.35; scale of 1–4); and a problem in friction and shear (mean, 1.89; scale of 1–3). The resulting PURAS mean was 15.13, which is interpreted as mild risk. After the PUB intervention, study patients had no impairment in sensory perception (4.00 mean; scale of 1–4); occasionally moist skin (mean, 3.83; scale of 1–4); "chair fast" activity (mean, 2.80; scale of 1–4); slightly limited mobility (mean, 3.20; scale of 1–4); adequate nutrition (mean, 3.80; scale of 1–4); and a potential problem in friction and shear (mean, 2.43 ; scale of 1–3). The resulting PURAS mean was 19.90, which is interpreted as not at risk for pressure ulcer development.

Significant differences were observed in all six subscales of the Braden risk assessment scale from pre-intervention to post-intervention. The total Braden score was also significantly higher post-intervention in comparison to pre-intervention ($p = 0.010$). The five interventions in the pressure ulcer bundle of care were effective as measured by the difference in Braden scores of study patients before and after the intervention.

Table 3. *Pressure Ulcer Risk Assessment Scores (PURAS) of Patients*

Braden scores	Pre-intervention Mean ± SD	Verbal Interpretation	Post-intervention Mean ± SD	Verbal Interpretation	t value	Sig.
Sensory Perception	3.31 ± 0.82	Slightly limited	4.00 ± 0.00	No Impairment	-4.54	p=0.0010*
Moisture	2.79 ± 1.01	Very Moist	3.83 ± 0.38	Occasionally Moist	-6.43	p=0.0010*
Physical Activity	1.73 ± 0.79	Bed fast	2.80 ± 0.62	Chair fast	-7.15	p=0.0010*
Mobility	2.80 ± 0.71	Very Limited	3.20 ± 0.70	Slightly Limited	-3.89	p=0.0010*
Nutrition	2.35 ± 0.94	Probably Inadequate	3.80 ± 0.48	Adequate	-7.91	p=0.0010*
Friction and shear	1.89 ± 0.50	Problem	2.43 ± 0.49	Potential Problem	-5.67	p=0.0010*
Total	15.13 ± 2.22	Mild Risk	19.90 ± 1.81	Not at Risk	-9.21	p=0.0010*

* Statistical significance was set at $p < .05$

Table 4. *Pressure Ulcer Risk Assessment Scores related to Four Interventions in the Pressure Ulcer Bundle of Care (N = 30)*

	Zero-Order r					β	sr^2	b
Variable	DM	HE	HDE	POS	PURAS			
POS					.229	.019	.053	.229
HDE				0.20	.464*	.074*	.215	.464
HE			.986*	.032	.496*	.079*	.246	.496
DM		.986*	1.00*	.020	.464*	.074*	.187	.464
						Intercept= .118		
Mean	2.67	2.66	2.67	4.86	19.9			
SD	.288	.290	.288	.15			R^2 =	.524*

* $p < .05$

Multiple linear regression analysis was used to develop a model for predicting PURAS of patients from the four PUB interventions (BA, POS, HDE, HE, and DM). Basic descriptive statistics and regression coefficients are shown in Table 4. Three of the four interventions had a significant effect ($p < .05$) in the full model; positioning had no significant effect in the model. The three predictor model was able to account for 52% of the variance in pressure ulcer risk scores of patients after the PUB interventions.

Discussion

Pressure Ulcer Risk Assessment Scores (PURAS)

PURAS of patients improved significantly from mild risk pre-PUB intervention to no risk post-PUB intervention on the Braden risk assessment scale. Braden risk assessment scores are predictive of a patient's pressure ulcer risk before and after intervention with the pressure ulcer bundle of care in this study. As shown in the findings of Serpa et al. (2011), Costa & Caliri (2011) and Satekova & Ziakova (2014), the predictive validity of Braden score for pressure ulcer risk in critical care patients revealed very good accuracy. However, Cox (2012) suggested that just four of the Braden subscales (sensory perception, mobility, moisture, and friction and shear) were associated with an increased likelihood of pressure ulcer development; whereas, physical activity and nutrition subscales were not found to be predictive. Tescher et al. (2012) expressed that the total Braden score is predictive of pressure ulcer development, but it does not assist the clinician in identifying a target population; however, the use of the subscale scores can enhance prevention programs and resource utilization by focusing care on the risk factors specific to the individual patient. The Braden subscale scores were utilized in our study, but their use was limited to the evaluation of the effectiveness of the PUB in preventing pressure ulcers.

