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RESEARCH ARTICLES

- A Voyage to the Twilight: Exploring Death Preparation among the Elderly
- Factors Related to Self-Care Among Older Persons of Makassarese Tribe, Indonesia
- The Integration of Spiritual Practices in Nursing Care
- Enhancing Community Motivation and Participation in Control of Smoking
- Level of Empowerment of Staff Nurses in Selected Private Hospitals in Cavite
- Filipino American Nurses' Knowledge, Perceptions, Beliefs and Practice of Genetics and Genomics
- A Concept Analysis of Mentoring

CASE STUDIES

- Utilizing Levine's Conservation Model in the Care of Patient with Lithium Toxicity: Caring Beyond the Symptoms
- The Champion: Conquering the Challenges of Bipolar Disorders

FEATURE ARTICLES

- Tita Rillorta & Her Life of Service
- Sister Remy Angela Junio, SPC: A Model of Faith and Exemplary Leadership

NEWS FEATURE

- PNA hosts the 1st Nurse Consultant Training on PMDT

LIVING RESEARCH:

Inspiring and Enhancing Patient Care and Service Delivery

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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

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Editorial

Living Research: Inspiring and Enhancing Patient Care and Service Delivery

There is no doubting the significance of research in our constant pursuit of knowledge. Our journey in living research might be riddled with ambiguities and uncertainties but still, we embrace and continue living research. We derive inspiration in our journey as we witness patient care and service delivery enhanced and improved. There are no blueprints, but we earn various significant insights through our day by day excursions. We engage in reflexivity towards a more responsive research journey, not only to inform us on how we shape our profession, our communities, our clients, and our world, but also for the consequences of what we do and how we live research.

This issue of the PJN presents articles that reflect how we *live* research. Robles' study, *The Integration of Spiritual Practices in Nursing Care*, describes the integration of spiritual practices in nursing care as a basis for developing a framework of nursing care management. The framework that was developed highlighted God's presence in the midst of relational, integral, moment, and spaces of presence. Sana's work, *A Voyage to the Twilight: Exploring Death Preparation among the Elderly*, relates that the informants' diverse concepts of death, the grieving process, their cultivated philosophies, and support system played major roles in helping them prepare for life's "twilight." The research could help us understand meanings of death and aging and make us better nurses of the elderly. Irwan and Balabagno's article on *Factors Related to Self-Care among Older Personsof Makassarese Tribe, Indonesia* details the relationship between Basic Conditioning Factors (BCF) to Knowledge, Attitude and Practices (KAP) on self-care, aiding nurses in conducting a complete and accurate practice of self-care among the elderly. The relationship of low education to self-care shows that "there is a need to create more interactive interaction among older persons and nurses, especially for women elderly to ensure enough time for clarification of the treatment and getting more information on self-care."

Mariano et al.'s *Level of Empowerment of Staff Nurses in Selected Private Hospitals in Cavite* is about the staff nurses today who feel empowered in their workplace. The research showed that empowering leadership ease feelings of burnout among nurses. Nurse supervisors are inspired to "uplift the staff nurses' level of empowerment in their workplaces because empowered nurses are effective nurses". Meanwhile, Saligan and Rivera's article, *Fillipino-American Nurses' Knowledge, Perceptions, Beliefs and Practice of Genetics and Genomics,* is an attempt to respond to the problem of"limited information on the knowledge, perceptions, beliefs, and practice, about genetics and genomics among Filipino-American nurses. It revealed that "Filipino-American nurses wanted to learn more about genetics and were willing to attend genetics/genomics trainings if offered by PNAA" signaling the role of PNAA and/or other nursing interests groups to incorporate genetics and genomics information in their educational programs.

On the other hand, Daenseekaew, et al.'s study, *Enhancing Community Motivation and Participation in Control of Smoking, using Participatory Action Research (PAR) approach*, identifies several strategies for enhancing community motivation and participation in smoking control in one municipality, in the north-eastern part of Thailand. The study is profuse with lessons learned by the communities, such that "health problems and high cost of cigarette were the greatest motivation for success, but suffering from smoking withdrawal symptoms attributed to unsuccessful quitting of tobacco."

Bascos explored the importance of mentoring though an extensive review of literature. The article, *A Concept Analysis of Mentoring*, shows that mentoring pushes personal and professional growth in mentees. Mentoring plays a central role in the development of novice nurses as they integrate theoretical concepts into their practice and its benefits are apparent in the increasing competency of nurses locally and globally. *Living research is also shown in two case studies presented during the Grand Case Presentations organized by the Philippine General Hospital Nurses Association. The two case studies, Utilizing Levine's Conservation Model in the Care of Patient with Lithium Toxicity: Caring beyond the Symptoms and The Champion: Conquering the Challenges of Bipolar Disorders,* showcase what and how it is to be a nurse – caring beyond symptoms and caring from the heart.

The two nurse exemplars' performances in leadership and serving the people are testimonies of living research. Sister Remy Angela Junio urges nurses "to continue touching lives and sustain passion to help all nurses in efforts to innovate and discover what is new from what is ordinarily seen. "Tita Rillorta's" life of service" unfolds the story of a dedicated community health nurse, who despite and in spite of having little, inspires us to never stop serving our community.

This issue shows that we shape our profession by living research in our practice. We are at the core of our health care systems, yet we are marginalized when it comes to decision making and health policy making. It is time to make a change. We need to live research to have the evidences and use these not only to improve our situation, but also the lives of those we serve as well.

ERLINDA CASTRO-PALAGANAS, PhD, RN

"The importance of doing away with the inappropriate and unnecessary conflict between quantitative and qualitative methodological approaches needs greater recognition. It is extremely dysfunctional when these research approaches are viewed as competing or mutually exclusive."

Dean, Kreiner et al., 1993, p. 229

PHILIPPINE NURSES ASSOCIATION, INC.

President's Message

Warmest greetings to all!

My personal commendations to the hardworking publication staff for the coming up with this PJN July-December 2014 issue with the theme: "Living Research: Inspiring and Enhancing Patient Care and Service Delivery". Living research means engaging on it, applying it, appreciating it.

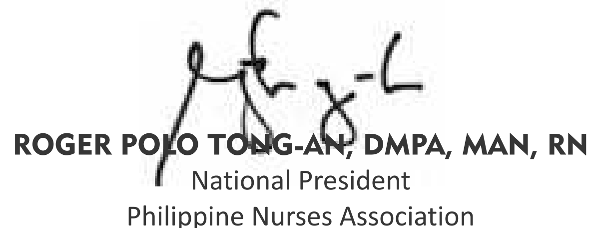
Nursing research is a highly significant component to the health care field. Nursing research helps implement new changes in the life long care of individuals and is used to develop treatments that provide the most optimum level of care. Nursing research always employs a holistic approach and views the treatment of the patient, family members, and caregivers as a whole. By utilizing such approach, quality of care is enhanced and the patient will receive the best care.

PNA has been recognizing the value of evidence-based practice and use of the results of research to the extent greatest possible to select intervention techniques and other procedures that have evidence of effectiveness. Professional nurses are accountable to society for providing high-quality, cost-effective services. Thus, we strive to provide the leadership, in partnership with our stakeholders, to keep searching for new and more effective ways to serve our people.

The health field makes significant advances every day. With nursing research, these new changes will continue to be implemented. New therapies and treatments will ultimately bring faster and more effective healing and treatment, and better quality of life to the patients who need them most. More outstanding researches and discovery means less disease, fewer illnesses, more vaccines, and a better quality of life for the community as a whole.

We have always to be reminded of roles expected of us: as caregiver, communicator, teacher, client advocate, counselor, change agent, leader, manager, case manager and a researcher.

May this PJN issue fan more the flames within us to continue treading the challenging, intriguing, but rewarding world of research. *"Mabuhay tayong lahat! Mabuhay ang mga Pilipinong Nars!"*



ROGER POLO TONG-AN, DMPA, MAN, RN
National President
Philippine Nurses Association

Research Article

The Integration of Spiritual Practices in Nursing Care

Sofia Magdalena N. Robles, PhDNEd, RN

Key words: *Spiritual care, spiritual practices, nursing care*

Abstract

Image source: http://annualcouncil.dioms.org/

The intent of this study was to describe the integration of spiritual practices in nursing care that could be a basis for developing a framework of nursing care management. The paper utilized a mixed method research design: qualitative approach was used through focused group discussion (FGD) and interviews with staff nurses affiliated with certain tertiary hospitals in Metro Manila selected through purposive sampling. Thematic results from the responses shared by the key informants were processed. These results consisted of the following: (a) Interpersonal relationship with God and personal outlook on values; (b) Caring for the Spirit; (c) Actualization of spiritual care; and, (d) The mission of meaningful service.

A spirituality tool was developed based on the emerging themes and was given to each nurse. The tool revolves around seven elements: general manifestation in rendering spiritual care, specific manifestations in rendering spiritual care, recipients of spiritual care, appropriate time in rendering spiritual care, venue for rendering spiritual care, relevance/meaning of spiritual care and institutional support. The statistical treatment of the spirituality tool shows that nurses practice/concur with the spiritual care at all times.

The framework on the Integration of Spiritual Practices in Nursing Care points to God's presence in the midst of relational presence, integral presence, spaces of presence and moment presence. Hence, this study puts emphasis on the integration in nursing care of spiritual practices where God's presence is visible.

Introduction

Nursing is a vocation that dwells on rendering holistic care to the patient. Addressing the wholeness of the human dimensions becomes a great challenge to nurses because of the tendency to focus only on what the job description states, namely: monitoring vital signs, giving medications, transcribing doctors' order, attending to the gadgets attached to the patient such as the task of fixing, removing, and, collaborating with other teams, to name a few. These things are necessary but there is a growing need to integrate the spiritual practices in nursing care to realize its holistic imperative. Neuman (in Pesut, 2008) emphasized that "nursing is concerned with the whole person, including the following dimensions: Physiological, Psychological, Socio-cultural, Developmental and Spiritual." Each dimension should be addressed, but oftentimes, the spiritual aspect is neglected.

In 2000, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) mandate**d** that each client admitted to an institution's care must be assessed for spiritual beliefs and practices (Kozier, 2008, p. 1048). In the Philippines, spiritual care is offered as an elective in the

nursing curriculum (CHED, 2009). It is also part of the Nurses' Code of Ethics and the core competency of the Board of Nursing (BON). However, there is no existing standard or guidelines on how to render spiritual care or on how to systematically do it.

Nurses identified patients' spiritual needs as religious beliefs and practices (prayer); absolution; seeking connectedness, comfort and reassurance; and healing or searching for meaning and purpose. The interventions initiated by nurses to meet patients' spiritual needs include: respecting privacy; helping patients to complete unfinished business; listening to patients' concerns; comforting and reassuring; using personal religious beliefs to assist patients; and observing religious beliefs and practices (Narayanasamy et al., 2004 as cited by Barber, 2008). But according to Jenkins (2009), there are nurses who are uncomfortable in providing spiritual care for their patients for several reasons: nursing is too biological; professionalism is synonymous with distancing; more emphasis is placed on technology than holistic care; and, nurses may be uneasy about their own spirituality. Nevertheless, “the neglect of spiritual needs of patients could have serious implications for their overall illness adaptation, particularly in extreme physical conditions” (O'Brien, 2011).

The different spiritual care practices obtained from the nurses during the focused group discussion (FGD) could be the basis for developing a framework for the integration of spiritual practices in nursing care in the Philippine setting. This framework could also enhance the practices in spiritual nursing care.

Research Questions and Objectives

The objectives of this study are: (1) to describe spiritual practices in nursing care; and, (2) to develop a framework on the integration of these practices to nursing in the Philippine context. In order to achieve these objectives, the paper addressed the following questions:

1. How is spirituality perceived by the nurses in the study in relation to nursing practice?
2. How are spiritual practices integrated in the nurses' provision of care to the patients?
3. What are the implications of these practices to the nurses' provision of care to the patients?

Methodology

This study utilized a mixed method research design. The study began with a focused group discussion (FGD) in order to understand the nurses' perception on spirituality in nursing care and how they addressed the spiritual needs of the patient. The development of the spirituality tool was the summary of the nurses' responses from the focused group discussion while the development of the framework was the combination of the emerging themes and the result of the descriptive comparative result of the spirituality tool from the three selected tertiary hospital.

Participants of the Study

The participants of this research were the registered nurses, male and female, ages 22-45 years, have been in the institution for a year to five years and working in selected participating tertiary hospitals in Metro Manila, Philippines. The inclusion criteria were the following: participants are registered staff nurses working in the identified participating tertiary hospitals willing to participate and handle adult medical surgical patients from critical and non critical areas. Only staff nurses doing bedside care were included. Excluded are nurses with managerial position, nurses handling pediatric clients and those assigned in Operating Room, Delivery Room and Out-Patient Department.

For FGD participants, a total of 33 participants were divided according to their respective institutions. There were 431 total respondents on the spirituality tool that was distributed in the three selected tertiary hospital.

Research Instrument and Instrument Validity

The research instrument that was developed by the researcher was generated from the findings of the FGD of the nurses from the three selected tertiary hospitals. The generated findings of the four FGD revolved on the nurses' understanding of spirituality, spiritual care, how spiritual care is being actualized. The significant findings of the FGD were grouped according to the main elements that emerged: what nurses are doing in spiritual care, how exactly nurses are rendering spiritual care, who are the recipients of this spiritual practices, when is spiritual care being rendered, when is the appropriate time in giving spiritual care, why nurses do spiritual care and what is the support offered by the institution in giving

spiritual care. The elements are the main categories around which the content of the spirituality tool revolved while all the statements under each main theme were lifted from the sharing of the participants during the FGD. The spirituality tool is a four - point scale with seven elements that consist of 64 items.

The reliability of the instrument underwent face validity and content validity by 38 experts in the field. The validation of the instrument came from the following: Roman Catholic nun, who is a nurse by profession, currently assigned in the infirmary ward, a lecturer who is a Seventh Day Adventist, teaching spiritual care as a nursing elective in the college of nursing, six (6) clinical instructors assigned in medical surgical adult wards and thirty (30) staff nurses assigned in medical surgical adult wards from both critical and non critical areas coming from an institution which has the same criteria set by the researcher but not included in the study. The six clinical instructors and thirty staff nurses had varied religious affiliation namely, Roman Catholic, 7th Day Adventist, Born Again Christian, Protestant and Jehovah's Witnesses.

The pilot testing results showed between .94 - .99. Reliability and stability of this instrument were established in the developed spirituality tool.

Ethical Consideration

In the observance of ethical principles, anonymity of the participants was protected while a number coding was used to represent the participating hospitals. Informed consent was also gathered before the FGD. Participation was voluntary and did not involve any monetary payment. The participants were also given the right to withdraw anytime the participants felt uncomfortable during the process.

The Internal Review Committee (IRB) of The Medical City granted the approval to conduct the study. The IRB committee required a protocol consent form where it was stated that participants, who were the nurses, could strengthen the spiritual practices in the institutions.

Data Collection and Analysis

The inquiry involved the following:

Phase I: Qualitative focused group discussion (FGD). The first phase aimed to solicit the perception of the participants' views on spirituality and spiritual practices in nursing care. Four FGDs at the three selected hospitals were conducted. Results were analyzed through thematic analysis that resulted to four emergent themes and ten sub themes.

Phase II: Quantitative Instrument Development. The four emergent themes were used for the development of the spirituality tool. The spirituality tool focuses on the actualization of spiritual practices using a four-point Likert scale.

Phase III: Descriptive-Comparative Result. Purposivesampling was used before the spirituality tool was administered to the nurses of the three selected tertiary hospitals. Using weighted mean, standard deviation and ANOVA, data yielded a descriptive - comparative result that described and compared the participants' attitudes and practices on the different spiritual practices in nursing care.

Phase IV: Framework Development. The fourth phase was the development of the framework on spiritual practices in nursing care. The framework was developed from the results of the FGD and the survey using the spirituality tool.

RESULTS AND DISCUSSIONS

Qualitative Results

The FGD yielded four emerging themes and ten sub-themes. It revolved around the following themes: identifying spirituality with God and personal values; defining spiritual care; how spiritual care is practiced; and, the effects of spiritual care.

Theme 1: Interpersonal relationship with God and personal values

The recognition of God in identifying spirituality was evident in the sharing of participants. This shows the belief of nurses on God as a Father and creator. They believed that connectedness with God helped developed good values as God is perceived as the model of goodness. The belief in God and the application of good values in life is closely associated with the perception of spirituality.

1.1 A personal connection with God

The participants perceived God at the core of spirituality and they represented it as connectedness with God, relationship with God, being one with the Lord, respect for the beliefs, faith and belief in the divine power or something greater than the self.

A participant (P6H2) stated, "Spirituality means integrating spiritual things that include faith, beliefs in God and entrusting unseen things that make us strong." "Spirituality, as a personal concept, is generally understood in terms of an individual's attitude and beliefs related to transcendence (God) or the non material forces of life and nature" (Emblen ,1992 as cited by O'brien, 2011, p. 5).

1.2 A personal outlook on values

The participants also associated the understanding of spirituality with their personal outlook on values. According to the participants, spirituality deals with goodness, holiness, guidance to know what is right and wrong as well as having a clean conscience.

According to a participant, "Spirituality means being true to your self and having a clean conscience, doing what is right and what is best" (P7H3)[1]. According to Murray and Zenter (1989), "Spirituality is defined as a quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any good."

Theme: 2. Caring for the spirit

Participants shared mostly the understanding of spiritual care as an act of doing or practice that respects the faith and beliefs of a person. Caring for the needs of the spirit means that one needs to look after the beliefs, faith, and practices of a patient.

2.1 Unconditional care

Participants viewed the meaning of spiritual care as unconditional care that provides compassion, and wholehearted caring, respect patients as human beings, helping them recover from anxiety and caring for them with a personal touch. One participant noted: "Spiritual care is a personal touch and concern on the spirituality of others" (P6H2).

2.2 Attending to the needs of the spirit

Attending to the needs of the spirit that pertains to faith and beliefs was done by providing time for worship or prayer. In other words, "Attending to the needs of spirit is respecting the belief of each individual no matter what their religion is and acknowledging who and what each believes" (P5H3). According to the participants, caring for the spirit also involves "Care that is based on patients' spiritual relationship, respect for practices, integrating spirituality like prayers, leading patient to Jesus Christ, respecting religious belief of each individual, and introducing a Christ - like character." Lim (2010) in his lecture said that "spiritual nursing includes whatever gives meaning, worth and value to the mind and body, effecting and affecting the healing process".

Theme 3: Actualization of Spiritual Care

The participants gave a comprehensive description on how spiritual care is practiced: how they did it, to whom this care was rendered, when and where was the appropriate time and place to render spiritual care, what was the relevance of spiritual care and what institutional support was obtained in providing spiritual care.

3.1 Bridging the needs of the Spirit

In bridging the needs of the spirit, the nurses serve as a channel through the use of the senses: observing the patients' religious practices, talking to or interviewing patients regarding preferences in relation to cultural practices, and listening to what their spiritual needs are. In particular, "During admission we ask for their religion and their practices to find out if there are special preparation/needs based on their religion" (P1H3).

3.2 Not One Left

Spiritual care is intended for everybody that includes the ill and the well, according to the participants. "Not one left" means that everyone has the opportunity to receive spiritual care, not only the identified patients who are dying, palliative, hospice, terminally ill, depressed, hopeless patient but even patients who are well. Even the "happy and grateful patients like for example patients for discharge, need spiritual care" (P9H2).

This implies that critical, non - critical and well patients including patients who are for discharge from hospital confinement can be recipients of spiritual care. However, researches reveal that majority of patients feel that spirituality or religion

[1] *P (Participant), H (Hospital)*

only becomes more important when a person is ill. They believe that rituals can help people when they are ill or suffering and consider it helpful for health professionals to know their beliefs.

3.3 Best time, time speaks; grounded in a peaceful environment

The generalized preferred place in rendering spiritual care is a quiet and peaceful environment where patients could meditate, pray, and reflect. On the other hand, the best time to give spiritual care is the time when the patients are ready and request it. Nurses can get the cue that patients need spiritual care during nurse patient interaction. One participant said that, "Every time we interact with the patient is the best time to give spiritual care" (P2H1). This implies the importance of nurse - patient interaction that gives nurses an opportunity to assess patients' spiritual needs.

3.4 Supplement the spiritual needs; filling the gap

As described by the nurses, spiritual needs were addressed through prayers, referral to chaplain or minister of choice, serenading with Christian songs, and respecting dietary special request related to religion, to mention some. Meanwhile, hospitals encourage nurses to practice and develop spiritual care by "providing them culture and sensitivity seminar, to help the nurses address the kind of caring for patients with different religions" (P1H1). The provision of sensitive and effective care to persons from cultures that are different from their own requires two things: "1. an awareness of one's own cultural values, beliefs, and recognition of how they influence the attitudes and behaviors; and, 2. understanding of the cultural beliefs and values of others and how they influence them" (Wintz and Cooper, 2009). The respect for patients' culture is important.

Theme 4: The mission of meaningful service

Spiritual care has a great effect on both patients and nurses. The mission of meaningful service is a representation of an evaluation on how the spiritual care impacts nurses and patients.

4.1 A comfort that brings life

Comfort that brings life refers to the effects of spiritual care on patients. As described by the participants, this sub-theme is manifested in various ways: patients look comfortable and relaxed, patients show satisfaction and comfort with the words and actions they made. One participant observed that "my patients in the midst of any circumstances act calmly and hopeful" (P3H1). In addition, "we make sure that we give a conscientious and holistic approach to our patients and *nakikita namin masaya ang itsura nila* (we see that patients are happy)" (P6H1).

This implies that spiritual care brings comfort to the patients, which helps in their recovery. Spiritual health or spiritual well-being "is manifested by a feeling of being generally alive, purposeful, and fulfilled" (Kozier, 2008, p. 1043).

4.2 Meaningful service

The effects of the provision of spiritual care to nurses brought a sense of meaningful service. Generally, the participants felt a sense of personal growth and satisfaction in the practice of spiritual care. The nurses described their experiences as fulfilling as if "it was part of Jesus works" (P3H2); there was "fulfillment in the career, as it was part of nurses' oath" (P5H1); and, satisfaction stems from "the fact that we are doing God's work" (P1H1). Nurses' experiences in giving spiritual care increases their confidence and positive awareness. It gains confidence and understanding that could be a life long learning (Deal, 2009).

Quantitative Findings

Spirituality Tool

The four themes and ten sub themes that surfaced in the discussion became the basis in the development of the instrument. The spirituality tool focuses on how the nurses in the real set - up were practicing spiritual care. As shown in the emerging themes, the spiritual practices in nursing care revolve around what they do in general (general manifestation), how exactly do they do it (specific manifestations), to whom do they do it (recipients of spiritual care), when they do it (appropriate time in rendering spiritual care), where they do it (venue for rendering spiritual care), why they do it (relevance/meaning of spiritual care) and what is the support of the institution (institutional support). *(Please refer to Table 1)*

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Table 1. Spirituality Tool Developed from the Qualitative Data

	SA	A	D	SD
1. General Manifestation in Rendering Spiritual Care				
1.1 During admission, I ask my patients' religious practices.				
1.2 I observe the presence of religious items of my patients such as rosary beads, Buddha beads, bible, etc.				
1.3 I utilize the Checklist/Assessment tool related to spiritual needs.				
1.4 I render spiritual care as an expression of the mission and vision of the hospital.				
2. Specific Manifestation in Rendering Spiritual Care				
2.1 I respond promptly to request on spiritual matters, e.g. Priests/pastors/counselors services (anointing, receiving communion, blessings).				
2.2 I offer silent prayers when at home especially to those terminally ill.				
2.3 I utilize "therapeutic-communication" questions, e.g. "What would you like to talk about?"; "What's bothering you?"				
2.4 I provide privacy by giving space for patients and relative for their prayer.				
2.5 I respect dietary preferences based on one's faith e.g. as a Muslim, Jehovah, Adventist.				
2.6 Part of spiritual care is empathizing with the patient.				
2.7 I maintain an open mind and heart for individual's religious practices.				
2.8 I listen attentively to my patient's stories				
2.9 I anticipate the need for spiritual intervention e.g., anointing, communion, blessing, pray-over.				
2.10 Spiritual care is part of the nurses' daily care.				
2.11 I am sensitive to non-verbal cues, e.g., silence, facial grimaces.				
2.12 I pray before any diagnostic and therapeutic procedure.				
2.13 I am sincere about my patient's concern e.g. request for confession before operation.				
2.14 I document at the nurse's notes the spiritual care I administered.				
3. Recipients of Spiritual Care				
3.1 Patients who are psychologically ill, e.g. depressed, suicidal, confused, needs spiritual attention.				
3.2 The critically ill and dying are those who most frequently need spiritual care.				
3.3 Palliative care and hospice patients need spiritual care.				
3.4 Patient for OR (Operating Room)/ undergoing surgery needs spiritual attention.				
3.5 Patients who received bad laboratory results, e.g., malignant for cancer, needs spiritual care.				
3.6 Patients in pain need spiritual attention.				
3.7 All patients including well patients need spiritual care.				
3.8 Patients who are losing hope e.g., HIV victims, cancer patient need spiritual care.				
3.9 Patients who are happy and grateful, e.g., patient for discharge need spiritual care.				
3.10 Abused patients, e.g., battered wife/child need spiritual attention.				
4. Venue for Rendering Spiritual Care				
4.1 Spiritual care can be given anywhere as long as there is privacy.				
4.2 A silent and peaceful environment for meditation and prayer is a place for spiritual care.				
4.3 Spiritual care can be rendered in a patient's room.				
4.4 Spiritual care is preferably done in the chapel/prayer room of the institution.				
5. Appropriate time in rendering spiritual				
5.1 Spiritual care is rendered when the patients request for it, e.g., to receive anointing.				
5.2 Spiritual care is appropriately done when the patient are calm and willing to listen.				
5.3. Spiritual care is given to patients who are in their lowest moment.				
5.4 Spiritual care is given every time nurses interact with the patients.				
5.5 Spiritual care is given when an emergency procedure is to be done with unknown outcomes.				
5.6 Spiritual care is best given in the morning as part of the daily routine.				
6. Relevance/meaning of spiritual care				
6.1 Spiritual care is based on the patients' religion, beliefs, and faith.				
6.2 Spiritual care is done through counseling and using therapeutic communication.				
6.3 Spiritual care is allowing the patients to practice their faith/beliefs.				
6.4 Spiritual care is a priority aspect of holistic nursing care.				
6.5 Spiritual care prepares patients to accept their illness/condition.				
6.6 Spiritual care is compassion.				
6.7 Spiritual care is respecting patients as human beings with heartedness.				
6.8 Spiritual care is assured when patients have a positive attitude towards their present illness.				
6.9 Integrating spirituality, like saying prayers, is a daily routine of healing in nursing.				
6.10 Taking care of patients with empathy is spiritual care.				
7. Institutional Support				
7.1 The availability of the chapel/prayer room as a place of worship is necessary for spiritual care.				
7.2 Provision of institutional assessment tool is integrated in spiritual care.				
7.3 Daily blessing of patients from religious sisters/priests is a component of spiritual care.				
7.4 A built in speaker place in each room for accessibility of hearing daily mass, is essential for spiritual care.				
7.5 Stipulation of Spiritual Care in FDAR (Focus Data Action Response) documentation is part of spiritual care.				
7.6 Spirituality imparted to all nursing staff through integration in culture and sensitivity seminar given by the HR is crucial in spiritual care.				
7.7 A checklist is utilized in assessing spiritual needs upon admission.				
7.8 The provision of religious leaflets, given to patients, augments spiritual care.				
7.9 Providing spiritual care through visitations and offering of Christian songs helps patients.				
7.10 A chaplain is available to give needs such as anointing the sick, blessing, giving communion, etc.				

The descriptive result of the Spirituality tool and the summary table of the combined result on the different elements of Spirituality Tool administered to staff nurses of the three tertiary hospitals are shown in Table 2 and Table 3 respectively. The highest among the elements is the "relevance/meaning on spiritual care" with a mean of 3.58, and the lowest is the "general manifestation of spiritual care practice" with a mean of 3.33. Overall, the seven elements of the spirituality tool got a verbal interpretation of strongly agree which means that nurses are practicing spiritual care at all times. In totality, all the three hospitals got a positive result in rendering spiritual care, but it varies on how frequently nurses are doing it. It varies because of the different orientation of the three hospitals where the two are faith - based hospitals and the other one is a member of Joint Commission International.

Table 2. Descriptive Result of Spirituality Tool

Likert Scale	Range	Verbal Interpretation	Description
4	3.26- 4.0	Strongly Agree	Practice/concur with the opinion on spiritual care at all times.
3	2.51 - 3.25	Agree	Practice/concur with the opinion on spiritual care most of the time.
2	1.76 - 2.50	Disagree	Hardly ever practice/concur with the opinion on spiritual care.
1	1.0 – 1.75	Strongly Disagree	Never practice/concur with the opinion on spiritual care.

Table 3. Summary Result of Spirituality Tool among the Three Tertiary Hospitals

	Hospital 1			Hospital 2			Hospital 3			Total	
	X	*SD*	*VI*	*X*	*SD*	*VI*	*X*	*SD*	*VI*	*X*	*VI*
1. General manifestation of spiritual care practices.	3.39	0.40	SA	3.40	0.42	SA	3.22	0.45	A	3.33	SA
2. Specific manifestation of spiritual care practices.	3.50	0.35	SA	3.62	0.27	SA	3.47	0.36	SA	3.53	SA
3. Recipients of spiritual care practices.	3.46	0.38	SA	3.64	0.27	SA	3.48	0.34	SA	3.52	SA
4. Venue for rendering spiritual care.	3.51	0.41	SA	3.58	0.33	SA	3.50	0.40	SA	3.53	SA
5. Appropriate time in rendering spiritual care practices.	3.38	0.45	SA	3.45	0.35	SA	3.40	0.43	SA	3.41	SA
6. Relevance/ meaning of spiritual care practices	3.55	0.35	SA	3.65	0.29	SA	3.53	0.36	SA	3.58	SA
7. Institutional Support for spiritual care.	3.38	0.39	SA	3.48	0.34	SA	3.40	0.51	SA	3.42	SA

Acknowledging the connection between spirituality and health implies that health care professionals should attend to spirituality when they provide care to patients. Waaijman (2002) notes that interest in spiritual issues in today's health care sector are growing from two perspectives. Firstly, from the perspective of the patients: the patients must not be identified with their illness; they should not be medicalized, and isolated. Their personal integrity should be respected. Secondly, from the perspective of care: the spiritual life of the patients must be an explicit part of health care. Nurses must be competently trained to address a patient's spiritual needs (Leeuwen, 2008).

Comparative Result of Spirituality Tool

Table 4 shows that among the seven elements included in the spirituality tool only three had significant differences in the three participating tertiary hospital while the rest showed no significant differences.

Three elements showed significant differences across three hospitals, namely: "General manifestation in rendering spiritual care," Specific manifestation in rendering spiritual care, and "Recipients of spiritual care. The results in element 1 stem from the institutions' different orientations. One is a member of Joint Commission International hospital, and the other two are faith - based hospitals belonging to different religions.

The significant difference in element 2 is due to the individuality of a person and the training provided by the institutions. Each institution has its own orientation. There is also a very significant difference in identifying the patients who are the recipients of spiritual care (element 3). Nurses in the three institutions, though they have similarities in identifying the recipients, vary in the degree of frequency. It means that each institution have their own orientation on how spiritual care is being rendered to the patient. The results for the other elements imply that it is transferrable to different contexts other than the participating hospitals.

Table 4. Comparative Result of Spirituality Tool in the Selected Tertiary Hospitals

	X	SD	F-Value	Significance	Remarks
1. General manifestation of Spiritual Care Practices					
Hospital 1	3.39	0.40	6.870	P = 0.001 < 0.01 Very Significant	Hospital 1 vs Hospital 3 Hospital 2 vs Hospital 3
Hospital 2	3.40	0.42			
Hospital 3	3.22	0.45			
2. Specific manifestation of Spiritual Care Practices					
Hospital 1	3.50	0.35	4.973	P = 0.007 < 0.01 Very Significant	Hospital 1 vs Hospital 2 Hospital 2 vs Hospital 3
Hospital 2	3.62	0.27			
Hospital 3	3.47	0.36			
3. Recipients of Spiritual Care Practices					
Hospital 1	3.46	0.38	7.746	P = 0.000 < 0.01 Very Significant	Hospital 1 vs Hospital 2 Hospital 2 vs Hospital 3
Hospital 2	3.64	0.27			
Hospital 3	3.48	0.34			
4. Venue for Rendering Spiritual Care					
Hospital 1	3.51	0.41	1.239	P = 0.291 > 0.05 Not Significant	
Hospital 2	3.58	0.33			
Hospital 3	3.50	0.40			
5. Appropriate Time in Rendering Spiritual Care Practices					
Hospital 1	3.38	0.45	0.828	P = 0.438 > 0.05 Not Significant	
Hospital 2	3.45	0.35			
Hospital 3	3.40	0.43			
6. Relevance/Meaning of Spiritual Care Practices					
Hospital 1	3.55	0.35	3.145	P = 0.054 > 0.05 Not Significant	
Hospital 2	3.65	0.29			
Hospital 3	3.53	0.35			
7. Institutional Support for Spiritual Care					
Hospital 1	3.38	0.39	1.692	P = 0.185 > 0.05 Not Significant	
Hospital 2	3.48	0.34			
Hospital 3	3.40	0.51			

Framework Development

The framework "The Spiritual Practices in Nursing Care" (Fig. 1),is based on the combined results of the thematic analysis of the FGD and the four elements in the spirituality tool with a verbal interpretation of "strongly agree" and bears "no significant differences" in the spiritual care practices in the three selected hospitals.

The light is the spiritual dimension of nursing care. The active presence of the caregiver for the client could be a source of healing. This is based on a transpersonal relationship, which aims at safeguarding the dignity, humanity, wholeness and inner harmony of both a nurse and the client receiving care (Baldacchino, 2010). The nurse is the instrument in bringing the spiritual care to the patients, which is represented by the smoke where "God's presence" evokes the four circles: relational presence, spaces of presence, moment presence, and integral presence.

God is present in the behavior of the nurse as he/she renders spiritual care through "relational presence", which means the physical presence of a nurse manifested in his/her attitude and behavior in bringing the spiritual dimension through respect, compassion, and empathy, and therapeutic communication. According to Zyblock (2010), presence is transformative when patient care experience has the potential to facilitate the patients' healing process, and when nurses can enhance relationship with their patients.

God is also present in the space provided to the patient. "Spaces of presence" are actualized through the provision of silence that allows faith-experience of a patient. The provided space is important to a patient especially for reflection on what is happening to him/her. The silence that the nurse provides gives an opportunity for the patients to be connected with their God.

God is also present in the "moment presence" when the patients are willing to receive spiritual care and when the patients request spiritual needs. Integral presence means that God is always present in the daily blessings and prayer, the provision of chaplain and the chapel/prayer room, the form of support given by the institution.

God's presence is the core of the spiritual practices in the nursing care and God's presence is visible in the nurses and the institution. God always accompanies nurses especially in attending to the spiritual needs of the patients.

Conclusion

Spiritual care is part of the holistic care that is rendered by the nurses. Spiritual care is a necessity to all patients admitted in the hospital and its provision is a primary role of a nurse. This study showed that the integration of spiritual

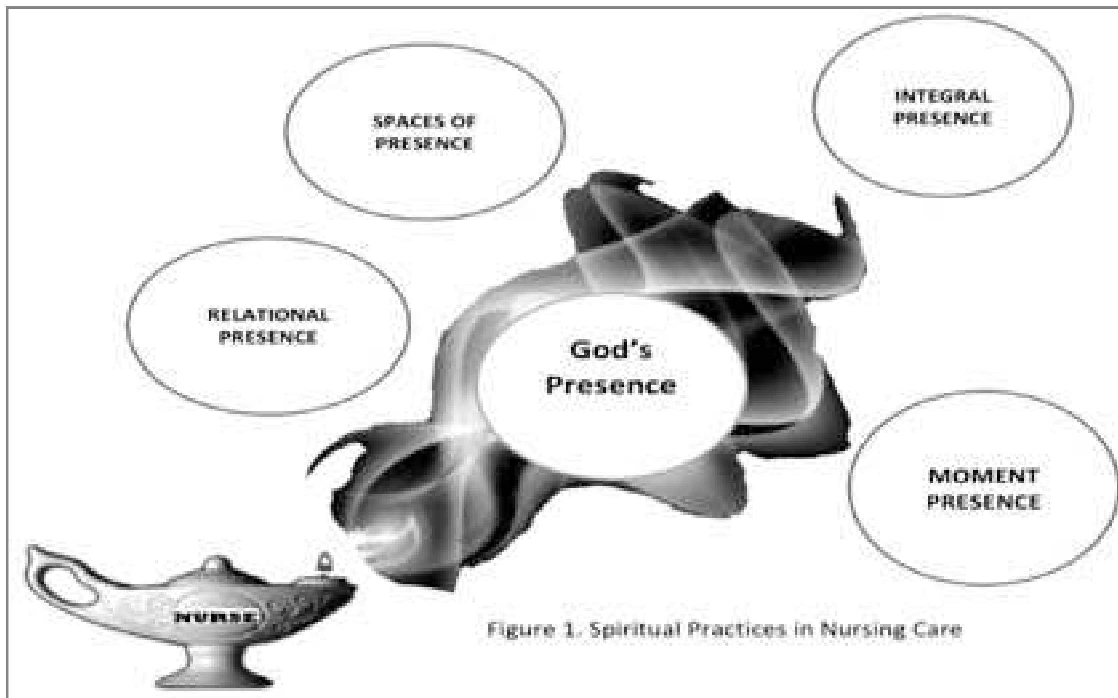

Figure 1. Spiritual Practices in Nursing Care

practices in nursing care creates meaningful experiences to both nurses and the patients. Spirituality is the intimate connectedness to God that reflects on nurses' behavior in taking care of his/her patients. Thus, the role of the nurses' spirituality is important. Nevertheless, spirituality of the nurses goes beyond religion because it speaks about values that include respect, care, compassion, commitment and love to their patient. Finally, the nurse is a channel for providing the spiritual needs of patients. The practice of spiritual caring brings God's presence in each encounter through the relational presence, spaces of presence, moment presence, and integral presence.