Pressure Ulcer Bundle of Care (PUB)

Patients were assessed for pressure ulcer risk, repositioned, received head and heel elevation at frequent intervals, and their diet was monitored frequently. It is conclusive that patients received the five interventions in the PUB at frequent intervals. It is inferred that three PUB interventions (head elevation, heel elevation, and diet monitoring) were significantly associated ($p = 0.012$) with the prevention of pressure ulcers as revealed by the significantly improved pressure ulcer risk scores after the PUB intervention. In this study, as well as

those cited within this paper, 1) the Braden risk assessment scale was found to be effective at measuring PURAS of patients, and 2) Braden assessments, head and heel elevation, and diet monitoring were effective at improving PURAS and preventing pressure ulcers (Reddy, Gill, & Rochen, 2006; Krapfl & Gray, 2008; Bluestein & Javaheri, 2008). The PURAS was significantly higher after the PUB intervention in comparison to pre-intervention in our study. Head elevation, heel elevation, and diet monitoring were found to be predictive of PURAS after the PUB interventions. The results are consistent with the result of the findings of Kimberly et al (2007), Baldelli & Paciella (2008), Young et al, (2010),Gray-Siracusa et al (2011) Cecile et al (2012), and Carson et al (2012). However head elevation is not found effective in the study of Cong et al (2012) and Estilo et al (2012). Positioning had no significant relationship with PURAS of patients after the PUB interventions. While repositioning is a mainstay in most pressure ulcer prevention protocols, there is insufficient evidence to recommend specific turning regimens for patients (Reddy, et al. 2006, Cecile et al. 2012 and Carson et.al 2012. The three predictor model revealed that the PUB interventions were able to account for 52% of the variance in the pressure ulcer risk assessment scores.

Conclusion

The three PUB interventions that included head elevation, heel elevation, and diet monitoring were effective in preventing pressure ulcers, while repositioning was not found to be effective in preventing pressure ulcers. Nurses should adopt the provision of bundle of care intervention(s) to patients in acute care settings to enhance patient safety and quality of care. Because of study limitations, the results may be applicable only to patients involved in this study. Additional research is needed to investigate the effectiveness of providing groups of nursing interventions (bundles of care) in a larger patient population, in a variety of care settings, using a complete set of evidence-based interventions to prevent pressure ulcers.

About the Authors

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NEWS FEATURE

Profiling Dr. Barcelo, the Outstanding Professional Nurse of 2015

Gerelyne Reboroso, RN
PNA Program Manager

Dr. Teresita Irigo-Barcelo has the much-coveted distinction of being Professional Regulation Commission (PRC)'s Outstanding Professional Nurse for 2015. This prestigious award was given to her for having demonstrated high levels of competency and integrity, her significant contribution to the advancement of the nursing profession, and effective discharge of the profession's social responsibility through meaningful contribution/participation in socio-related activities. The colorful awarding ceremonies were held at the Manila Hotel, One Rizal Park in Manila last June 18, 2015.

An Unparalleled Professional Competence

Through her years of unselfish service to the nursing profession and nurses, she was deservingly hailed as the Anastacia Giron Tupas (AGT) Awardee year 2000, the highest award given by the Philippine Nurses Association (PNA) to perpetuate AGT's legacy as the founder of the Filipino Nurses Association (FNA).

She is currently the Dean of Centro Escolar University (CEU) College of Nursing, a Professorial Lecturer of University of the Philippines Manila College of Nursing (UPCN), University of Sto. Tomas Graduate School (UST-GS) and University of the Philippines Open University (UPOU). She served as the Vice Chancellor for Academic Affairs of UPOU.

The Outstanding Professional Nurse of 2015 is a certified Maternal and Child Nurse (MCN) specialist. She has also served as the President of the UST Nursing Alumni Association. She is a nationally acclaimed nursing researcher, a training program developer, workshop facilitator and speaker on various issues.

A Life of Meaning

Apart from the exceptional professional life she has in the academe, she has also been a woman of service. was a member of the Commission on Higher Education-Technical Committee on Nursing Education (CHED-TCNE), 2010-2014 and the National President of PNA, 2009-2011, country representative to the International Council for Nurses (ICN) and World Health Assembly.

As President of the PNA, she led the purchase of the building for its Headquarters, initiated the implementation of systems and processes in the PNA, and led the advocacy for exploited nurses. She has attended various seminars representing the PNA here and abroad.

Not only is she active in these organizations, she's also adept at sharing her knowledge through the number of books she's written. She published books in Maternal and Child Nursing, Nursing Research, Nursing Curriculum and Reproductive Health, and modules on Distance Education. She has also published several articles in professional nursing journals and developed video-CDs related to nursing and education.

Social Responsibility

She has participated in socio-civic activities particularly as lecturer/resource speaker on women's health and natural family planning. She has received community recognition as national finalist of Metrobank Outstanding Teacher Award by Metrobank Foundation & Outstanding Women Leader in 2012 by the City of Manila.

Dr. Barcelo is a proof of a living hero in this modern time. She is more than her achievements and awards. She is a true leader and advocate. She is a nurse with a compassionate and dignified heart that allowed her to contribute to the nursing profession in ways many could only dream of.

"Science at its best can help us listen to the cry of the earth."

• Manila Archbishop Luis Antonio Cardinal Tagle

Philippine Nurses Association, Inc.
PHILIPPINE JOURNAL OF NURSING

FEATURE ARTICLE

Remembering The Lady with the Lamp

Maria Bernadette R. Daplas, RN, MAN, EdD

The sculpture of Florence Nightingale

Traveling has always been a part of my annual routine during semestral breaks or summer vacations. The 19 years of teaching in the College of Nursing has taught me to slow down and unwind. It helps me revitalize before another school year or semester opens. Last October 2014, the opportunity to have another European tour, this time, in the United Kingdom – England, Scotland and Wales came. Part of my itinerary in London, the vibrant capital city of England, is the opportunity to see the grand palaces, the Tower Bridge, the Parliament and the Big Ben, the abbeys, and the museums. Like any other tourist, those are the places that I also want to see. But something seemed deficient, and I kept on thinking for I know that there is something in London that I need to see. Then I finally realized FLORENCE NIGHTINGALE! I almost forgot a well-known figure and a significant place in the history of the nursing profession where Florence Nightingale has begun to modernize the nursing practice. And so, I allotted a day out of my official days of tour to trace, appreciate and see before my eyes what I have so far only seen in books about the history and the life of the Lady with the Lamp.

My first day in London was dedicated to visiting the Florence Nightingale Museum. This place was established to preserve the traces and pieces of her noble works; honor her great accomplishments; and recognize her exceptional traits. The museum is situated inside the vicinity of St. Thomas Hospital, an institution that she funded to establish in 1860. It is also situated in the very same place where she established the Nightingale Training School for Nurses.

As I entered the museum, a sculpture of Florence Nightingale captured my eyes. This sculpture was made by Sir John Steel, a famous Scottish sculptor in 1862. He was commissioned by the British army and was paid for by its soldiers.

In the interior, the collection of more than two thousand valuable pieces that honor Florence's life and vocation made me recognize and admire her more.

As a person, she has always been known and described as a strong-willed lady. Most references reveal how she defied her parent's wish when she chose to continue her calling to become a nurse. Her determination to overturn the unsanitary and inhumane condition, the outbreak of diseases and high death rates during the Crimean War manifest her enormous courage.