Recommendation

A day of recollection or a retreat can be given to staff nurses to be able to renew the relationship with God. Spending a day with the Lord can energize and empower the nurses' capacity to render excellent spiritual practices in nursing care. A value formation could be given to staff nurses for revisiting values in life. The Spirituality Tool that could serve as a guide for the nurses in rendering spiritual care could be recommended to nursing administration of the hospitals. Also, the framework can be shared with the academe, ADPCN (Association of the Deans of the Philippine College of Nursing) where the students can be guided in the actualization of different spiritual care practices in Filipino context. Education can help the future nurses on how to be competent in giving spiritual care. Also it can be shared with nurses' organizations like the Philippine Nurses Association and the Board of Nursing since there is no existing standard for spiritual nursing care. This study can contribute to this aspect.

Implication to Nursing

Spiritual care, together with physical, emotional, social and psychological care is one of the aspects of holistic care. Studies have proven that spiritual care helps in the recovery of the patient. The result of this study strengthens the spiritual dimension in the nursing care of the staff nurses who have the direct access to patients since these nurses do bedside care.

The Spirituality Tool could be useful for the nursing practice. It could serve as a guide in attending to the spiritual needs of the patients. The framework shows how spiritual care practices are being actualized in the Filipino context. Since there is no existing standard on spiritual care, the framework may be used to develop it, which can be a big contribution to the nursing profession.

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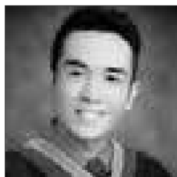
Research Article

A Voyage to the Twilight: Exploring Death Preparation among the Elderly



Carlo Paul C. Sana, MAN, RN

Abstract

Image source: http://imgarcade.com

What if the angel of death suddenly came knocking on your door? Death and aging are inevitable. However, since investigations usually assume that death unanimously provokes anxiety, death is often termed the last taboo which makes it painful for most people to talk about, think about, or even plan for it. This study was conducted to determine the philosophies and attitudes of the elderly in terms of the physical, psychosocial, and spiritual aspects of death preparation. The study also sought to determine importance of a support system for the elderly faced or are facing near-death experiences and/or terminal illnesses. The study utilized phenomenology as its research design. Eight informants from the different cities and municipalities of Pangasinan were chosen through purposive sampling. All of them have been involved in a near-death experience and/or are in a dying state. Data was gathered in the form of a semi-structured interview. The study found that the informants' respective concepts of death, the grieving process, their cultivated philosophies, and support system played major roles in helping them prepare for death.

Key words: *Death, dying, death and dying, death preparation, elderly, geriatrics*

Introduction

What if the angel of death suddenly came knocking on your door? Death and aging are inevitable. However, since investigations usually assume that death unanimously provokes anxiety, death is often termed the last taboo which makes it painful for most people to talk about, think about, or even plan for it. Death is an inescapable phase of every person's journey in life. Death may occur at any time as we go through this journey. One may experience fear, anxiety and apprehension during old age, because as one grows old, the chances of meeting death are greater. But this could also be the perfect time for them to prepare for it.

Death according to Merriam-Webster Dictionary, is a permanent cessation of all vital functions: the end of life. However, Marchant & Middleton (2007) said that we are not completely certain what being dead means because defining death is much more complicated than it appears. In addition, Nettle (2010) mentioned in one of her articles that death is not something to be feared; it is accepted as a small part of the cycle of life.

According to Nesbitt (2009), death is inevitable. He said it is one of the only things guaranteed in this life along with taxes. Regardless of who a person is, or where he / she came from, death is certain. Despite this certainty, people still avoid thinking about it and face it only when it is thrust upon them. Finlayson (2011) described death as an inevitable part of life hence, one must take some time to think about how he / she personally feel about death, death as a whole and also his / her own death. In addition, once they are aware of where their fear lies, they are in a much better position to action a solution to it.

Fear and anxiety are among the most frequently used words to characterize orientations toward death. Investigations typically assume that death universally elicits anxiety . But then, anxiety towards death in the elderly may then be alleviated with appropriate planning and preparations. Planning in advance for your own death can spare your loved ones the anguish of making difficult decisions while in a state of grief . In addition, a study showed that an elderly with sound emotional health, married and with more number of children, with satisfactory family ties and more life satisfaction received less death anxiety scores (Death Anxiety Among Elderly, 2008)

Elisabeth Kubler – Ross has established a basis for understanding how loss affects human life. As she attended to clients with terminal illness, a process of dying became apparent to her. Through her observations and work with dying clients and their families, Kubler – Ross developed a model of five stages to explain what people experience as they grieve and mourn: First is Denial which is characterized by shock and disbelief regarding the loss. Second is Anger which may be expressed toward God, relatives, friends, or health care providers. Third is Bargaining which occurs when the person asks God or fate for more time to delay the inevitable loss. Depression follows, which results when awareness of the loss becomes acute. The last stage of the grieving process according to Kubler – Ross is the Acceptance stage, which occurs when the person shows evidence of coming to terms with death (Videbeck, 2006).

Kubler-Ross' model of the 5 stages of grief was introduced in the book On Death and Dying written by Elizabeth Kubler-Ross. However, this theory has been refuted by many authors who claim that these stages do not justly explain the process of grief. They believe grief is too complicated to be defined by just seven neat little stages. For most people, it is an engulfing flurry of varied emotions. There is no scientific backup or public consensus which supports that two people will go through the same types of stages while mourning for their loved ones.

Domingo, Asis, Jose & Kabamalan (1993) approached the study of living arrangements among the elderly in the Philippines by exploring the views of the elderly and family members on various issues: actual living arrangements, preferred living arrangements, with a focus on the young and old, the living arrangements of the frail elderly, benefits of co-residence, strains of co-residence, factors encouraging co-residence, social changes and the factors that threaten the family's ability to care for the elderly, and prospects for institutionalized care for the elderly. The study used data from a set of transcripts from 18 focus group discussions conducted in Metro Manila and two rural villages in 1990 and 1991. Participants consisted of the elderly (ages 60-85) and adult children (ages 35-55). Results showed a close correspondence between actual co-residence and preference for such an arrangement, although there were indications that some elderly would prefer to be on their own were it not for factors such as the children's needs and health reasons.

Applying these in this study, I aim to discern how the elderly perceive death, the stages that they undergo whenever they experience loss of wellness, their attitudes and philosophies about the physical, psycho-social, and spiritual aspects of death preparation, and lastly, the effects of having a support system to an elderly who faces death.

Methods

I utilized phenomenology as the research design of this qualitative study. A qualitative interview research design was chosen as an appropriate means of obtaining data relevant to the assimilation of elderly towards death preparation. According to Bodgan and Taylor (1975, p.4) "qualitative methodologies refer to research procedures which produce descriptive data: people's own written or spoken works and observable behavior". Ely, et al. (1991, p.4) noted that qualitative research is better understood by the characteristics of its methods than by a definition. Among the characteristics of qualitative research are the following: "qualitative researchers want those who are studied to speak for themselves, to provide their perspectives in works and other actions. Therefore, qualitative research is an interactive process in which the persons studied teach the researcher about their lives. Qualitative researchers attend to the experience as a whole, not as separate variables". This study has utilized descriptive phenomenology as its research design.

Eight informants were purposively selected for this study from four cities/municipalities in Pangasinan namely: San Carlos City, Dagupan City, Urdaneta City, and Villasis. These areas were chosen since the researcher is an inhabitant of the Pangasinan, hence the relevant data needed for the success of the study will be very much accessible. Extreme *case sampling was utilized*, which focuses on cases that are rich in information because they are unusual or special in some way . The selection of

informants used the following criteria: must either be a male or a female resident of Pangasinan, 60 years old and above, must possess a sound mind, must have had a near death experience before or is presently having a terminal illness during the time of the interview, and they must be living with others. Four of the informants are Ilocanos and the other four are Pangasinenses.

I utilized social integration to build rapport with the informants. This was followed by individual interviews. A semi-structured interview was used by utilizing standardized open-ended questions. All responses of the informants were recorded and then transcribed. The informants' names were replaced with planet names to maintain confidentiality.

Brief descriptions of the informants are as follows:

Venus, 86 year old female is an Ilocano and is a resident of Villasis. She is a retired teacher. She lives with her son, and grandchildren. She has been hit by a tricycle on 2005, which led to a temporary loss of consciousness.

Mars, 82 years old female is an Ilocano and is a resident of Villasis. She is a housewife and lives with her daughter and her family. She was diagnosed with a pleural effusion.

Jupiter, 68 years old male, is an Ilocano, and is a resident of Urdaneta City. He lives with his eldest daughter, son-in-law, and his grandchildren. He usually stays in and watches over their small store. Jupiter was hospitalized due to uncontrolled coughing. He was hospitalized on 2009.

Neptune, 70 years old male, is an Ilocano, and is a resident of Urdaneta City. Neptune lives with his wife. He is a faith healer. Neptune's house contains various religious icons and the altar is situated right in front of his door. He had a heat stroke on 2004.

Earth, 85 years old female, is a Pangasinense, and is a resident of San Carlos City. She is a retired teacher. She lives with her two granddaughters and her husband, who is bedridden due to Parkinson's disease. Earth had a heart attack on 1975. Another near-death experience that she had was when she had an internal bleeding during her operation with her second child. She said that it was crucial since it is either her or her child will die. Eventually both survived.

Mercury, 88 years old female, is a Pangasinense. She lives with her granddaughters in Dagupan City. Mercury had a stroke then. But she has recuperated. The only problem she has during the interview is her blurring vision.

Saturn, 65 years old male, is a Pangasinense who lives in San Carlos City. He stays with his wife, and his son. Saturn is a farmer who had a stroke on 2011. He stayed in the Intensive Care Unit for almost a week.

Pluto, 73 years old male, is a resident of Dagupan City. He is a Pangasinense who lives with his diabetic wife and bedridden son. Pluto was diagnosed with Chronic Obstructive Pulmonary Disease and is already in the terminal stage of the disease. An oxygen tank is placed on his bedside. Pluto's legs were already edematous. His wife looks after his home health and palliative care.

Data were presented from the perspective of the lived experiences of the informants. These experiences were then compared to identify similarities and differences. Moreover, non-verbal responses of the informants were noted in the interview protocol sheet. All salient statements were reduced to generate themes and sub-themes. The recorded interviews were later destroyed.

Informed consent were requested before the interviews and the informants were told that they can withdraw from the study any time they wish to. Privacy and confidentiality were observed dutifully through the course of this study.

Findings

The following are the findings and analysis of the informants' statements about dying and death highlighting the four major themes and their respective sub-themes. The themes included The Meaning of Death, The Sequence of Living in a State of Dying, The Philosophies of an Elderly's Living Soul, and Significance of a Support System.

I. The Meaning of Death

Death may be defined in various ways. But for the informants, who have been involved in a near-death experience, death is defined in two ways: it is an inevitable phenomenon and it is a portal to the Creator's realm.

A. *Inevitable event*

The informants thought of death as an inescapable phenomenon. Death is a part of life.

They said that they cannot do anything about it:

Venus: "Kung yan ang gusto ng panginoon na mamatay na ako, wala naman akong magagawa." *(If the will of God is for me to die, I cannot do anything)*

Mercury: "Nu alaen to ak la (refers to the Supreme Being), antoy nagawaan mo ey?" *(If He will get me [refers to the Supreme Being], what can I do?")*

The informants have one phrase in common which conveya how inevitabile death is. The phrase "I cannot do anything" entails the paramount surrender of their hopes that they too, will face death as a conclusion of their being.

B. *Portal to the Creator's Realm*

Death was also associated to a door, which opens to another world, another domain, or another dimension.

Pluto: "Death for me is a sign of God, because you can't go to heaven if you will not die. Papaano ka makakapunta ng langit kung buhay ka? Kaya mamatay ka muna bago ka pumuntang heaven." *("Death for me is a sign of God, because you cannot go to heaven if you will not die. How will you go to heaven if you are still alive? That is why you still need to die before entering heaven.")*

Earth: "Ooohh.. That is second life. Ang alam ko sa death, ay paradise. My dream, my wish, and my prayer is to go with the Lord. Yan ang iniisip ko. Ayoko yung eternal fire." *("Ooohh..[Amazed by the question, "What is death for you?"] That is second life. Death is a paradise. My dream, my wish, and my prayer is to go with the Lord. That is what I think of. I do not want the eternal fire.")*

II. The Sequence of Living in a State of Dying

This sequence has been adopted from Elisabeth Kubler-Ross' Stages of Grieving Process. Based on the informants' responses, I have identified Realization as a part of the grieving process and it is manifested before the stage of Bargaining. The Grieving Process is a progression of stages that a person undergoes as he / she perceives a loss. This loss may indicate various things such as the loss of a loved one, loss of a job, loss of an important object and even a perceived loss of self. The informants in this study have had perceived losses of selves and their health during their near-death experiences.

A. *Denial*

Denial is a defense mechanism used by an individual to escape from unwanted thoughts, feelings, emotions, or situations. Denial is manifested among the informants when they doubt their perceived losses of selves and resort to not wanting to talk about such loss.

Jupiter: "Hindi ko alam ang kamatayan kasi hindi ko pa nasubukan. (laughs)" *("I do not know what death is, because I have not experienced dying yet." [laughs])*

Neptune: "Sa akin walang kamatayan. Ayan oh (points at his altar filled with religious icons), Sila ang gumamot sa akin." *("As for me, there is no death. Look, [points at his altar filled with religious icons], they were the ones who treated me.")*

Mars: "Hindi ko pa nakausap ang mga kamag-anak ko kung sakaling mamatay ako. Wala pa kasi sa isip ko ang mamatay. Hindi ko pa naiisip ang preparasyon sa aking kamatayan kasi wala naman akong sakit. Ayokong pag-usapan pa yan." *(I have not talked to my relatives yet if ever I would die. Dying is not yet in my thoughts. I have not thought of any preparations regarding my death yet, because I have no illness. I don't want to talk about it yet.")*

B. *Anger*

Anger can be a normal and healthy reaction when situations or circumstances are unfair or unjust. But anger becomes negative when the person denies it, suppresses it, or expresses it inappropriately.

Pluto: "I'm suffering from my sins. Pag sinumpong yan (points at his chest, referring to his lungs), hindi ko talaga alam kung ano'ng susunod na mangyayari. Kaya kung minsan, nakakapagsabi ako sa Panginoon na "Parang hindi nyo ako anak. Bakit hanggang ngayon, wala parin akong nararamdamang kahit na pagbabago? Nung una, I doubted God, pero nabasa ko sa bible, na ang nagbigay sa akin ng sakit ay ang demonyo. Kasi ang Diyos hindi nagbibigay ng sakit yan eh. Nagpapagaling." *(I am suffering from my sins. When this flares up, (points at his chest, referring to his lungs) I usually am not knowledgeable of what will happen next. That is why sometimes, I question the Lord, "It is as if I am not your child. Why is it that until now, I am not feeling any change at*

all? At first, I doubted God, but when I have read the bible, it said that the devil is responsible for my giving me my disease.)

C. *Realization*

Realization stage among informants happened through either one of the two components of this stage: (a) realization of the *Causes* of the illness / near death experience; and, (b) realization of the *Effects* of having the illness / near death experience. The realization of the causes of the illness / near death experience was expressed by some of the informants:

> Pluto: "Siguro, sa dami ng kasalanan ko, ito ako ngayon; nagsusuffer. At ang suffering na ito… excuse me…(Coughs) alam mo… ahhhmm… pahinga muna ako sandali. Hinihingal ako kapag napapagod… dadalhin ako sa kamatayan." *(Maybe, because of the many sins that I have committed, this is what I am now; suffering. And this suffering… excuse me… [coughs] you know… ahhhmm… I will rest for a while. I easily gasp when I get tired… will bring me to death.")*

> Jupiter: "Magaling akong manigarilyo noon. Pinagbawal na ng doktor na manigarilyo ako, kasi yun daw ang ikakamatay ko, kaya hininto ko na kasi gusto ko pang mabuhay." *(I am good at smoking before. The doctor prohibited me to smoke, because it will be the cause of my death, that is why I have stopped it because I still want to live.")*

Regret is a salient point in this component of the realization stage. It is through regret that one thinks of change to counteract the illness that they once had or are having in the present.

The following talks about the realization of the effects of the illness / near death experience according to the informant:

> Earth: "When I had those near death experiences (heart attack and internal bleeding during an operation), naisip ko yung mga children ko. Kung mawawala ako, paano na sila, kasi wala na silang guidance. Hindi masyado sa lalaki ang ganun (referring to her husband)" *("When I had those near death experiences [heart attack and internal bleeding during an operation], I have thought of my children. If I will die, how will they be, because I can no longer guide them? This is not usual among males [referring to her husband].")*

Realization of the effect(s) of the illness or near death experience is a way of determining various possibilities which may be caused by the existing problem. Conceptualization is a salient point in this component of the realization stage and it is where one plans for the future.

D. *Bargaining*

Bargaining is where a person asks God or those whom he / she thinks as superior (such as doctors) for more time to postpone the foreseeable loss.

> Mars: "Kung kukunin na ako ng Diyos, di handa na ako. Pero kung maaari sana hindi pa. Kayat ko pay ti ag-biag. (laughs)" *("If God would get me, then I would be prepared. However, if possible, he would not get me yet. I still want to live." [laughs])*

> Mercury: "Mikakasi ak labat la ya amay makmaksil su laman ko agew, labi. Mikakasi ak lanlanang ya sayay matak et makanengneng labat anggano daiset kwanko." *("I pray that I would still be having a strong body, day and night. I always pray that my eyes could see even just a little.")*

> Pluto: "Ang ginagawa kong devotion ngayon, humihingi ako ng tawad sa Panginoon, nagbabagong buhay (voice trembles and eyes became teary). Na sana patawarin ako. Bigyan pa Niya sana ako ng konting panahon kasi mga apo ko, maliliit pa eh. Gusto ko pa silang makitang lumaki" *(The devotion that I am doing today, is that I ask God for forgiveness, I am trying to change my life for the better [voice trembles and eyes became teary]. I hope He would forgive me. I hope He would give me a little more time because my grandchildren are still small. I still want to see them grow.")*

> Saturn: "Mandadasal ak ya lanang ya kumon unabig ak tapyan napabaleg ko ni iray apo'k" *(I always pray for me to recover so that I could still guide my grandchildren as they grow.")*

> Neptune: "Nung nagkasakit ako, hindi naman ako nagalit sa Kanya. Sa halip, nagdasal ako, "God, sana tulungan mo pa akong mabuhay ng matagal kasi gusto ko pang makita ang apo ko" kasi nasa malayo pa siya noon eh." *("When I got sick, I never really got mad at Him. Instead, I prayed, "God, I hope You would help me to live longer because I still want to see my grandchild." My grandchild was far away from me that time.")*

Venus: "Maganda naman ang pananalig ko sa Diyos. Nung hindi pa ako matanda, lagi akong nagsisimba. Member ako sa church noon. Ngayon naman, nagdadasal ako sa Apo na sana tulungan nya akong mabuhay pa para makita ko pa ang mga anak kong nasa malayo at sana may pension pa sila hanggang ngayon." *("My faith with the Lord is good. When I was not that old yet, I always attend Chruch masses. I was a member of the church back then. Now, I am praying to God that He would help me to live longer so that I may still be able to see my children from afar, and I hope that they are still receiving their pensions today.")*

The informants stated that they are prepared to die but if possible, they are bargaining with God for a longer life to do some things for their families.