The author at the frontage of the Florence Nightingale Museum

St. Thomas Hospital in Lambeth Palace Rd, London

But inside the museum, I have also seen the soft side of her. She does not only have a heart for the ill and the poor people but even for God's smallest creations. Florence rescued an owlet while she was in Acropolis, Athens. She named it Athena after the Greek's goddess of wisdom. The owl became her constant companion, resting in her shoulder or in her pocket. It was during the Crimean War, and her absence coincided with the death of her pet owl. This made her very upset. Florence even wrote "poor little beastie, it was odd how much I loved you". Her pet Athena is preserved in a glass cage.

Florence's pet owl, Athena

Despite her seriousness to pursue her true calling, Florence' adventurous side is clearly seen from her travels and collections. A snake skin and rock specimen from her visit in Italy, her travel journals while traveling Greece, a record of sites visited and miles traveled in Egypt, a letter sent home while traveling the Nile and a wooden headrest given by an Arab sheikh who was impressed by her courage traveling the Nile using a small boat are well maintained in the museum.

Florence's travel collections

Being a nurse is her true passion, and is imbedded with her. Even at a very young age she was active in philanthropy and ministering the poor and the sick. Her impressive work when she took a hospital job after returning to London in 1850 had promoted her to superintendent within just a year of being hired.

She also rose to her calling when asked to organize a team of nurses to tend the sick soldiers in Crimea. When they arrived at the site, she reversed

A Turkish lamp that Florence used during her nightly rounds

Earliest copy of Florence's Notes on Nursing

A collection of hospital floor plans, Florence' inscription to architects and a book on sanitary conditions of hospitals

the inhumane and unsanitary condition in Scutari, in the British based hospital. Using hundreds of brushes, they cleaned the floors and ceilings, she spent every minute caring for the soldiers and during the dark nights, she moved in the hallway carrying a lamp and doing her rounds. This last attribute had made her known as the "Lady with the Lamp", and it greatly convinced me that the story behind the lamp is not just a fairy tale but absolutely true. I was so fascinated to see before my eyes the Turkish lantern or fanoos used in Scutari during the Crimean War displayed in an enclosed glass. It is believed to be carried by Florence during her nightly rounds in the ward. Artists often illustrate her holding a Greek lamp or a genie lamp, but only just to put in a sentimental image.

And lastly as a leader, she was fiercely determined, and dedicated to improve health care and alleviate patients' suffering. Nightingale continued her work even during her later life, homebound and bedridden.

The museum proves this trait, as they hold the earliest known copy of her internationally bestselling book, Notes on Nursing, which was published in 1860 to help ordinary women to care for their family. It includes many practical hints on diet and stressed the importance of cleanliness and hygiene.

Other notable collections are the hospital floor plans and the script of Florence's advice for building a healthy hospital. She has not only studied the hospital designs in Britain and across Europe but she was often consulted by architects and doctors from across the world. Florence knew that bad design would weaken the best nursing and medical care. A book on sanitary conditions of hospitals was also finely kept. Florence served as an authority on public sanitation.

The traces of valuable materials about the origin of the Nightingale Training School, wherein she became actively and personally involved in the 1870s, were also well preserved. She set reforms in nursing education, as seen from the collections of the following: a copy of regulations of Nightingale Training School, a memorandum to the ward sisters which enumerate the duties expected from Nightingale probationers, list of courses that a student needs to learn, and the introduction of lectures and examinations. These helped revolutionize the nursing education system.