E. Depression

According to Kubler-Ross, depression results when awareness of the loss becomes acute . Hopelessness may affect the person's physical being. In the case of some informants, it resulted to disturbed sleeping patterns:

Saturn: "Nu unya ak lanlamang ay (referring to when he was still immobile and dependent due to stroke attack), gabay ko ni lanlamang su umpatey kwanko. Nu talagan kapalaran ko, kapalaran kon talaga. Maminsan agak makaugip." *("I told myself: If this is how it is really supposed to be [referring to when he was still immobile and dependent due to stroke attack], I would rather choose to die. If it is really my fate, then be it. Sometimes I find it hard to sleep.")*

Pluto: "So I'm keeping myself busy to be close to God. Yun ang ginagawa ko ngayon. Nights and days; kulang pa nga ako ng tulog eh. Tignan mo tong mata ko, malalim na. Insomniac na ako. Complicated na ang lahat. Lumaki na yung puso ko eh. Yun na ang last choice ko." *("So I am keeping myself busy to be close to God. That is what I am doing today. Nights and days; As a matter of fact, I still am lacking some sleep. Look at my eyes, they are already deep. I am an insomniac. Everything now is complicated. My heart is already enlarged. That is my last choice.")*

F. Acceptance

Acceptance is where the affected person may say that he could combat the illness or might as well just prepare for it instead. Preparedness happens when choice is no longer an option. I have found out that acceptance goes with two factors. First, acceptance happens because they no longer have any choice since it is God's willpower to give them such trials.

Venus: "Oo, handa na akong mamatay. Wala na akong magagawa kung iyon ang gusto ng Apo." *("Yes, I am ready to die. I cannot do anything if it is God's will.")*

Pluto: So whether you like it or not, you must have to accept what God will give you. *("So whether you like it or not, you must have to accept what God will give you.")*

Second, acceptance happens because of a mission met in life.

Saturn: "Nu kapalaran ko, umpatey ak la; talagan untay bilay kwanko. Tinanggap ko la. Ta ankabaleg la ray anako" *("If it is my fate, then I would die; that is life, I said. Besides, my children are already grown-ups.")*

III. The Philosophies of the Elderly

The following subthemes make up the philosophies or attitudes of the elderly persons as they prepare themselves for death in terms of the physical, psycho-social, and spiritual aspects:

A. "Bahala na"

The informants have demonstrated the "bahala na" (*"come what may"*) system, a common aspect of Filipino culture, in terms of preparations and expenses when they die, leaving all things up to God or to their loved ones. Financial constraint is the main reason for having this philosophy among the informants.

Venus: "Hindi ko pa sila nakakausap tungkol sa aking kamatayan. Sila na lang bahala sa akin kung mamamatay na ako." *("I have not talked to them [referring to the relatives] yet regarding my death. I will just have to leave it all up to them when I die.")*

Venus: "Hindi ko pa sila nakakausap tungkol sa aking kamatayan. Sila na lang bahala sa akin kung mamamatay na ako." *("I have not talked to them [referring to the relatives] yet regarding my death. I will just have to leave it all up to them when I die.")*

Mars: "Mga kamag-anak ko na ang bahala. Nakapasok naman ako sa Senior Citizen Association. Kasi pag namatay ako, may ibibigay ang Senior Citizen." *(It will all be up to my*

relatives. I am a member of the Senior Citizen Association. If I die, the association will help out.")

Neptune: "Kung lote lang na paglilibingan sa akin ang pinag-uusapan, meron na doon sa byenan ko. Ang panggastos lang ang wala pa sa ngayon. Kapag namatay ako, bahala na yung mga maiiwan. Pero si misis, meron siyang mahuhugot sa buwan buwan niyang binabayaran sa insurance." *("If you were to ask me about the lot where I would want to be buried, then it is not a problem. I already have one which was the lot used by my late mother-in-law. When I die, it will all be up to the one who is left. However my wife will have something to spend coming from the monthly insurances that she is paying."*

Mercury: "Anggapo ni ginawak ya preparasyon ed ipatey ko. Saray agik lay akauley ed siak. Sikaray pikakasian ko,syempre anggapoy pakayarian daray anako. Imbagak ed sika ra, bukot-bukoten ta kila nu umpatey ak. Say kwanda, ay agyo ibabaga tan nanang ta anggapoy mangipunpon ed sikayo nu inatey kami met la (laughs)" *("I have not done any preparations yet regarding my death. It will all be up to my siblings when I die. I always plead them, because of course, my children have nothing to spend too when I die. I told them that I would haunt them when I die, and they told me that I should not because no one would take charge of my burial if they die too. [laughs]")*

Earth: "Sabi naming mag-asawa dati, kung sino ang mauuna, yung maiiwan ang bahala sa pagpapalibing and all. (Laughs) Besides, may lote na kami sa public cemetery, dun sa mother ko. I will also get some benefits from a life plan when I die because I have been availaing from their promos." *("My husband and I have decided that whoever from us dies first, the one left will be responsible for the burial and all [laughs]. Besides, we already have a lot in the public cemetery, where my late mother is buried too. I will also get some benefits from a life plan when I die because I have been availing from their promos.")*

B. Family-oriented

Like most Filipinos, the informants value their families. Attachment is the salient point in this elderly philosophy; they want to live longer so that they can spend more time with their families.

Jupiter: "Ipinagdarasal ko na sana humaba pa ang buhay ko para makita ko pa ang mga apo ko, pag mag-aasawa na sila, ganun." *("I always pray for a longer life, so that I could still see my grandchildren until they get married.")*

Pluto: "Bigyan pa Niya sana ako ng konting panahon kasi mga apo ko, maliliit pa eh. Gusto ko pa silang makitang lumaki." *(I hope He would give me a little more time because my grandchildren are still small. I still want to see them grow.")*

C. Belief that God Extends Life

The informants believe in the existence of a Creator. The Creator has the power to make them live longer through divine healing and they become closer to God through prayers.

Mars: "Mabuti naman ang pagdarasal ko ngayon. Mas malapit ako sa Diyos ngayon kasi gusto kong mabuhay pa." *("My devotion is fine. I became closer to God now because I still want to live.")*

Mercury: "Mas imasingger ak lalaingen ed Diyos natan ya tinmakken ak tapian mikasi ka ak andukey ni bilay ko. *("I was brought closer to God, especially now that I grew older, so that I could ask for a longer life.")*

Pluto: "So I'm keeping myself busy to be close to God. Yun ang ginagawa ko ngayon." *(So I am keeping myself busy to be close to God. That is what I do today.")*

Saturn: "Mas naging malapit ak ed Diyos natan ya nansakit ak, ta sikato labat su makatambal basta mikasi ka ed sikato." *(I became closer to God when I got ill, because He is the only one who could cure me for as long as I keep my faith on Him.")*

IV. Significance of a Support System

Support system may be the presence of loved ones, financial support, and moral support, among others. Fajemilehin and Odebiyi (2011) argued that living with spouse and the type of marriage (be it mono or polygynous) were relevant for positive health behaviours during old age. I have found out in this study that a support system has two kinds of effects among the informants: first, it serves as a cure; and second, it could strengthen family ties:

a. The Cure

The presence of a support system was one of the reasons why the informants have survived their

ordeals or why they are still thriving. When the informants were ill, it was their loved ones who took care of them. One of the informants even stated that financial support may be a good factor of his living but without the presence of a physical care, and then it would not be possible for him to live.

Pluto: "Itong asawa ko, siya lahat ang gumagawa dito sa bahay. At may mga anak din ako na nasa abroad, tumutulong sila financially sa mga pangangailangan namin dito. Maganda ang epekto nila sa pagtanda ko. Isipin mo kapag wala itong asawa ko. Paano na lang kami ng anak ko? Baka matagal na kaming wala. Kahit pa may perang pang-sustento sa iyo, kung wala namang mag-aalaga, useless. My life was extended because of her help." *(My wife does all the chores in the house. I also have some children abroad who help me financially with our needs here. They have a good effect with my elderly life. Imagine life without my wife. How will I and my son be? Maybe we have died for a long time already. Even if there is money to support us, if there is no one to care, it is useless. My life was extended because of her help.")*

Saturn: "Sikara'y (Referring to his family members whom he is living with) manaasikaso ed siyak nen mansasakit ak. Nu anggapo ira, umpano agak la immabig, umpano sikato lay ipatey ko. Balbaleg su pakatulong da ed impan-abig ko natan." *(They [Referring to his family members whom he is living with] are the ones taking care of me when I was ill. If they were not around, maybe would not be healed, and will be the reason for my death. They are of big help to my health's improvement.")*

Earth: "The people around me play a big role kung bakit andito pa ako sa mundo ngayon. Without their support and care, I might not be able to be talking to you right now." *(The people around me play a big role, and they are the reason why I am still in this world today. Without their support and care, I might not be able to be talking to you right now.")*

b. Strengthened Family Ties

Another significance of having a support system is that it strengthens family relationships. The presence of a support system during the time of illness created a better understanding of their relationships..

Earth: "The people around me plays a big role kung bakit andito pa ako sa mundo ngayon. Without their support and care, I might not be able to be talking to you right now. Lalo na yung isang apo ko. Talagang hindi niya ako pinapabayaan. Minsan, tatabihan pa niya ako sa pagtulog sa gabi. Mas naging malapit kami sa isa't isa dahil narin sa pag-aalaga niya sa akin." *("The people around me play a big role and they are the reason why I am still in this world today. Without their support and care, I might not be able to be talking to you right now. My other granddaughter never leaves me behind. Sometimes, she sleeps with me at night. We became even closer with each other because of how she cares for me.")*

Neptune: "Mas matibay ang relasyon naming mag-asawa ngayong tumanda na kami at kaming dalawa na lang sa bahay. Kung ano ang ayaw ng asawa ko, hindi ko gagawin. Kung ano ang ayaw ko naman, hindi din niya gagawin. Nirerespeto naming ang isa't isa. Minsan kahit na ganito na kami katanda, naghoholding hands pa kami. Kami-kami narin ang nag-aalaga sa isa't isa ngayon." *(My relationship with my wife strengthened now that we are already old, and that it is just the two of us living together now. I do not do what she do not like. She do not do what I do not like. We respect each other. Sometimes we even hold hands while we are walking, even if we were this old. We take care of each other.")*

Discussion

The methodology of this study attempts to deepen our understanding of the elderly at the last stage of their life. Only naturally, we value newness and energy. We avoid the old. Oftentimes, social death occurs before biological death. Marjorie Kagawa-Singer in her study called Diverse Cultural Beliefs and Practices About Death and Dying in the Elderly wrote about this stage in life as "graying". It occurs when the elderlies inch toward the peripheries as their social value decreases. At death, many elderly are peripheral to families and younger community members (Kagawa-Singer, 2008). In this graying, they are rarely seen or heard. Hence, this study's strategic methodology banked upon the elderlies' thoughts and opinions.

The study utilized the qualitative research method of open-ended interview where the informants were able to express their own thoughts regarding the topic of death. This strategy provided the study with the perspective of the elderly, hence a rigorous and genuine means of extracting the essence of their human experience during their twilight years. The study of Chan and Yau (2010) probed

deeper focus on this stage, especially for an elderly. They highlighted the importance of the process of dying and coping, and how it is supposed to help the elderly to achieve ego integrity even during this final stage of their life.

The questions and gathered answers were grouped into varying themes in relation with their respective questions to resemble an essential structural whole. The themes brought together built a strong organic definition of death: it is inevitable because it is in God's plans.

This is consistent with the research findings on the elderly's philosophies which primarily revolve on religion – its operative definition being afterlife. Ya Hui Wen (2012) showed that there is lower death anxiety in people with strong, integral religious views and greater in people with more expedient religious beliefs. The promise of afterlife provides people with enough strength to cope and overcome the initial anxiety and grief. This leads to acceptance, where their family and support system awaits them in warmth welcome, making peace to the near end of their human experience and leading them to a new dimension of life.

Despite the complex array of feelings and stages of grief brought upon the immediacy of death, the informants found positive aspects in the meaning and overcoming of their twilight years. Hope and calm were created through recollection and rebuilding of their relationship with their immediate social circle, and a rekindling of their religious faith. The findings in this qualitative study ultimately leads to the positive influence of religion on death acceptance. The crucial key points proven by the statements of the informants were: religiosity, its operative term being afterlife and extending to their family and support system. Their faith lead to strengthened family ties and through the grace of God, a form of hope and acceptance of their situation.

The influence of religiosity to an elder's handling of death anxiety and acceptance as manifested in this study ("How will you go to heaven if you are still alive?" – Pluto; "Yes, I am ready to die. I cannot do anything if it is God's will." – Venus) is parallel to the study by Falkenhain & Handal (2003) claiming a relationship between belief in afterlife and intrinsic religion and death acceptance. In the process of examining the relationship between religion and death anxiety, it was noted that a significant sample of elderly look at afterlife as a mediating variable in their relationship between religion and death anxiety.

Plenty of literatures focused on the strong pull of religiosity in the face of death. Most discovered a positive relationship between religious beliefs and clinically meaningful levels of death anxiety. This study, however, did not intentionally bring up religion: it naturally came out of the informant's experiences and thoughts. Their definition of death is strongly anchored on its inevitability, an inevitability they attribute to the all powerful being, God. The faith that they dedicate to God is so strong and all-encompassing it influences not only how they perceive death but as well as their belief that their lives can be prolonged and extended with adequate prayers and devotion. As much as they surrender everything to God, this is still alrgely symbolic of how much faith they have in God: he can take your life, and only he too can give you a longer one; as Mars said, "I became closer to God now because I still want to live".

Fear is only natural. Despite acknowledging God's will and the promise of heaven, people still fear death. As Finlayson (2011) said, "death is something which many people avoid thinking about until such a time it is thrust upon them". As we grow older, the immediacy of death increases until such a time that it is staring us right in the face: this is how it feels like for the elderly.

Conclusions

Despite the different stages and approaches people write about and take on when it comes to accepting and coping death, this study focused and found out what becomes most significant when an elderly approaches his twilight years: religion and family.

The study found out the elderlies' deepest thoughts when it comes to this final stage of their human experience. Contrary to being peripheral in their family and younger community members, they were able to voice out what it means to die and how it is making them feel. With strong religious influences affecting their perception of death and coping, ultimately it all boils down to their connection with their family which they gladly rekindled through the grace of God. Since the reason why we go through life despite knowing it will end one day is the people we value and who in turn, value us. We may vary with the way we handle death and bereavement, and in the cultural processes that go with dying and grieving but we are all the same: we are all trying to make the best of the time God gave us in this planet.

Recommendations

Based on the findings and conclusions drawn from this study, it is thus recommended that a similar study, having teenagers or other age groups who have encountered near-death experiences as its informants, should be conducted to provide a more holistic perception about death all throughout life. Moreover, since the study focused on elderly persons with significant others, it is also recommended that a similar study could be steered on elderly persons who are living alone to know whether or not their death perceptions would vary or not. Furthermore, other factors, such as economic status, religion, educational attainment, and the like may be utilized in the conduct of an analogous study to provide a holistic approach in the view of death.

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Research Article

Factors Related to Self-Care Among Older Persons of Makassarese Tribe, Indonesia

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Abstract

Image source: http://singledadhouse.com/

PURPOSE. Self–care refer to the activities and practices performed and initiated by an individual on one's behalf in maintaining life, health and well-being. Maintenance of self-care requires use of special skills and scientific knowledge into which nursing plays a vital role in designing and implementation of the plan of care. Literatures have shown that nurses' support to existing older persons' capabilities promote active participation and responsibility for his or her own self-care. Promotion of self –care reduces problems resulting from reactions of older persons in unnecessary dependent roles. Community nurses of Makasar City, South Sulawesi, Indonesia in their task of providing health service of older persons have limited data on characteristics of older persons seeking care, and the common symptom experiences of older persons. Knowledge of the interplay of these factors are important to provide better health services. The objective of the research is to determine the relationship between predisposing factors known as basic conditioning factors (age, gender, marital status, educational level, occupation, living arrangement and common symptoms experience) and the experiences (knowledge, attitude, practice) on self-care of older persons.

METHOD. A descriptive correlational research design was used. The sample consisted of 98 Makassarese older persons who live in Paropo Village, Makassar, South Sulawesi, Indonesia. Survey questionnaire was used for the profile of the respondents and the knowledge, attitude and practice (KAP) on self- care. There were seven (7) who participated in the focus group discussion (FGD). Data was analyzed using descriptive statistics. The relationship between basic conditioning factors and KAP on self-care of older persons was determined. Appropriate processes for ethical consideration was done.

RESULTS. The results of the study showed that the mean age of Makassarese older persons is 71 years, more females, mostly married, widow, not completed elementary school, not working, and living with their children. The common symptom experiences were: joint pains, low back pain; vision problem, myalgia. As to KAP on self-care, Makassarese older persons have fair knowledge, positive attitude, and low level of

Key words: *: older persons, self-care, basic conditioning factors*

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practice on self- care. There is significant relationship between knowledge on self-care and education, attitude on self-care and common symptom experiences, practice on self-care and age, gender and education. FGD on practice of self-care showed the following. To stay healthy because of chronic ilness, such as, diabetes and hypertension and to deal with other health problems(e.g. toothache, diarrhea), they resorted to self-remedies and prayer,consuming soft diet, reducing salty and sweet food. Nurses were perceived as important in giving information on health care.

CONCLUSION. Knowledge of the interplay of basic conditioning factors and self-care practices among older persons guide nurses on better and effective nursing care towards self-care. Support in terms of education on self-care for older persons have to consider the basic conditioning factors, and the common symptom experiences of older person to help reduce dependency for their health needs.

BACKGROUND

Maintenance of self-care requires use of special skills and scientific knowledge into which nursing plays a vital role in designing and implementation of the plan of care. Literatures have shown that nurses' support to existing older persons' capabilities promote active participation and responsibility for his or her own self-care. Promotion of self –care reduces problems resulting from reactions of older persons in unnecessary dependent roles. This study uses Orem's self-care theory on the concept of self-care agency. Self-care agency is referred to as the acquired ability to meet ones' continuing requirements of care. The concept of self-care agency proposes the important role of the nurse to help clients meet their health needs. However, there are basic conditioning factors that would lend support to the understanding of self-care agency in the care of older persons. Limitations in performing self-care exist when the experiences in terms of knowledge, attitude or skills required for a given self-care action maybe inadequate or nonexistent. Orem (2001) identified basic conditioning factors that may influence or modify self-care agency. In this study, these factors include age, gender, marital status, educational level, occupation, living arrangement and common symptoms experience. These factors may affect the experiences (knowledge, attitude, practice) on self-care of older person.