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FEATURE ARTICLE

Methodology and Methods: Why the Confusion amongst Novice Researchers

C. Patricia Mazzotta, RN, BScN, MScN[1]

Introduction

As I embark on a new chapter in my life as a doctoral student, I find myself amidst vast amount of terminology, concepts, and new ways of viewing and conducting nursing research. I consider myself novice in the field of research; theoretical perspectives and quantitative studies influence my worldview, mainly because of my areas of practice and past education. Hence, I realize I need to challenge my thinking and myself if I am to embrace a fluid approach in order to appreciate diverse standpoints especially when the concepts are abstract and unfamiliar to me. For instance, terms such as *methodology and method* are interchangeably utilized in the research world and maybe confusing for a novice like myself. Therefore, it is imperative for researchers to understand the terms *methodology*, and *method* if we are to conduct studies that are credible and generate new knowledge.

The goal of this paper is twofold, one, a reflective piece whereby I provide a brief explanation of my experience with research and therefore, my understanding of *methodology* and *method*. The second part of this paper examines diverse perspectives on how researchers define *methodology* and *method* and lastly, I will summarize what I have gleaned from both parts of this paper and what it means to me as a doctoral student as I contemplate the type of research I will conduct.

My Understanding of Methodologies and Methods

As I reflect on my practice and the influence research has had on me as a critical care and trauma nurse, I am aware that working in a teaching hospital limited my understanding of qualitative research; the reason being was that quantitative research influenced our interventions and directed our care. I felt comfortable knowing physicians and drug representatives would *tell me* what I needed to know. Although, I was always cognisant of how I nursed and took great pride in establishing meaningful connections with clients and their loved ones. I was influenced by a particular view of science, that of natural science. Until the moment that forever changed my perspective of qualitative research, it happened a

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few years ago when a 19 year old was brought to the trauma room; he had been shot in the chest. I remember talking to him when he arrived and in a matter of 15 minutes, I knew him as a person.

Despite heroic measures, we were unable to save his life. I sat in silence with his mom; 40 minutes later, she turned to me and asked, "Were you kind to him?" I said, "Yes, I was," I proceeded to tell her about her son. I realized at this moment that science could not capture the meaning of this interaction and a scientific environment was insufficient to the manner in which I practiced as a nurse. I am not a doctor, I am a nurse, and as such, I should complement medicine without losing the essence of who I am. It was at this point that, I began to challenge the status quo in my environment and became a consumer of research. Appreciating the importance of integrating evidence-based practice founded on the best research evidence (Burns & Grove, 2011) was fundamental and congruent within a critical care environment-one dominated by science. Rather than viewing research as a dichotomy of quantitative versus qualitative, I immersed myself into trying to extend my understanding of the importance of both approaches in an environment where nurses and doctors relied heavily on science and technology to keep a patient alive. What was evident to me was that quantitative research could not capture the essence of life experience or meaning. Therefore, nurses must educate themselves in diverse methodologies to extend their knowledge of nursing research that informs their care and patient outcomes.

My Master of Nursing Program introduced me to my first qualitative research course. I began to understand the importance of understanding epistemology (interpretation)- (Streubert Speziale & Rinaldi Carpenter, 2007) the theory of knowledge (Polit & Beck, 2008, p. 13) and ontology (interpreter) (Streubert Speziale & Rinaldi Carpenter, 2007)-"what is the nature of reality" (Polit & Beck, 2008, p. 14) and the influence both of these terms have on *methodology* and *method*. For example, ontology consists of multiple truths; the participants themselves construct these truths because it is their own reality (Polit & Beck, 2008). The epistemology is the interaction that occurs between the researcher and participant and knowledge interpreted; essentially epistemology is embedded within a theoretical perspective and methodology (Polit & Beck, 2008). Meaning, that *methodology* is the research design itself, and the research question determines the type of *methodology* one should use. Therefore, the *method* is the techniques used by researchers to gather and analyze the information in order to answer the research question (Polit & Beck, 2008). The manner in which *methodology* and *method* was introduced to me in my master's program is consistent with my doctoral program.