There is a dearth of literature, especially in Indonesia, with regard to the relationship of conditioning factors to knowledge, attitude and practice (KAP) of older persons in terms of self-care. Thus, this study aimed to determine the relationship between the basic conditioning factors (BCF) and knowledge, attitude, and practices (KAP) on self-care.

METHOD

Research Design and Variables

A descriptive correlational research design was used in the study. The aim is to describe relationships among variables, rather than to infer cause and effect relationship. The independent variables are age, gender, marital status, educational level, occupation, living arrangement and number of common symptoms experience. The dependent variables are knowledge, attitude and practice on self-care.

Research Setting, Population and Sample

The study was conducted in Paropo village, Makassar, South Sulawesi, Indonesia. Paropo village is located ten kilometers from the western part of Makassar city. Makassar is the capital city of South Sulawesi, Indonesia in which 95% of the population belongs to Makassarese tribe.

The sample consisted of 98 older persons, who live in Paropo Village. Based on the data from Batua Public Health Center, there were 128 older persons who live in the village in 2010. Using purposive sampling, the subjects were men and women of the Makassarese tribe, 60 years old and above, have good hearing, sight, and mental condition, can communicate in Bahasa, and can perform activities of daily living.

Data Gathering

The survey questionnaire used had two components: profile of respondents and KAP on self-care. Profile of the respondents includes the following: age, gender, marital status, leve of education, occupation and living arrangement. The researcher developed the questionnaire on KAP based on the component of Orem's theory as well as the result of researcher's observation in the research setting. The instrument was translated into

Bahasa and reviewed its content and language by the Indonesian researchers who conduct studies on self-care topic. The Cronbach's alpha coefficients were 0.93 for knowledge, 0.90 for attitude and 0.93 for practice on self-care instrument.

Data Analysis

Descriptive statistics was used to summarize the socio demographic data, and the Chi square and Fisher's exact test were used to establish relationships between variables.

RESULTS

Makassarese older persons belong to the young old (mean age: 71.12; SD 8.49) with more females compared to males, mostly married, had not completed elementary education, not working, and who live with their children. As shown in Table 1, the most common health symptoms were joints pain and around one-fourth of the respondents suffered from five health symptoms in the last 6 months.

Table 1. Distribution of Respondents according to Socio Demographic Variables of Makassarese Older Persons (n=98)

Variable	f	%
Age		
60-74	63	64.3
75-84	24	24.5
≥ 85	11	11.2
(Mean ± SD)	(71.12 ± 8.49)	
Gender		
Male	32	32.7
Female	66	67.3
Marital Status		
Single	6	6.1
Married	51	52
Widow/er	41	41.8
Educational Level		
Not completed elementary school	74	75.5
Elementary school or higher	24	24.5
Occupation		
Not working	81	82.7
Working	17	17.3
Living Arrangement		
Spouse	19	19.4
Children	67	68.4
Relatives	11	11.2
Alone	1	1

Table 2 shows that there is no significant relationship between knowledge on self-care and the following variables: age (p= 0.68), gender (p= 0.47), marital status (p=0.43), occupation (p=0.29), living arrangement (p= 0.11), and number of common symptoms experience (p= 0.48). However, there is a significant relationship between knowledge on self-care and education (p= 0.01).

Table 2. Distribution of Respondents according to Common Symptoms Experience and Number of Common Symptoms Experience within the Last Six Months (n=98)

Variable	f	%
Common symptoms experience in the last 6 months		*
Joint Pain	67	68.4
Low Back Pain	62	63.3
Vision problem	54	55.1
Myalgia	53	54.1
Number of common symptoms experience in the last 6 months		
0-1 symptoms	16	16.3
2-6 symptoms	77	78.6
7 symptoms	5	5.1

As shown in Table3 (page 27), there is no significant relationship between attitude on self-care and the following variables : age (p= 0.65), gender (p=0.32), marital status (p= 0.82), occupation (p= 0.20), and living arrangement (p= 0.86). The only significant relationship is between knowledge on self-care and number of common symptoms experience (p= 0.00).

There is no significant relationship between practice on self-care and the following variables: marital status (p= 0.11), occupation (p= 0.24), living arrangement (p=0.61), and number of common symptoms experience (p= 0.74). However, there is a significant relationship practice on self-care and the following variables: age (p= 0.01), gender (p= 0.00) and educational level (p= 0.00). (Table 3)

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As shown in Table 3, no significant relationship between attitude on self-care and the following variables: marital status, occupation, living arrangement and number of common symptoms experience.

DISCUSSION

The finding of this study that knowledge on self-care had significant relationship with education were also found in several studies. Badzek, Hines and Moss (1998)

Table 3. The Relationship of Socio Demographic and Common Symptoms Experience to Knowledge, Attitude and Practice on Self-Care

Variables	Knowledge			p	Attitude			p	Practice			p
	Deficit	Fair	Total		Negative	Positive	Total		Low	High	Total	
	f (%)	f (%)	f (%)		f (%)	f (%)	f (%)		f (%)	f (%)	f (%)	
Age												
60-74	11 (17.5)	52 (82.5)	63 (100)	0.68[1]	4 (6.3)	59 (93.7)	63 (100)	0.65[2]	28 (44.4)	35 (55.6)	63 (100)	0.01[1]
75-90	5 (14.3)	30 (85.7)	35 (100)		1 (2.9)	34 (97.1)	35 (100)		25 (71.4)	10 (28.6)	35 (100)	
Gender												
Male	4 (12.5)	28 (87.5)	32 (100)	0.47[1]	3 (9.4)	29 (90.6)	32 (100)	0.32[2]	10 (31.2)	22 (68.8)	32 (100)	0.00[1]
Female	12 (21.2)	54 (78.8)	66 (100)		2 (3.0)	64 (97.0)	66 (100)		43 (65.2)	23 (34.8)	66 (100)	
Marital Status												
Married	10 (19.6)	41 (80.4)	51 (100)	0.43[1]	3 (5.9)	48 (94.1)	51 (100)	0.82[1]	24 (47.1)	27 (52.9)	51 (100)	0.11[1]
Single	0 (0)	6 (100)	6 (100)		0 (0)	6 (100.0)	6 (100)		2 (33.3)	4 (66.7)	6 (100)	
Widow/er	6 (14.6)	35 (85.4)	41 (100)		2 (4.9)	39 (95.1)	41 (100)		27 (65.9)	14 (34.1)	41 (100)	
Educational Level												
Uneducated	16 (21.6)	58 (78.4)	74 (100)	0.01[2]	4 (5.4)	70 (94.6)	74 (100)	1.0[2]	47 (63.5)	27 (36.5)	74 (100)	0.00[1]
Elementary school or higher	0 (0)	24 (100)	24 (100)		1 (4.2)	23 (95.8)	24 (100)		6 (25.0)	18 (75.0)	24 (100)	
Occupation												
Not working	15 (18.5)	66 (81.5)	81 (100)	0.29[2]	3 (3.7)	78 (96.3)	81 (100)	0.20[2]	46 (56.8)	35 (43.2)	81 (100)	0.24[1]
Working	1 (5.9)	16 (94.1)	17 (100)		2 (11.8)	15 (88.2)	17 (100)		7 (41.2)	10 (58.8)	17 (100)	
Living Arrangement												
Spouse	1 (5.3)	18 (94.7)	19 (100)	0.11[1]	1 (5.3)	18 (94.7)	19 (100)	0.86[2]	12 (63.2)	7 (36.8)	19 (100)	0.61[1]
Children	15 (22.4)	52 (77.6)	67 (100)		4 (6.0)	63 (94.0)	67 (100)		34 (50.7)	33 (49.3)	67 (100)	
Relatives	0 (0)	11 (100)	11 (100)		0 (0)	11 (100)	11 (100)		6 (54.5)	5 (45.5)	11 (100)	
Alone	0 (0)	1 (100)	1 (100)		0 (0)	1 (100)	1 (100)		1 (100)	0 (0)	1 (100)	
Number of common symptoms experience in the last 6 months												
0- 1 symptom	1 (6.2)	15 (93.8)	16 (100)	0.48[1]	2 (12.5)	14 (87.5)	16 (100)	0.00[1]	8 (50.0)	8 (50.0)	16 (100)	0.74[1]
2– 6 symptoms	14 (18.2)	63 (81.8)	77 (100)		3 (3.9)	74 (96.1)	77 (100)		43 (55.8)	34 (44.2	77 (100)	
7 symptoms	1 (20)	4 (80.0)	5 (100)		0 (0)	5 (100)	5 (100)		2 (40.0)	3 (60.0)	5 (100)	

[1]probability using *Pearson chi-square test*
[2]probability using *fisher exact test*

found that education influence self-care knowledge among elderly hemodialysis patients.

Some variables did not have significant relationship to knowledge on self-care. Badzek, Hines and Moss (1998) also revealed that there was no significant relationship among self-care knowledge and gender in elderly hemodialysis patients. Kart and Engler (1994) found that the importance of marital status diminished in the presence of more detailed measures of social support. Futher, in a meta-analysis study on self-care in Thailand by Klainin and Ounnapiruk (2010) concluded that age and gender had weak relationship on self-care.

The significant relationship between attitude on self-care and number of symptoms experience was also found in Callaghan study (2006). He reported that medical problem or disability had significant relationship to self-care in adolescents.

Several variables did not have any relationship to attitude on self-care. Living arrangement variables is only associated with lower level of life satisfaction (Borg, Hallberg & Blomqvist, 2005). Futher, marital status is associated with functional ability & higher level of life satisfaction, but not in self-care (Mroczek & Spiro, 2005). Horsburgh (1999) even found that marital status did not influence self-care in Canadian adults with end-stage renal diseases. Klainin and Ounnapiruk also argued that several existing studies on self-care are unpublished. As a result, supporting studies showed the non significant relationship between sociodemographic variables and self-care is limited. They also added that except for health status, all basic conditioning factors (BCF) variables showed weak relationships.

In this study, three variables were found to have significant relationship to practice on self-care. The variables on conditioning factors (age, gender, education) may influence or modify self-care agency and physical functioning. It is consistent with Orem's theory (2001) and Zimmer et al (2003) . In Zimmer study, respondents who were older, female and had low education, were more likely to have higher functioning difficulty scores.

Significant relationship between practice on self-care and age was also found in some studies. The result is congruent with a study done on self-care and well being model for elderly women by Wang, Shieh and Wang (2004) where there was association between age and self-care practice of older persons in Taiwan. Added by Soderhamn, Lindencrona, & Ek (2000) who found that the ability to do self-care was declined after people reached age 75 because of genetic and constitutional factors, culture, life experiences and health status. While according to Aldridge, self-care practices is more challenging and problematic in older persons because of the multiplicity and chronicity of other diseases (as cited in Washington, 2009).

Molarius and Janson study (2002), descibed that older women have poorer health than man. It is reflected that women may need extra attention from health care professionals. Another study by Bai, Chiu and Chang (2009) revealed that male older persons with diabetes in Southern Taiwan had significantly higher self-care behaviour scores than females. Another two studies reported that women receive more help from others (Norburn et al, 1995, Kart & Engler, 1994). It is suggested that women may need extra attention from health-care professionals and in nursing care (Tannenbaum & Mayo, 2003; Molarious & Janson, 2002; Bai et al, 2009).

In Bai et al study (2009) , there were also significant differences in the self-care behaviour scores due to educational level. The older persons who had educational level of senior high school and above had higher self-care behaviour scores than those with only elementary school educations. It is indicated by the higher awareness of diabetes among those who had high level of education compared to them with low level of education. Leenerts et al (2002) added that education is the channel for promoting self-care practice through self-care ability. In addition, Notoadmodjo (2010) suggested that social factor such as age and education will give impact to individual behavior.

This study showed there is significant association between education and practice of self –care as reflected in the higher percentage of respondents with low educational background. There seems to be a tendency to purchase over –the-counter drugs as the first action to solve health problems. Older persons with low educational background may not know the dangerous and side effects of consuming drugs without prescription.

Kreager & Butterfly (2007) found that family networks is a key source of support in Indonesia, but this study did not examine whether family had been a good support for health care practice or not. Furthermore, Klainin and Ounnapiruk (2010) set a series of requirements of what to be called as good relationshipswithin family. They said that family relationships indicated the degree to which family members performed the following activities together: spending leisure time together watching TV and listening to music, taking trips, consulting each other before doing activities, asking advise from older persons, problem-solving together, taking good care of older persons, and expressing affection and concern one to another.

Zimmer et al (2003) showed that socioeconomic status indicators are linked to physical functioning of older adults. These findings were conducted from studies in Asian societies.

In summary, three variables were found to have significant relationship to practice on self-care. These included the variables on conditioning factors (age, gender, education).

Complaints on joints pains were the most common among the health symptoms. This may have influence on the limitations in physical functioning.

Overall, the Makasarese older persons had fair knowledge , positive attitude, but low practice on self-care. The study showed a relationship between practice of self-care and age, gender and education. Concerns for self care were identified through the focus group discussion. These were on the areas of health complaints, efforts done to meet their health problems, efforts to stay healthy, nursing needs, and sources to learn self-care. Participants of the study recognized the importance of support system, to include family and the community.

CONCLUSION

Knowledge of the interplay of basic conditioning factors and self-care practices among older persons guide nurses on better and effective nursing care towards self-care. Support in terms of education on self-care for older persons have to consider the basic conditioning factors, and the common symptom experiences of older person to help reduce dependency for their health needs.

RECOMMENDATIONS

The recommendations include improving access to health care facilities, further study on reasons why older persons do not prefer health care facilities, and interventions to improve self-care practices of older persons.

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Research Article

Enhancing Community Motivation and Participation in Control of Smoking

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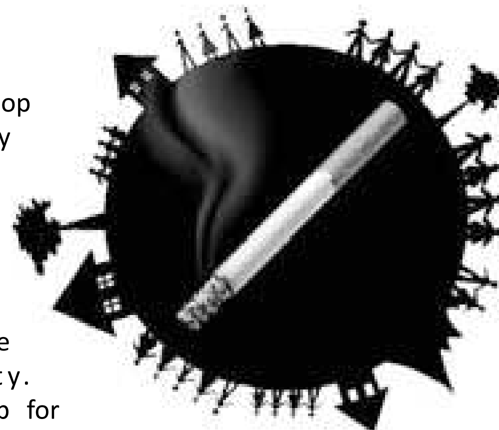
Keywords: *Smoking cessation, tobacco control, community empowerment, participatory action research*

Abstract

The aim of this study was to develop strategies for enhancing community motivation and participation in smoking control in one municipality, in the North-eastern part of Thailand. The Participatory Action Research (PAR) approach was used whereby the researchers facilitate and empower a community. Community meetings were set up for exchange of experiences and for volunteers who could participate in a counseling training program. These volunteers were screened to promote group motivation, initiate a culturally relevant medium, and to create a network for community organization. Motivation was enhanced by volunteers among three partners: 1) smokers - to become healthier through counseling about information of the harmful effects of smoking and benefits of quitting smoking; 2) families - encouraged household members to assess their health, expenditure, and outcomes if any of their own family members stopped smoking; and 3) communities - raised awareness toward smoking control among housewives, workers, seniors, and adolescent groups, who founded a sense of caring for one another as their cousins, increased the number of free-smoking zones in temples, schools, health centers, ex-smokers' houses and areas for community activities. Lessons were learned by the communities, health problems and high cost of cigarette were the greatest motivation for success, but suffering from smoking withdrawal symptoms attributed to unsuccessful quitting of tobacco. 10 out of the 19 villages continued those activities for 18 months. These villages enhanced community motivation and participation in smoking control; however, decreasing the number of new smokers remains of considerable concern.



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Introduction

Morbidity and premature mortality from diseases attributable to tobacco use is increasing (World Health Organization, WHO, 2009). This is one of the most challenging issues for any health care team in the world (US Department of Health and Human Service, 2000; Sarntisart, 2003; National Statistic Office of Thailand. 2007). Approaches to prevent at the individual, community or societal level differ depending on cultural, social, medical, and economic factors (Leartsakulpanitch, Nganthavee, & Salole, 2007; Stephen, Nsimba, & Steve, 2006; Chitanondh, 1994). Numerous theories are used for the control of smoking such as, self-care theory (Vateesatokit, 2001), social cognitive theory (Andrews, et al., 2007), the stage of change theory (Pornapa, et al., 2006; Yerger, Wertz, McGruder, Froelicher, & Malone, 2008), organizational development theory (Cronk, et al., 2010), and community empowerment theory (Monica, 2008; Froelicher, Doolan, Yerger, McGruder, & Malone, 2010). Among these, the most fitting theory for this study is the empowerment theory.

Even though various innovative strategies for tobacco control are in place including public health education and information, a ban for tobacco advertisements, deterrents for tobacco smuggling, and the use of increased tobacco taxes are expanding. All parts of the world are called upon to initiate effective strategies to further reduce the number of premature deaths due to tobacco use and to prevent second hand smoking (Fiore, 2008; Choochai, 2007; Wangkeo, 2000)

The Global Adult Tobacco Survey (GATS) (Global Tobacco Surveillance System, GTSS, 2008) reported the prevalence of adult tobacco smokers in Thailand as 45.6% of men, 3.1% of women, and 23.7% overall among the 12.5 million adults. This situation leads to problems such as cancer, stroke, and heart attack (Chanthana, & Somsri, 2009; Hathai, 2003). As such, the Thai government established a national policy to promote control on smoking and expanded public policies to prohibit sales of cigarette to youths under the age of 18 years to prevent the initiation of new smokers (Tobacco Control Research and Knowledge Management Center, 2008; National Statistic Office of Thailand, 2007; Wisit, & Natchaporn, 2005). As nicotine in tobacco is highly addictive, stopping smoking is extremely difficult without adequate interventions (Pornnapa, et al., 2009). However, while the researchers were working on a smoking control project using a PAR targeting three populations: sugar truck drivers, construction labors, and public transportation drivers, it was found that providing the smoker with a clear understanding of the dangers and benefits of quitting smoking helped to reduce the number of smokers as well as empowered the stakeholder to run a sustainable community development project (Daenseekaew, Klungklang, 2009). The results from a pilot study in one suburban municipality by the researchers, revealed that: 1) almost all families in these villages had a long term smoker member; 2) smoking was accepted as a norm in their culture; 3) smoking among the teenagers was acceptable; and 4) adults and senior men smokers with tobacco related illnesses attempted to find strategies on how to quit smoking. These preliminary findings inspired the present study in terms of encouraging, assisting, and supporting smokers to quit smoking and preventing teenagers to start smoking. Therefore, the researchers and village leaders initiated the PAR self-governance using their own experiences for smoking control (Marcia, Jennifer, & Simon, 2007; Norman, 2000, Chesler, 1991).