Contrasting my graduate programs, my undergraduate nursing research course solely focused on quantitative research and statistics. The term *methodology* was explained as either "quantitative or qualitative" (Burns & Grove, 2011). In one lecture, I learned what qualitative *methods* were, for instance *methods* are the *types* of qualitative research (designs), for example, "phenomenological, grounded theory, ethnographical and historical research" (Burns &Grove, 2011, p. 21). *Methods* were not considered the *how to* of research; rather *methods* were what I now understand are *methodologies*. This caused great angst for me in my graduate studies because I was confused by how researchers used the terms methodology and methods interchangeably. As my confidence and knowledge evolved I was able to differentiate between the two concepts, however, what was illuminating for me was the importance of conceptually defining these two terms for consistency and avoid ambiguity. This required me to relearn concepts and familiarize myself with the proper terminology, definitions, and application of concepts.

What Do The Researchers and Literature Say?

As a novice researcher, I often encounter barriers to understanding research. One of the reasons is because researchers who conduct studies use the terms methodology and method interchangeably. For instance, Crotty (1998) suggests constructing a research proposal does not have to be complex if the researcher asks what *methodology*, and *method* the researcher is conducting and how are they justified. Crotty (1998)

simplifies these questions by emphasizing the method is *how* data is collected and analyzed; the *methodology* is the process of carrying out the study. Embedded within methodology is the theoretical perspective which gives structure and meaning to the study by providing the philosophical underpinning that will guide the study. The epistemology is rooted in the theoretical and *methodology* of the study (Crotty, 1998) because knowledge is generated. Similarly, Carter and Little (2007) posit that *methodology* provides researchers the means of understanding how research should proceed, in addition, a theoretical underpinning helps justify the *method*. The authors define *method* to include "sampling, data collection, data management, data analysis and reporting" (Carter & Little, 2007, p. 1318). Petty, Thompson and Stew (2012) expand on both Crotty, Carter and Little's definition of *methodology* by reiterating that *methodology* is inclusive of theoretical, political, and philosophical underpinnings. These concepts influence social research and have implications to *methods* employed by the researcher. However, Petty et al's (2012) definition of *methods* is a simpler one, whereby, they suggest *methods* are the tools of data collection and analysis. Congruent with the aforementioned examples is Byrne (2001) who suggests that grounded theory is a *methodology* and its research *method* include resources that a researcher employs to yield information regarding social interaction, in essence, the collection of data, analysis, and dissemination of findings.

In contrast, Burns and Grove (2011) use the term *research approaches* to describe the types of methodology for instance in quantitative research, they include "descriptive, correlational, quasi-experimental, and experimental" (p. 34) and in qualitative research "phenomenology, grounded theory, ethnographic and historical research" (Burns & Grove, 2011, p. 73). These authors consider *methodology* to mean "quantitative, qualitative and outcomes research" (Burns & Grove, 2011, p. 3), this is very confusing, because when I reflect on the definition of *methodology* according to Burns and Grove (2011), I think of the assumptions underpinning quantitative and qualitative research. Similarly, Munhall (2012) refers to qualitative research *methods* as having something to offer "as research paradigm" (p. 61) which leads me to believe she is referring to *methods* as the assumptions of qualitative research and not the *methodology* that constitutes methodological designs. This approach is congruent with my earlier understanding of *methodology*. Burns, Grove and Munhall's definitions of *methodology* and *method* are misleading to researchers and without taking advanced courses in research, I would be reading studies and interpreting them erroneously.

In summary, it is impossible for me to capture the enormity of the barriers facing novice nurse researchers when experts use terminology interchangeably. I often find myself thinking for extended periods and wonder if I have made a mistake in the manner I have interpreted a study based on how researchers have used certain terms. Nevertheless, I must be mindful that a researcher's worldview influences how they use terminology and interpret concepts. Research continues to evolve, therefore, a researcher may hold biases because of their education and training they received from their mentors, hence, influencing how they conduct studies. This does not mean studies are wrong, rather, I realize I have a responsibility to understand the terms, be able to analyze and interpret what the researcher is communicating, because in doing so, I become increasingly knowledgeable and am able to determine the credibility of a study.