The key aim

The key aim of this study is to decrease smoking through achieving community awareness accompanied by mutual learning among participants and researchers.

Research objectives:

(1) Investigate the communities' abilities, attempts, and motivation to stop smoking;
(2) Identify barriers to quitting; and
(3) Develop community mobilization strategies and efforts to enhance community participation in smoking control.

Conceptual framework

The theoretical perspective of empowerment is best operationalized through PAR. The key aim of the study was to achieve community awareness accompanied by mutual learning among participants and researchers (Cameron, Hayes, & Wren, 2000). Furthermore, PAR has been described as a democratic, collaborative relationship and as a research method to empower communities. Thus, the participants initiated the innovation for community motivation in order to increase the awareness of individuals, families, and communities (Rice, & Stead, 2000). This approach developed their sense of responsibility to reduce the harmful effects of smoking, and to improve individuals' use of skills to quit smoking

based on their knowledge and an understanding of existing situations (Marcia, Jennifer, & Simon, 2007; Ulla, et al., 2006; Chesler, 1991). At the end, the participation process was used to help communities develop the necessary interventions for assessing and monitoring tobacco consumption (Gibbon, 2002; Norman, 2000).

Design and methods

PAR with the researchers as facilitators to empower the villagers' participation had performed from October 2008 to June 2010 in 19 villages, with 256 participants of one sub-district in Northeast Thailand. Community leaders joined the stop smoking project. The research process consisted of three phases:

1. **Situational analysis phase**: The researchers identified community needs and structures. Data were collected using four methods. Firstly, three brain storming meetings (for two groups of six villages and one for seven) with community leaders were set up for outcome objectives, for soliciting input for the design and calling for community participants. The second method was the use of focus group discussions during community meetings with five focus groups of the following constituents: (1) ten men who had successfully stopped smoking; (2) twelve men who had made attempts to stop smoking; (3) twelve wives who encouraged and supported their husbands to successfully quit smoking; (4) ten teenagers who were willing to participate in the project; and (5) twelve community leaders who were unsuccessful in their efforts to control smoking and who were eager to learn from the researchers for advancing their stop-smoking-project. The third method was an in-depth interview with 25 key informants who either succeeded or failed with previous smoking cessation efforts. The fourth method was participant and non-participant observation during the community meetings, in-depth interviews, and focus group discussions.

   The information gained from the data collection was then taken to the meetings between the villagers and the researchers to collaboratively perform an analysis of the local situations. The qualitative data were analyzed using content analysis to obtain an accurate view of factors influencing the successes and failures based on the key informants' experiences with smoking control. The data were analyzed at three levels: the communities, families, and individuals. The findings were then presented to the community members at each village meeting to verify, reflect on, and confirm the information and its interpretations.

2. **Community empowering phase**: The researchers called for volunteers from 19 villages. Each village had the volunteers work with the researchers along with the implementation through community participation in the smoking control project. As mentioned earlier at the education phase, when the participants realized the gravity of their real situations, they attained a sense of empowerment to address their problems. Therefore, they decided to conduct implementation based on their plans. The purpose of the implementation was to mobilize their communities in sharing their experiences and to collaborate with the project using three guiding principles: experiential learning, participation, and education. In the meetings, the researchers and chairperson created an atmosphere for open dialogues, reflection, and established action plans based on local needs. Later, the communities implemented these action plans and reflected on them as well as revised the plans as necessary.

3. **Evaluation and strategic development phase**: The last phase consisted of evaluation and conclusion for further development. The volunteers conducted the meetings and expanded these to include other groups such as the youth and women groups, local civil servants, and facilitators of the narcotic control center who volunteered to participate in the meeting. The community implementation plans were constructed during the empowerment phase and aimed to evaluate the outcomes after the first six months of the second phase. The outcomes were evaluated by comparing the situations prior to the implementation of plans and the situations subsequent to the implementation of plans.

Ethical considerations: The proposal for this research project was approved by the Humanities and Social Ethical Committees of Khon Kaen University, Thailand. Permission was also obtained from the District Committees in the study areas. The community leaders were encouraged to comment on the study and to initiate the research objectives cooperatively with the researchers. Non-verbal consent was obtained from the locals participating in the study. All participants were also notified of their right to withdraw from the research

anytime. However, it was made clear that if anyone displayed symptoms of nicotine withdrawal and needed recovery or treatment, the researchers would consult with the community leaders to assist with a referral of the individual to a hospital. Moreover, the researchers committed to share the study's data with the villagers throughout the conduct of the research. Upon the study's completion, all confidential files and notes were destroyed, and the community leaders verified the contents of the study and granted their permission to publish the findings.

Results:

The local's perspectives were revealed as the following areas: individual, family and community were associated with success or failure in smoking cessation.

1. The factors associated with successful smoking cessation.

1.1 Individual-level factors: These included the intention and personal commitment to stop smoking, which resulted from the individual's health concerns. 15 people out of 21 ex-smokers had upper respiratory infection, cough, and pulmonary asthma, felt uncomfortable and had insomnia. Ex-smokers and their caregivers explained the feelings toward a success of stopping smoking similar to the coding below.

"The highest factor was the deep intention as a result of smokers' illness and individual health concerns. I decided to stop smoking by myself and I did control over my smoking behaviors. I threw away cigarettes and its supportive equipment, showered when sweating, drank plain water and squeezed lemon juice to my dry mouth, walked around and kept busy by working. Then, I was successful with healthier living without smoking." (Voice of a 52 year- ex-smoker man)

1.2 Family-level factors: One of the most important factors were their concern for the family member's health, for their household members and increase in household expenditure.

"It was caused by my family bonding. I loved and had a willingness to be caregivers for grandchildren. So, my wife asked me to stop smoking. Also, my cousin convinced me to do health promotion and risk prevention for the sick lover before dying. I thought a lot of that and then, I decided to stop smoking." (Voice of a 47 year- ex-smoker man) (sic)

"I had economic crisis, I didn't have enough money for my son go to school. I needed some more money. Smoking sucked my money. Currently, its cost is so expensive of both factory and self- rolled cigarettes. So, it led me to stop smoking." (Voice of a 35 year- ex-smoker man)

1.3 Community-level factors: These influenced smoking cessation success and were identified as: 1) social factors included a sense of caring and concerns for others' health, particularly when participating in community activities; and (2) environmental factors, especially for the increasing number of smoke-free zone such as in temples, schools and health care centers.

"I am the head of a community. I think that the social factor was a sense of caring for my community members. I felt guilty while participating in community activities with non- smokers. I thought I poisoned them. Then, I tried to stop it." (Voice of a 55-year, a village head man and ex-smoker)

"We wanted to keep a healthy environment. Community members wanted to increase free smoking zones, especially at a temple, school, and health care center. Then, I was a leader. I had to be." (Voice of a 53- year, village head man and ex-smoker)

2. Factors associated with unsuccessful smoking cessation

On the other hand, the data revealed that there were three factors that resulted in smokers craving cigarettes and to "light up" again even though the villagers wanted them to resist their temptation to smoke. They included Individual-level, Family-level and Community factors.

2.1 Individual-level factor: These included feelings of physical discomfort, stress, loneliness, suffering and craving for cigarettes that occurred when trying to quit smoking.

"My friend and I decided to quit smoking many times, but we failed. I got sick and felt signs and symptoms such as discomfort, anxiety, loneliness, and desire to smoke. I felt I was missing it. I desired to smoke again like I felt hunger." (Voice of a 34- year man)

2.2 Family-level factors: Family-related factors consisted of poor relationships between family members, ignorance about family member's health

status, lack of supports for smokers considering stopping smoking, and existing smokers within the family.

"I felt lonely when my family was in a bad mood, neglecting and blaming me when I told them that I wanted to smoke again; stopping smoking was very hard for me." (Voice of a 43- year man)

"My household had a grandfather who had been smoking for a long time. After deciding to stop smoking, I felt something was missing when I came home. I could not stop it if my family still had another smoker in family." (Voice of a 40- year man)

2.3 Community factors: These factors can be explained as: (1) community perceptions that "smoking was a common daily activity due to smoking culture"; and (2) an environmental factor related to going into gatherings and drinking that also induced smoking.

"The leader and some community members wanted to educate the community members to learn about the nation and community policy for protecting a second hand smoke, but it was very hard because some of them, especially working men gathered to drink after work, and then they also smoked. This induced an environment conducive to smoking for the kids. Some parents allowed boys to try smoking as they did when they were young." (Information from meeting)

3. Community participation in smoking control

From community meetings, the participants would like to control the number of smokers and protect their children from becoming new smokers. In the situational analysis phase, they suggested to have some more counselors to help while they were suffering from quitting smoking and for raising their understanding of the benefits of stop smoking as well as the harmful effects of smoking. They believed that this would become a sustainable strategy for smoking control projects. Throughout the study, the villagers participated very well in both cycles of implementation. *(Figure1)*

3.1 First cycle

There were six strategies of community participation as described below.

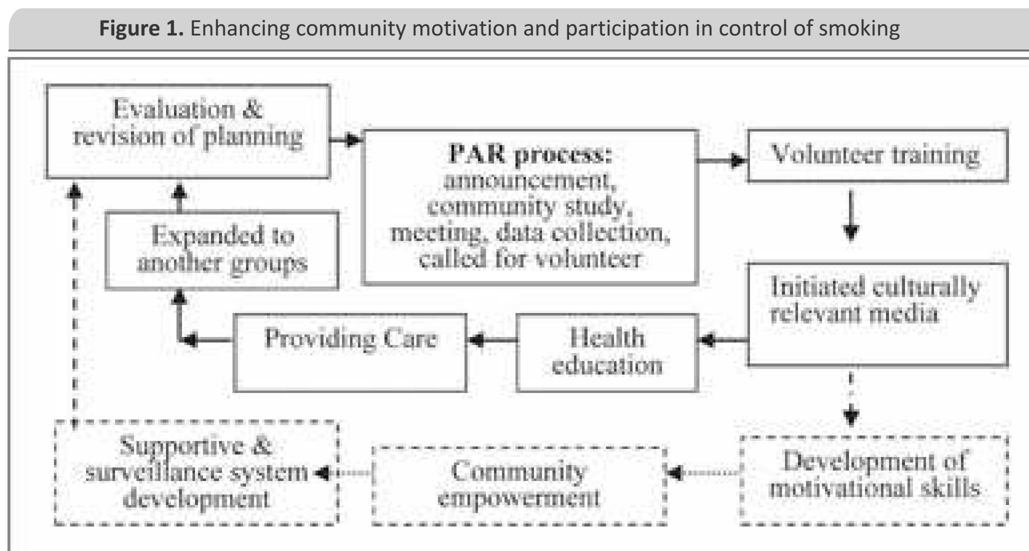
3.1.1 Community study

The research started with a community study and data collection- focus group, in-depth interview, and observation. Community leaders set up community meetings to empower the villagers to participate in this project, made project announcements, and called for volunteers, particularly ex-smokers, caregivers, whoever offered to become a volunteer.

3.1.2 Volunteer training

The researchers trained 57 volunteers from 19 villages. They were ex-smokers, and caregivers who intended to motivate and care for smokers who wanted to stop smoking. The main training topics were the concept and process of PAR, facilitating group learning, motivating smoking cessation, explaining strategies to reduce smoking withdrawal symptoms, and contacting people for any smoking control project problems.

Figure 1. Enhancing community motivation and participation in control of smoking



3.1.3 Creation of health education materials
The following were created while conducting the study.

1) Culturally relevant songs
A small group of volunteers with good local singing abilities wrote local songs and arranged the accompanying music, and made a CD record. These songs were distributed to each village by the leaders.

"We express our experiences on fighting against smoking, the harmful effects of smoking, benefit of stopping smoking, enhancing a long life for our families. We also provide information on how to quit smoking (take it easy, relax, image for a new life and better living), and we add more knowledge how to deal with the heavy suffering after smokers throw their cigarettes away". (Voice of the head of singers)

2) Educational handbook
Community leaders participated with a group to create the handbook on the topic **"Stop Smoking Now, You Can."** The content of this handbook was quite similar to the song. It was prepared for the smokers to encourage smoking cessation. It was small in size and portable.

3) Stickers "Smoke Free Zone"
The stickers were made by the youth group upon the request from ex-smokers among household members who wanted to protect their life from visitors who smoked and to educate their cousins.

3.1.4 Health education
In the meantime, the volunteers gave health education lessons to the local people at three levels: (1) **individual education:** this was offered by the volunteers with the aim to share knowledge and give the handbook to every smoker; (2) **group education:** gave the hand book and the sticker and discussed with the aim to persuade the smokers to control smoking. The volunteers expanded the activities to another adult group, wives, school teenagers, and out of school teenagers in order to persuade them to join this project; (3) **public education:** an announcement by a leader in a meeting, community activities and song played by louder speakers, and stickers with the title "Smoke Free Zone" were attached in schools, temples, community meeting halls, and families' houses in order to draw on the concern of community members.

3.1.5 Care Provider
The volunteers and researchers set up an extended clinic for smoking control. They called for ex-smokers (volunteers), smokers and families' caregivers to participate in verbal screening, physical examination of lung capacity test, counseling, stop smoking commitment with "the significant person" (wife, kid, volunteers, community leaders), a home visit to follow up the new non-smoker and visiting families with a smoker in order to motivate and offer counseling for the next person who wants to stop smoking.

3.1.6 Evaluation and further planning
Every two months, the researchers collaborated with the volunteers to conduct a community meeting to evaluate and further -implementation of the reflections and solutions in the meeting in order to raise the community's awareness of smoking control.

3.2 Second cycle: there were three strategies of community participation as below.

3.2.1 Developing motivational skills
The researchers provided the volunteers opportunities to learn and practice listening, questioning, dialoguing, responding, and offering emotional support.

3.2.2 Community empowerment
During the community meetings, the villagers were empowered to think, learn, share, and initiate the new methods for controlling smoking in their own community. The results showed that they increased in free smoking zone, expanded understanding about benefits of smoking cessation and the harmful effects of smoking, and reduced the smoking and drinking atmospheres in their own villages.

3.2.3 Development of a support and surveillance system
The volunteers conducted group discussions with adults, seniors, adolescents, and wives of participants who had successfully quit smoking. They called for volunteers to observe their friends or cousins while they were having a problem with controlling smoking and consulted with the volunteers before referring a smoker for health care personnel attention. Figure 1, previously shown, presents a schematic of the interrelationships of the Participatory Action Research used for this study.

Results after one year of implementation 10 out of 19 villages have implemented, continued activities and

had community commitment. These villages enhanced community motivation and participation in smoking control; two examples are: public announcements of the legal prohibition of selling cigarettes to the youth under 18 years and prohibiting smoking in public areas.

Discussion

The three most important findings were the factors that were associated with successful smoking cessation. Firstly, individual-level factors included the intention and personal commitment to stop smoking that the participants attributed to their concerns about their health. Secondly, family-level factors included family bonding, love, and concern for the health among family members, and increased household expenditures associated with ill health. Lastly, community-level factors also influenced smoking cessation success. These were the : 1) social factors such as a sense of caring and concerns for others' health, particularly when participating in community activities; and 2) environmental factors, especially the increasing number of smoke-free zone in temples, schools and health centers (Ulla, et al., 2006; Chan, et al., 2003).

Conversely, three groups of factors were associated with unsuccessful smoking cessation and these were the main reasons given for their relapse to smoking. Individual-level factors included physical discomfort, stress, and loneliness, suffering and craving for cigarettes. Secondly, family-related factors consisted of poor relationship with family members, ignorance about family member's health status, lack of support for stopping smoking, and other smokers in the family. Finally, community-level factors consisted of the communities perceptions of "smoking was part of community culture and a common daily activity". Further negative contributing factors were the physical environments that provided incentives for continuation of smoking were gathering places for drinking and smoking in the community, and spaces for smoking (Jian, et al., 2007; Gibbon, 2002).

The interrelationships of the three levels of factors mentioned above related to the success or failure of stop smoking (Prochaska, & Velicer, 1997). This finding provided further incentives to developing strategies to enhance community participation in the control of smoking. On the individual level, participants were able to achieve improvements in their knowledge, proper attitudes, self-control, and life skills (Hammond, McDonald, & Fong, 2004). On the family level, families solidified their existing bonds, inner power, improved their relationships and functioning. On the community level, communities were able to have a sense of mastery over their lives and improve their management and political skills. These three factors may have been conducive to group networking, to think and plan, and contribute skills, experiences, and resources to the community (Sirirassamee, et al., 2008).

The strategies to enhance community participation used the synergy of the communities, families, and participants. Most villagers (e.g. community leaders, heads of family units, wives, teenagers, and seniors) participated and assumed responsibility in the community smoking control programs (Marcia, Jennifer, & Simon, 2007; Chesler, 1991).

The villagers created the health education materials, trained the new volunteers, and set up home visits for the families with smokers. Moreover, they encouraged another group of adults, wives of husbands who were successful quitters, students and teenagers to join the project. In the meantime, the public announcement stickers in the form of posters with the title "Smoke Free Zone" were prominently displayed at schools, temples, community meeting halls, and in houses, as a means to sustain the convictions of the villagers. (Zhu, Melcer, Sun, Rosbrook, & Pierce, 2000; Population Based Smoking Cessation, 2000).

This PAR proved to be embraced through excellent participation resulting based on three principles: empowering, participation, and collaboration (Termsirikulchai, et al., 2008; Daenseekaew, et al., 2005). This was essential to the mobilization of the communities to find a social surveillances system for smoking control as a self-initiative model using PAR as its methodology. PAR proved to be a valuable process for small group gatherings to form a coalition of, small groups, families, governmental and non-governmental sectors to participate in a sustained development project.

Conclusion

The aim of this research was to decrease smoking through achieving community awareness accompanied by mutual learning among participants and researchers. The findings of this study indicated how to develop the strategies for enhancing community motivation and participation in smoking control by using the PAR. Also, PAR in this study was proved to be an appreciated process for gathering a small group to work for the smoking control project in their communities through the empowerment, participation and collaboration. People in the communities learned about the greatest motivation for success of

smoking control, which was the smokers' awareness of their health problems related to smoking and the cost of cigarette. After one year of the project implementation, 10 out of 19 villages had implemented, continued activities and had community commitment. These villages enhanced community motivation and participation in smoking control. The public announcements of the legal prohibition of selling cigarettes to the youth under 18 years and prohibiting smoking in public areas were initiated. However, the suffering from smoking withdrawal symptoms attributed to unsuccessful quitting of tobacco. Moreover, decreasing the number of new smokers remains of considerable concern.

Recommendations for future initiatives

The results of this study justify projects that should be continued:

1) Training of youths to strengthen their life skills should be continued to prevent the initiation of new smokers.
2) Women in the family should continue to protect family members from tobacco.
3) The community should preserve the smoke free environments. Community members should be encouraged to promote the relationships and bonds among teenagers, families, and community networks through surveillance to sustain the gains that have been achieved.
4) The community's awareness should continue in order to protect the community, families and participants from the harmful effects of smoking. Community members should develop community learning centers for education related prevention and control of smoking.

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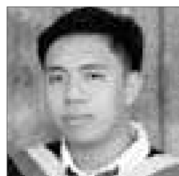
Research Article

Level of Empowerment of Staff Nurses in Selected Private Hospitals in Cavite



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Abstract

The main objective of the study was to establish a clear demographic profile of staff nurses in Cavite, and to determine the level of empowerment of staff nurses in Cavite. Kanter's Structural Model of Empowerment (1977) was used as its backbone in the course of the study since it has been widely applied to practice of nursing management (Nedd, 2006). Descriptive research design was utilized. Self-made, expert reviewed, non-standardized questionnaires was the distributed among private hospitals in the seven districts of Cavite. Results found for demographic profile that there were almost equal distribution of male and female staff nurses, majority were young, finished Bachelor's degree in Nursing and new in service with salary quite low. Staff nurses were found to be moderately empowered in their workplace with all the three power tools based in Kanter's structural model of empowerment (1977), with the following results: systemic power actors (M=4.11; SD=0.607), access to empowerment structures (M=3.96; SD=0.634), and psychological empowerment (M=4.07; SD=0.602). Supervisors and managers are the key to their empowerment (Wilson and Laschinger, 2004, 2004). Empowering leadership is one that could help ease the staff nurses' burnout (Bobbio, Bellan, Manganelli, 2012). Thus, researchers highly recommend various intercessions from their supervisors to uplift the staff nurses' level of empowerment in their workplaces because empowered nurses are effective nurses. It transcends not only to staff nurses themselves, but as well to the recipients of their care.

Key words: *: Empowerment, staff nurses, workplace*

Introduction

Empowerment can create a satisfactorily working attitude among employees. As many authors asserted, empowerment can lead to a productive working attitude among staff nurses in their workplaces (Steward, McNulty, Griffin, and Fitzprick, 2010; Finegan and Laschinger, 2001; Laschinger, Almost, and Tuer-Hodes, 2003; Manojlovich, 2007; Wilson and Laschinger, 2004, 2004), with patient satisfaction (Donahue, Piazza,Quin, Dykes, and Fitzpatrick, 2008), and with higher retention and commitment to the organization (Hauck, Quin, and Fitzpatrick, 2011). Though according to one study, it suggested that nurses, among other hospital personnel, had the lowest empowerment level (Hassan, 2002).

Empowerment is the act of which giving power to a person. And power was viewed as the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet. Furthermore, power is needed to influence others. It is asserted that powerless nurses are ineffective nurses (Manojlovich, 2007).

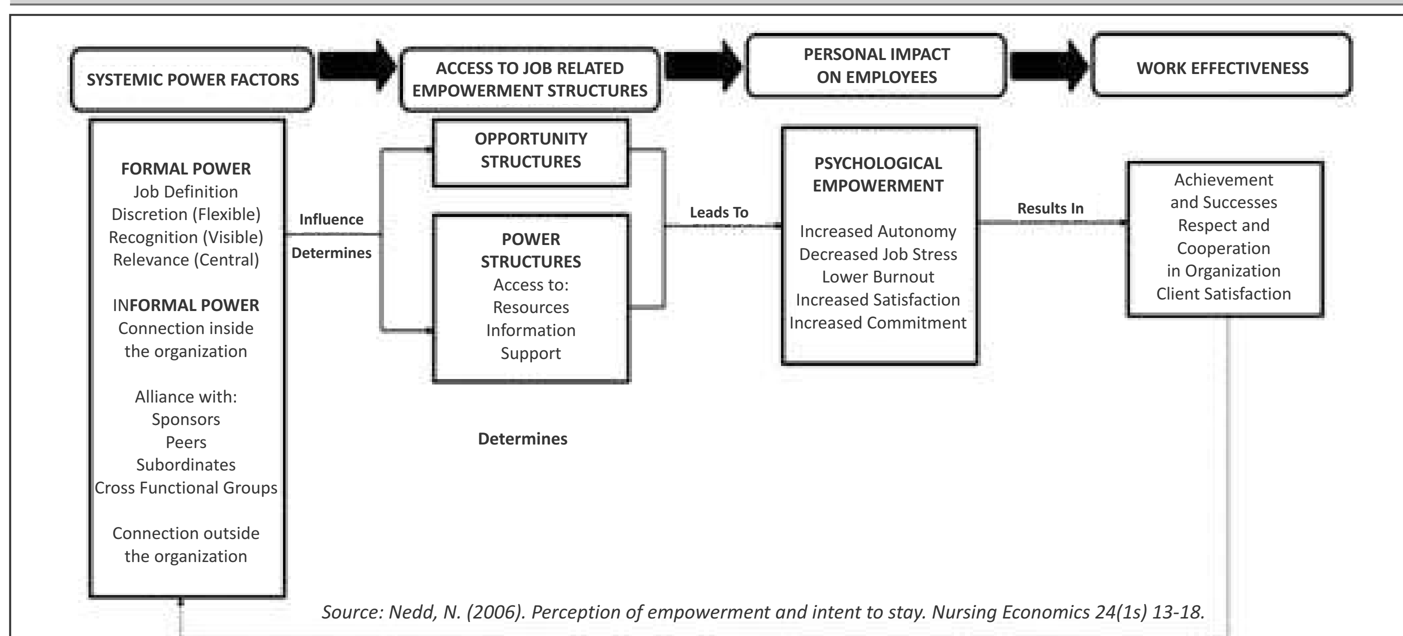
Empowerment can arise from the work environment especially from immediate manager (Wilson and Laschinger, 2004). Empowering leadership was found as an important predictor of empowerment (Bobbio, Bellan, and Manganelli, 2012) and may result to lower levels of job tension and increased work effectiveness (Laschinger, Wong, McMahon, and Kaufmann, 1999); and in overall, organizational effectiveness was seen (Laschinger, Finegan, Sharmian, and Casier, 2000).

Though many literatures were known in the investigation of level of empowerment among staff nurses, yet little was known about the current status of empowerment level in the Philippine setting and among its professional nurses in their workplace.

Thus, this study was aiming to determine the level of empowerment of staff nurses in their workplaces. Specifically, the objectives of the study were (1) to establish demographic profile of the staff nurses, and (2) to determine their level of empowerment in their workplaces. The study was conducted in the province of Cavite which has several private hospitals scattered among its seven districts. Furthermore, this study uses Kanter's Structural Model of Empowerment (1977) as its backbone in the course of the investigation (see Figure 1) since it has been widely applied to practice of nursing (Nedd, 2006).

Figure 1 shows that empowerment was seen through three power tools to attain work effectiveness. First power tool was systemic power factors. It was composed of two factors: formal and informal power. Formal power factors were those factors recognized by the institution like job definition, flexibility, visibility, and creativity. It is also comes from jobs that were considered relevant and central to the organization. Informal power is developed from relationships and networks with peers, subordinates, superiors within and those significant others outside the organization. Informal power factors were those not recognized by the institution though still had impact with regards to empowerment like connection inside or outside the organization. The second power tool was access to job related empowerment structures. It was comprised of opportunity and power structures. Instances of power structures were information, resources and support. *Information* relates to the data, technical knowledge, and expertise required in performing one's job. *Access to resources* refers to the ability to acquire necessary materials, supplies, money, and personnel needed to meet organizational goals. *Support* refers to guidance and feedback received from subordinates, peers, and supervisors to enhance effectiveness (Nedd, 2006).The third power tool was psychological empowerment. It was the most personal level among the power tools and it was comprised of perceived competence, meaning, self-determination and impact (Bartram, Joiner, and Stanton, 2004). Sets of questions were created per power tool and pertaining to its comprising factors in the creation of research instrument.

Figure 1. Kanter's Structural Model of Empowerment (1977)



Source: Nedd, N. (2006). Perception of empowerment and intent to stay. Nursing Economics 24(1s) 13-18.

This study was half-part of a research conducted in the Cavite State University – College of Nursing by a team of researchers entitled:"Gender Empowerment of Staff Nurses in Selected Private Hospitals in the Province of Cavite".

The following covers the creation of a research instrument statistically validated and reviewed by pool of experts, sampling in the coverage of the staff nurses working in private hospitals in Cavite, and the results, discussion, limitation, and recommendation of the study will be all discussed further.

Methodology

This study utilized descriptive research design to clearly determine the level of empowerment of staff nurses. Cluster sampling was used to select the private hospitals in the seven districts of Cavite. In order to get the sample of the respondents, non-probability purposive non-quota sampling was used to take small samples per hospital in every district.

A non-standardized, self-made questionnaire was used to quantitatively measure level of empowerment using Likert scale (see Table 1). It was composed of two parts: (1) the demographic profile which includes sex, age, educational background, civil status, salary, and the total length of service; and (2) a 62 item questionnaire based upon Kanter's Model of Structural Empowerment. It was reviewed by a pool of experts before and after it was pre-tested to ten participants not included in the study. The research instrument had undergone into Reliability Analysis Scale – Alpha for three empowerment structures: systemic power factors (α=0.9130), access to empowerment structures (α=0.9466), and psychological empowerment (α=0.8396). Any unsatisfied questions in the questionnaire were removed. Mean, standard deviation and percentage analysis were used as statistical treatment.

Table 1. Verbal interpretation for the mean score of level of empowerment

Mean Score	Level of Empowerment
1.00 – 1.79	Not Empowered
1.80 – 2.59	Slightly Empowered
2.60 – 3.39	Empowered
3.40 – 4.19	Moderately Empowered
4.20 – 5.00	Highly Empowered

Criteria were set in the recruitment of respondents: (1) must be registered nurses, and currently employed at the time of the study. Ethical considerations were done in the recruitment of respondents. A cover letter was attached to the research questionnaire explaining the objectives and purpose of the study, and specifying non-disclosure of their identity and their responses to the questionnaire. Likewise, a letter of consent was sent to hospital administrators stating the intent of the study, its objectives and non-disclosure of the response of their respective staff nurses before the conduction of the study in their respective hospitals. Respondents were also had the discretion whether to participate or not in the survey.

Seventy-two percent (72%) of questionnaires were returned and found complete and ready for statistical treatment.

Results

In the establishment of the demographic profile of staff nurses in the province of Cavite, the survey had reported the following results (see Table 2). Female staff nurses (n-56; 55.4%) were slightly predominant in number compared to their male (n-45; 44.6%) counterpart. It was evident that majority of respondents were 24 years old and below (n-58; 57.4%). In terms of civil status, most were single (n-82; 81.2%). Bigger part of the samples

Table 2. Demographic profile of staff nurses in the province of Cavite

Demographic Profile	Frequency (N=101)	Percentage (%)
Sex		
Male	45	44.6
Female	56	55.4
Age		
24 years old and below	58	57.4
25 to 29 years old	30	29.7
30 years old and above	13	12.9
Civil Status		
Single	82	81.2
Married / Separated	19	18.8
Educational Attainment		
Bachelor's degree	94	93.1
Master's units / degree	7	6.9
Length Of Service		
Less than 1 year	26	25.7
1 to 2 years	36	35.6
2 to 3 years	17	16.8
More than 3 years	22	21.8
Salary		
PhP 5,000 and below	33	32.7
PhP 5,001 to PhP 10,000	61	60.4
PhP 10,001 to PhP 15,000	7	6.9

reported baccalaureate level (n-94; 93.1%)as their educational attainment. Majority stated of having one to two years in their length of service (n-36; 35.6%). And most of the respondents reported a salary ranging from 5,001 Php to 10,000 Php (n-61; 60.4%).

In determining the level of empowerment, here was the result of the survey (see Table 3). It was found in the study that there was moderate empowerment to all power tools, systemic power factors, access to empowerment structures and psychological empowerment.

In systemic power factors (Table 3), it was seen that among its two factors, informal power factor (M=4.20, SD=0.595) consisted of connection inside (peers, supervisors, colleagues, etc.) and connection outside (friends, families, etc.) their organization was reported to have higher score than formal power factor (M=4.01, SD=0.607). Formal power factors are recognized by the institution like discretion, recognition and relevance.

Table 3. Level of empowerment of staff nurses in the province of Cavite

Power Tools	Mean	Standard Deviation	Verbal Interpretation
Systemic Power Factors	4.11	0.607	Moderately empowered
Access to Empowerment Structures	3.96	0.634	Moderately empowered
Psychological Empowerment	4.07	0.602	Moderately empowered

Though, it was seen in the access to empowerment structures were found equal in interpretation: Power structures (M=3.95, SD=0.647) such as resources, information and support, and Opportunity structures (M=3.98, SD=0.703). Their scores as moderately empowered in accordance to the results of the survey. In power structures, access to support (M=4.09, SD=0.700) contributed more than to access to information (M=4.03, SD=0.700) and access to resources (M=3.73, SD=0.760).

In the result of psychological empowerment, the highest score came from meaning (M=4.19, SD=0.699), followed by perceived competence (M=4.16, SD=0.641), then self-determination (M=4.10, SD=0.692), and impact (M=3.85, SD=0.731).

Discussion

This section discusses about the demographic profile such as sex, age, civil status, educational attainment, length of service, and salary, and level of empowerment among staff nurses in Cavite.

Demographic Profile

Sex

It was found in the study that the majority of respondents were female (55.4%). Many authors had presented the same sex distribution in the nursing profession. But unlike to their results, sex distribution among nurses to other countries was seen that there was large difference in number of female and male in the nursing workforce. In survey conducted in US, it was approximated 5.8 percent of male nurses in their nursingworkforce (minoritynurse.com). In Taiwan, a study reveals that male nurses comprise of only 0.58 percent in the nursing (Lui, 2008; Kuo et al., 2007) and in Turkey it was reported that there were no male in their nursing profession (Cavus, and Demir, 2010). Likewise, Canada, British Columbia, and the Netherlands had also low number of male nurses compared to their female counterpart in the profession; though it was also reported in literature that there was substantial number of male nurses in the Philippines and Germany (virtualcurriculum.com).

It was expected that there was larger number of female nurses in the profession as accordance to the result. The predominance of women in the profession can be traced back to its pioneer that Nightingale discouraged men in nursing (Masters, 2005). It was also evident in the history and literary works that women were performing the trade of care (Kozier et al., 2004; Crowther, 2002). It was observed that caring or basically nursing the sick can be traced to their home where mothers or women perform the job while men were the hunters or protectors (Kozier et al.). According to Crowther (2002), socio-cultural impact maybe was the reason of why women predominates the nursing profession because it was more accepted and had no conflict to womanhood.

Age

The study suggested that the majority in nursing workforce of Cavite were in between the ages 24 years old and below (57.4%). Few literatures were found in describing age distribution, though one internet site had provided insightful age distribution in relation to year periods in US alone. According to georgian.org, the average age in US nursing workforce was 46.8 years old in year 2004, and these remains throughout time from 1980 up to 2004 with ages mainly ranging from 35 to 45 years

old. Laschinger et al. (2003) reported through their study that the average age of nurses was 40 years old. In Taiwan, 34-85 years old were the mean age of their nursing workforce (Kuo et al., 2007). Cavus and Demir (2010) reported that the mean age of nurses in Turkey was 32.7 years old. The result of the study may suggest that due to high number of young individuals among the staff nurses may arise from high number of graduates in nursing program in recent years. Also, high turnover rate of experienced nurses maybe the reason of why they were quickly replaced by younger ones in Cavite. The discrepancy in the comparison of other literature to the study's result maybe because of their low number of graduates of other countries and employing younger nurses were not feasible. But due to limited literature about age of nurses, it remained inconclusive of what was the reason of the discrepancy between the result of the study and of other literatures.

Civil Status

It was found that there were more single (81.2%) staff nurses in Cavite. There was limited literature available in describing of civil status of nurses. Few of these literatures asserted that there were more married nurses than those who were never married (georgian.org; Kuo et al., 2007). In Filipino context, the average marrying age was around 24.7 years old for females and 29.7 years old for men in the year 2007 (Philippine Statistics Office, 2010). Thus, this was maybe the reason of why there were mostly unmarried. Though, due to limited cited literatures, this remained unclear and need further evaluation.

Educational attainment

Mostly among staff nurses reported that they obtained baccalaureate degree (93.1%). It was a prerequisite for entry level position of being staff nurse was to obtain a Bachelor of Science degree in nursing in order to take licensure examination for nurses. Furthermore, the licensure examination for nurses was for the recognition of nursing graduates as registered nurses in the Philippines as mandated by RA 9173(Philippine Nursing Act of 2002). In compare to US setting, georgian.org reported that most number of entry level position for nurses had come from diploma. Though, there were different guidelines in any regulation of profession like nursing in every country or state. Little was known about educational attainment of staff nurses in literature, thus the inadequacy may provide a minimal understanding of this demographic component.

Length of service

Many of staff nurses reported that they had 1 to 2 years (35.6%) followed by those who reported of less than 1 year (25.7%) in their length of service. As it was expected, in relation to the result from age of staff nurses, length of service can be seen to the figure provided that there was minimal number of years as well. Entry level position as nurses can be seen through this also. According to Laschinger et al. (2003) reported that average nursing experience was 8 years length of service to their current job, and it was seen in the study ofKuo et al. (2007) that the average length of employment was 35 – 94 months (2.9 – 7.8 years). This contradicts the present study. It showed in the study that staff nurses had less number of length of years compared to other countries surveyed.

Salary

Majority of the surveyed respondents reported that they earned salary between 5,001 Php – 10,000 Php (60.4%) as staff nurses in their respective hospitals. It was inconvenient to compare salary among other countries because of many socio-political and economic factors in the determination of how they pay their workers like salary grade in each country, economic status and others. Though, the researchers still deemed it as important especially in the establishment of demographic profile of staff nurses. According to Kuo et al. (2007), their nurses earned with as average of 10,000–20,000 TWD (US $306–US $612) per month. In the US, it was reported that $57,785 average annual salary (about US $4,815 per month) (minoritynurse.com). Though as accordance to RA 9173, the recommended salary grade for nurses is salary grade 15 which is equivalent to 24,000 Php. And as per the circulation of salary matrix promulgated by the Department of Budget and Management, nurses in the Philippines must earn in accordance to salary grade 11 which is equivalent to 17,000 Php to 18,000 Php (nursingguide.ph). Other monetary and non-monetary benefits mandated by law in the Philippines like the Magna Carta for Public Health Workers were not applicable in the course of comparison because the target respondents are working staff nurses in the private hospitals. They were not covered of such benefits; though other deemed factors in the benefit giving is highly discretionary to the hospital administrators. It was seen that staff nurses earned below the minimum mandated by the Philippine laws. With large number of staff nurses earning between 5,001 Php to 10,000 Php, it was revealed that staff nurses were earning below of what they should have been earning.

Level of Empowerment of Staff Nurses

In the measurement of level of empowerment, empirical evidence shows that staff nurses were moderately empowered with all the power tools presented in Kanter's Structural Model of Empowerment (1977). It will be discussed in three parts.