As a researcher I must be aware of my own biases, I realize this is vital for me as an educator and doctoral student to avoid influencing others perception of research. For example, my comfort lies within a positivist paradigm, because my practice experience and professor influences have been with quantitative studies, maybe this is why I feel the need to have a conceptual definition that clearly defines *methodology* and *methods*. However, as I transition as a doctoral student, I understand what is most important is not what methodology I am comfortable with, because ultimately, the research question is what guides research *methodology* and thus *methods*. Therefore, as a researcher I must be cognisant in that, I may need to step out of my comfort zone in order to appreciate the diversity within the world of nursing research.

About the Author

C. Patricia Mazzotta is a full time Professor in the RPN to BScN Bridging to University Nursing Program at Centennial College in Toronto Canada. Currently she is enrolled in the PhD Nursing Program at the University of Victoria, British Columbia, Canada. She has a research interest in 'Mentorship of expert nurses and (re)enacting compassionate and wholistic care for nurses practicing in Emergency/Trauma units.' Patricia's clinical expertise includes Coronary Intensive Care, Emergency, and Trauma nursing. She was a point of care nurse for over 17 years; her passion includes mentoring, curriculum development, transformational teaching, and learning.

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Remembering the Lady....(from page 73)

At the end of my visit, it made me realize that this short but memorable visit to the Florence Nightingale Museum had deepened my thoughts about Florence Nightingale. It gave me the opportunity to know her more:

- As a person who is often described as strong-willed and courageous lady but has a soft heart for the poor and the ill.
- As a nurse who is committed to her vocation, who shows compassion to the sick and the dedication to her craft surely entitles her to another name, as the Angel of Crimea.
- And as a leader who caused an enormous transformation in the field of health care, particularly in nursing, a once dishonored job but revolved into an honorable profession.

Truly, the legacy of Florence Nightingale, her life and her works, is worth commemoration and celebration.

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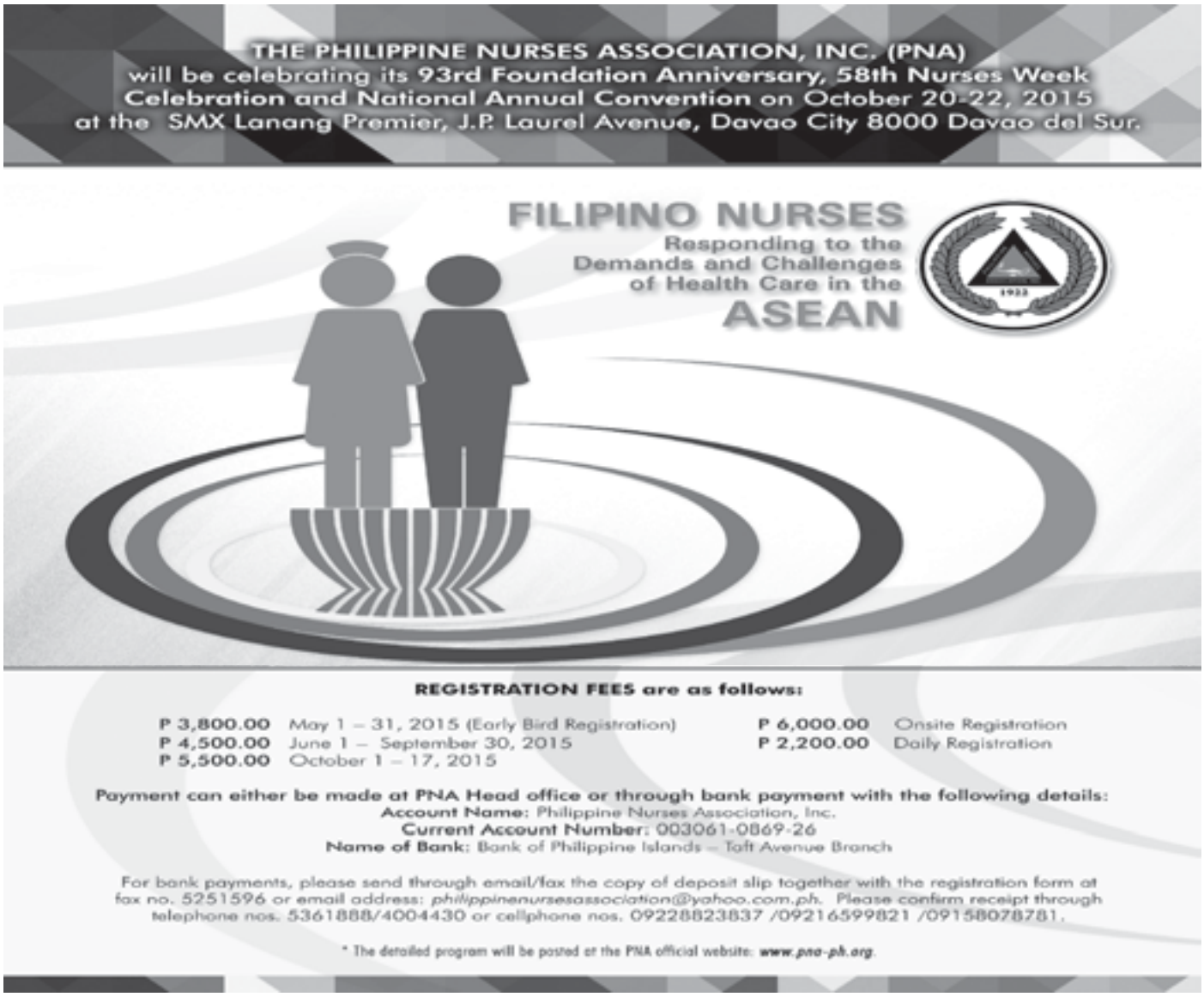
Maria Bernadette R. Daplas, EdD, RN is a faculty member of the College of Nursing and the College of Nursing Graduate Studies of De La Salle Health Sciences Institute. She is the author of Nursing Education across Asian Cultures ....the trend in East Asia where her passion and her professional interest in nursing education and research, transcultural nursing and global nursing trends is revealed. She also served her institution as the former level 4 coordinator for nursing and former vice dean of the College of Nursing and School of Midwifery. She is actively involved in nursing related committees, research/ thesis advising and a member of the Technical Review Panel in the undergraduate and graduate nursing program of her institution.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Theme: "Innovative Strategies for Nursing Education, Practice and Research"

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PNA HYMN

We pledge our lives to aid the sick
To help and serve all those in need
To build a better nation that is healthy and great

We'll bring relief to every place
In towns and upland terraces
In plains and hills and mountains
We shall tend all those in pain

Beneath the sun and stormy weather
We shall travel on
To heed the call that we must be there
With our tender care

We pray the Lord to guide our way
To carry on our work each day
And grant us grace to serve the sick
And love to help the weak

Cover of the Philippine Journal of Nursing Volume 85, Issue #1

The theme for this issue of the Philippine Journal of Nursing (PJN) is Advancing People's Health through Nursing Research. The cover briefly outlines the contents of the issue, as well as the relevant affiliating organizations. The front cover contains three main elements: an abstract human person whose body and arms are depicted by an arrow pointing upwards. The human person is standing in front of the planet earth. Behind the earth, representing the environment upon which the human person lives, is the sun shining brightly. These images are befitting of the theme of the issue. It emphasizes the human person as a focus of nursing, and how nursing research, represented by the sun, shines the light on the person by way of advancing their health (depicted by the arrow). The image of the planet earth also gives emphasis to the importance of the environment. Additionally, the main colours used for these images, namely, white, blue and yellow further complement the three elements, as these colours represent growth and creativity, security and trust, and, the scientist who constantly learns (Olesen, 2015). **Dr. Edward Venzon-Cruz**

Reference: *Olesen, J. (2015). Color meanings – Learn about colors and symbolism. Retrieved from Color Meanings - Learn about Colors and Symbolism*

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