Systemic power factors

The results showed that staff nurses were moderately empowered in respect to the level of empowerment in systemic power factors (M=4.11, SD=0.607). Among other studies, it was also evident that they also reported that staff nurses in their researches were moderately empowered as well in this aspect of empowerment (Sarmiento et al., 2004; Kuo et al., 2007; Laschinger et al., 1999; Laschinger, Wong, and Greco, 2006). Systemic power factors are comprised of formal and informal power factors. The greatest contributor of the level of empowerment of staff nurses was informal factors (M=4.20, SD=0.595). This was consisted of their connections with their managers, supervisors, colleagues and other member of their workplace. In this factor, having good connections with friends, families and other people outside the workplace can also contribute in the empowerment level of the staff nurses. As Kuo et al. (2007) asserted that there is higher degree of empowerment level in informal power than to the formal power factors which corroborates in the result of the study. Furthermore, informal connections were seen as a great contributor as an empowering factor (Laschinger and Finnegan, 2005).

Access to empowerment structures

In access to empowerment structures, it was found that staff nurses were moderately empowered (M=3.96, SD=0.634). It agreed with several researches that staff nurses were moderately empowered in this aspect of empowerment (Hassan, 2010; Kuo et al., 2007; Hauck et al., 2011; Almost and Laschinger, 2002). Though various accounts that access to resources was higher (Hassan, 2010), or support was higher (Kuo et al. 2007) than any other components of the power structure. But, the results showed that there is minimal discrepancy in score between, resources, support and information. The interplay of these components greatly contributed to the level of empowerment of staff nurses in this aspect of empowerment.

Psychological empowerment

In the aspect of psychological empowerment, it was presented in the results that the staff nurses were moderately empowered (M=4.07, SD=0.602). Other researchers also concurred with the findings (Cavus, and Demir, 2010; Finegan and Laschinger, 2001; Faulkner and Laschinger, 2008). But with the interplay of components of psychological empowerment constitute truly to the level of empowerment in this aspect of empowerment (Bartram et al., 2004). Meaning, as a component, having the highest scores shows that they have deep connection with their job and sees it as satisfying and significant to themselves. Though the other components have lesser score than meaning, the interplay of these components produces a clear picture of the psychological empowerment of staff nurses.

Limitations

There were various limitations in the study that the researchers considered. These were the sampling, research instrument, and number of literature. There were a small number of sample that had been recruited from the population of staff nurses due to limited time. If the study will be replicated or retested, there would be a chance that unpredicted factors could affect the results if there was a larger sample. The samples that the researchers recruited were only from the staff nurses of Cavite. The researchers did not include those of the public health sector, primary health care, or in other place or time. Interpretation of results is also seen as limitation to the study. Another limitation is the sampling technique done. Because of the limited time that researchers had, it made them choose the convenient way to sample the population of the staff nurses.

The survey questionnaire was considered a limitation. Though tested and found to be reliable, there was still a need for the research instrument to be retested as to establish further its validity and reliability to assess level of empowerment.

Due to limited number of literature about empowerment especially in the Filipino context and its nursing workforce, it was deemed that this was also considered as limitation to the study. Limited comparative analyses of other literature and the study may lack in the provision of context to time, places and

people. In further understanding the concept of empowerment, other unpredicted or untested componentsmay also be overseen in the nursing workforce in different contexts that other literatures may provide.

Conclusion and Recommendations

Various research literatures were agreeing that level of empowerment affects job performance, burnout, working attitude, organizational commitment and patient outcome. It is recommended that various interventions should be planned in order to empower staff nurses in their workplaces. Supervisors and managers are the key to their empowerment (Wilson and Laschinger, 2004). Empowering leadership is one that could help ease the staff nurses' burnout (Bobbio et al., 2012). This research may become an insight of the empowerment status of staff nurses that supervisors and hospital administrators may create plan or intervention to uplift their staff nurses' empowerment status. Empowered nurses were effective nurses (Minajlovich, 2007).

Empowering staff nurses in their workplace can proceed to betterment of their service. There were many ways to empower staff nurses. The supervisors must entrust staff nurses with their resources, information, and support. They must show confidence with their staff nurses. Believing in what they can do can result to betterment of themselves. The workplace must have supportive environment that fosters good communication and understanding with all its personnel. In both ways, staff nurses and their supervisors must give each other trust and respect in order to find harmony in the workplace. Supervisors must value the views and opinions of their subordinates toward their work.

Though empowerment is seen to have a direct effect among nurses in the workplace, the end product of empowerment still lies among their recipients of care, the patients, who needs effective and work efficient nurses that could help them in their greatest time of need.

Due to limitation of the study to sampling, there should be more rigorous and thorough sampling technique should be taken into accord to be able to generalize the result of the study. It must be tested to other provinces and regions in the Philippines as to assess level of empowerment in other cultural contexts. Also, it is highly recommended that it should be retested to other fields of nursing such those in the public health sector, primary health care, and nursing education.

As well, further analysis and testing should be done for the research instrument in order to make it more reliable by testing it in other contexts such as culture and other nursing fields.

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Research Article

Filipino-American Nurses' Knowledge, Perceptions, Beliefs and Practice of Genetics and Genomics[1]

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Abstract

Introduction: There is limited information on the knowledge, perceptions, beliefs, and practice, about genetics and genomics among Filipino-American nurses. The National Coalition of Ethnic Minority Organizations (NCEMNA), in which the Philippine Nurses Association of America (PNAA) is a member organization, conducted an online survey to describe the genomic knowledge, perceptions, beliefs, and practice of minority nurses. This study reports on responses from Filipino-American survey participants, which is a subset analysis of the larger NCEMNA survey.

Objective: The purpose of this study was to explore the knowledge, perceptions, beliefs, practice and genomic education of Filipino-American nurses.

Method: An online survey of 112 Filipino-American nurses was conducted to describe the knowledge, perceptions, beliefs, and practice of genetics/genomics. Survey responses were analyzed using descriptive statistics.

Results: Most (94%) Filipino-American nurses wanted to learn more about genetics. Although 41% of the respondents indicated good understanding of genetics of common diseases, 60% had not attended any related continuing education courses since RN licensure, and 73% reported unavailability of genetic courses to take. The majority (83%) of PNAA respondents indicated that they would attend genetics/genomics awareness training if it was offered by their national organization during their annual conference, and 86% reported that the national organization should have a visible role in genetics/genomics initiatives in their community.

Conclusion: Filipino-American nurses wanted to learn more about genetics and were willing to attend genetics/genomics trainings if offered by PNAA. The study findings can assist PNAA in planning future educational programs that incorporates genetics and genomics information.

Key words: *: Filipino Nurses, Minority Nurses, Genetics and Genomics education, Genetics and Genomics knowledge and practices*

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Introduction

Recent findings from a national nursing workforce survey on nursing attitudes, knowledge, and practice in genomics from 619 registered nurses practicing in the United States revealed that more than 50% of nurses are inadequately prepared to translate genomic information into clinical practice (Calzone, Jenkins, Culp, Bonham & Badzek, 2013). The group that conducted the survey recommended that targeted genomic nursing education is necessary to optimize workforce preparation to integrate genomic information into clinical practice (Calzone et al., 2013). Two concepts that are important for nurses to understand are genetics and genomics. Genetics is the study of specific genes and their role in inheritance, and genomics refers to an organism's entire genetic makeup (National Human Genome Research Institute (NHGRI) (2014). Both concepts are very important to health, because errors in single genes (genetic) can predispose an individual to specific genetic disorders, while understanding the interactions of genes (genomics) with non-genetic factors such as diet, exercise, or smoking, may prevent the development of complex diseases.

The integration of genomic information into routine clinical practice for nurses has the potential to improve care outcomes (Calzone, Jenkins, Culp, Bonham & Badzek, 2013). Moreover, translation of genomic information to clinical practice will assist patients and families with making therapeutic decisions, understanding their susceptibility to diseases, and monitoring disease burden and recurrence (Calzone et al., 2013). Another major role in the application of genetics and genomics is assisting families in making decisions related to preconception, prenatal testing, and newborn screening (Calzone et al., 2013). Thompson and Brooks (2011) found that nurses are unprepared to deal with questions raised by patients/families or by health care providers related to genomic information. Increasing nurses' understanding of the relevance and the limitations of genetic and genomic information will enable nurses to better assist families with options related to health.

Study Aims

This paper reports findings on the knowledge, perceptions, beliefs, practice, and genomic education of Filipino-American nurses who participated in the survey conducted by the National Coalition of Ethnic Minority Nurse Associations (NCEMNA). In addition, this paper provides publicly available resources that can assist Filipino-American nurses learn basic and advanced genetic/genomic concepts and information. The ultimate goal of this paper is to assist Filipino-American nurses to acquire and translate genomic knowledge into practice.

The collaborative goal in conducting the parent NCEMNA survey was to explore how well nurses have integrated genomics into practice. The specific study aims of the NCEMNA survey were: (1) to determine minority nurses' beliefs, practices and competency of integrating into practice genomic information related to common multi-factorial diseases, and (2) to assess the knowledge of minority nurses on human genetic variation and the use of patient characteristics including ethnicity, gender, genes, and race in diagnostics, treatment, and referral decisions. The NCEMNA represents 350,000 nurses and is composed of five ethnic minority nursing organizations, namely: Asian American / Pacific Islander Nurses Association, Inc. (AAPINA), National Alaska Native American Indian Nurses Association, Incorporated (NANAINA), National Association of Hispanic Nurses, Incorporated (NAHN), National Black Nurses Association, Incorporated (NBNA), and the Philippine Nurses Association of America, Incorporated (PNAA) (Coleman, Calzone, Jenkins, Paniagua, Rivera, Hong, Spruill, Bonham, 2014).

Filipino nurses make up almost 40% of internationally trained nurses practicing in the United States (U.S.), comprising about 3.7% of the total U.S. nursing workforce (Xu & Kwak, 2005). Most Filipino nurses practicing in the U.S. hold a Bachelor's degree in Nursing earned from nursing schools in the Philippines. However, not all nursing schools in the Philippines are teaching courses related to genetics/genomics or on how to manage genomic information.

Methods

Study Design

A descriptive survey design with a convenience sample was used in this study. Responses from PNAA participants who voluntarily participated in the parent NCEMNA survey were included in the analyses. The detailed data collection procedure and results of the parent NCEMNA survey has recently been published (Coleman et al., 2014). The study was conducted online and there were 112 PNAA members who participated in the NCEMNA survey. Some of the PNAA respondents opted not to answer some items of the survey, hence total responses from survey items ranged from 106-112, as described in the tables.

Instrument

The instrument used was a compilation of the following five instruments, namely: Knowledge, Attitude and Interest of African American Nurses (α =0.65), Bonham and Sellers' Genetic Variation Knowledge Assessment Index, Bonham and Sellers' Health Professionals Beliefs about Race scale (HPBR-BD α=0.69, four items and HPBR-CD α = 0.61, three items), Bonham and Sellers' Radial Attributes in Clinical Evaluation (RACE) scale (α=0.86, seven items) and the Genetics and Genomics in Nursing Practice, which have been combined and piloted by Coleman et al (2014). The compiled survey was a 61-item instrument divided into seven sections: beliefs, knowledge, practices, use of race, ethnicity, education, and demographics. The tool included multiple choice, dichotomous (Yes or No), and Likert scale questions. The instrument may be completed in 20 minutes or less. Data were stored in a password-protected file available only to study investigators.

Procedure

An institutional review board approval was obtained from Cedars Sinai and the National Institutes of Health Office of Human Subjects Research and Protection prior to conducting the study. Recruitment was made through e-mail invitation, newsletters, and during each NCEMNA members association's annual event. PNAA members were also provided with a hyperlink to the survey, which was posted on the PNAA and NCEMNA websites. Participants were not offered any incentives. They received written instructions that participation in the survey was voluntary and required informed consent. No identifying information from survey participants was collected or stored. The survey was available electronically to all PNAA members for a total of 10 months. Participation to the survey was limited to licensed registered nurses with access to the online survey. Membership to any NCEMNA organization was not an eligibility requirement for survey participation.

Statistical Analyses

Demographic data are presented as raw numbers and/or percentages. Descriptive data analysis was conducted on survey responses presented as frequencies and percentages. All analyses were conducted using SPSS 19.0 program.

Results

Demographic and Work Characteristics of Participants

There were 389 participants who participated in the parent NCEMNA survey, 112 of those are PNAA members, which is <1% of the current estimated PNAA membership (3,957 PNAA members). The PNAA participants were primarily women (89%). All (N=112) identified themselves as non-Hispanic and 90% reported Asian as their ethnicity. Overall, 66% worked in the hospital, where half primarily provided direct patient care and 61% of their work time was spent seeing patients. Respondents worked in nursing for an average of 31 years, and 50% held a baccalaureate degree and 44% held a master's degree. Table 1 lists the demographic characteristics of the sample.

Table 1. Demographic Characteristics of PNAA Participants of the NCEMNA survey

Demographics Total N=112	*n* (%)
Sex (*n*=108)	
Male	12 (11%)
Female	96 (89%)
Highest Level of Nursing Education (*n*=109)	
Diploma	1 (1%)
Associate Degree	2 (2%)
Baccalaureate Degree	54 (50%)
Master's Degree	48 (44%)
Doctorate Degree	4 (4%)
Number of Years in Nursing (*n*=106)	
Mean	31
Number of Years in Current employment (*n*=108)	
0-2	12 (11%)
3-5	10 (9 %)
6-10	12 (11%)
>10	74 (68%)
Primary Role (*n*=111)	
Administration	28 (25%)
Education	8 (7%)
Research	2 (2%)
Patient Care	56 (50%)
Other	17 (15%)
Percent of Time Spent Seeing Patients (*n*=102)	
Mean	(61%)

Beliefs

Table 2 provides an overview of the respondents' beliefs related to genetic/genomic information. The majority of Filipino-American nurses (87%) strongly agreed that family health history can help identify at risk families and believed that family health histories can be used to teach patients and family members about the importance of genetics/genomics and disease prevention. However, majority of participants either held a neutral opinion (30%) or disagreed (28%) that genetic testing discriminates against ethnic minorities.

Table 2. Beliefs Measures (Total N = 112)

Measure	*n* (%)
Do you believe that family health history can help to identify at risk families? (*n*=109)	
Strongly agree	95 (87%)
Agree	12 (11%)
Neutral	0 (0%)
Disagree	1 (1%)
Strongly disagree	1 (1%)
Do you believe that family health histories can be used to teach patients and family members about the importance of genetics /genomics and disease prevention? (*n*=111)	
Strongly agree	97 (87%)
Agree	11 (10%)
Neutral	0 (0%)
Disagree	2 (2%)
Strongly disagree	1 (1%)
Do you believe that genetic testing can be used to discriminate against ethnic minorities? (*n*=106)	
Strongly agree	18 (17%)
Agree	30 (28%)
Neutral	30 (28%)
Disagree	19 (18%)
Strongly disagree	9 (8%)
There are genetic differences in racial groups that influence health (*n*=106)	
Strongly agree	62 (58%)
Somewhat agree	36 (34%)
Somewhat disagree	4 (4%)
Strongly disagree	2 (2%)
Unsure	2 (2%)
Race is the best proxy clinicians have to identify genetic effects on health (*n*=105)	
Strongly agree	31 (30%)
Somewhat agree	40 (38%)
Somewhat disagree	18 (17%)
Strongly disagree	11 (10%)
Unsure	5 (5%)

Of the PNAA respondents, 60% believed that self-reported race is informative of a racial group's genetic ancestral background, and majority (57%) agreed that a clinician's best predictor of treatment response is the patient's self-identified race. Further, 44% strongly agreed that a patient's race can also identify who can benefit from referral to genetic services for certain diseases, and 46% of the sample strongly agreed that human genetic variation provides clues to unraveling the primary causes of specific racial and ethnic disparities in health.

PNAA participants believed that integrating an understanding of genetics of common diseases into their clinical practice will have potential advantages. These advantages included better decisions about recommendations for preventive services (86%), better treatment decisions (61%), improvement of services to patients (59%), better adherence to clinical recommendations among patients (57%), and optimizing patient's visit time by better genetic risk triaging (50%). However, they also believed that integrating use of genetic information of common diseases into their clinical practice would also have some disadvantages. These disadvantages included an increase in insurance discrimination (57%), increase patient anxiety about risk (52%), may not be reimbursable or may be too costly (50%), a need for professional "re-tooling" (31%), can pose medico-legal problems for nurses related to testing (27%), can place greater burden of responsibilities on nurses (27%), and can take too much time (27%).

Practice

The PNAA respondents reported that family history (71%), age (64%), race/ethnicity (57%), genetic profile (54%), and gender (52%) are essential information to consider when delivering nursing care. Majority of respondents (73%) completed a heath history on patients in their practice setting (Table 3, page 52). When a patient indicates a disorder in the family, 91% of the sample expressed that a standard family history assessment should include information about the patients' relationship to family members afflicted with the disorder, 82% wanted to know whether the disorder is present in both sides of family, 80% wanted to know the age at diagnosis of family members with the condition, 76% chose race/ethnicity, and 66% selected age at death of family members with the condition.

Table 3. Practice Measures (Total N = 112)

Measure	n (%)
Do you know how to complete a family health history? (n=111)	
Yes	97 (87%)
No	4 (4%)
Uncertain	10 (9%)
Have you ever completed a family health history on yourself? (n=109)	
Yes	77 (71%)
No	32 (29%)
Have you ever completed a family health history on your family? (n=110)	
Yes	51 (46%)
No	59 (54%)
Have you ever completed a family health history on patient(s) in practice setting? (n=110)	
Yes	80 (73%)
No	30 (27%)
I consider my patient's race to better understand their genetic predispositions. (n=108)	
All the time	33 (31%)
Most of the time	45 (42%)
Some of the time	13 (12%)
A little of the time	7 (6%)
None of the time	10 (9%)
I consider my patient's race when administering medications. (n=108)	
All the time	28 (26%)
Most of the time	25 (23%)
Some of the time	23 (21%)
A little of the time	11 (10%)
None of the time	21 (19%)
I consider my patient's race when determining age of initiation of screening for certain diseases. (n=108)	
All the time	18 (17%)
Most of the time	36 (33%)
Some of the time	25 (23%)
A little of the time	2 (2%)
None of the time	9 (8%)
Not applicable	18 (17%)
I consider my patient's race in determining genetic risk for single gene conditions. (n=107)	
All the time	30 (28%)
Most of the time	36 (34%)
Some of the time	14 (13%)
A little of the time	9 (8%)
None of the time	18 (17%)
I consider my patient's race in determining how aggressively to treat particular diseases. (n=108)	
All the time	14 (13%)
Most of the time	26 (24%)
Some of the time	29 (27%)
A little of the time	4 (4%)
None of the time	17 (16%)
Not applicable	18 (17%)

When respondents were asked about important factors that influence decision-making in their clinical practice, 31% always considered a patient's race to be an important factor to understand one's genetic predispositions. Further, 26% of sample always took into account their patient's race when administering medications and 17% always considered the patient's race when deciding to initiate screening for certain diseases. Of the sample, 13% always considered a patient's race in determining how aggressively to treat particular genetically-linked diseases.

Knowledge

When asked about broad genetic knowledge, 76% of the respondents know that common structural genetic variations is important to health and disease, and 65% know that all genetic variations in an individual can be attributed to inherited changes in the human genome. However when asked about specific genetic knowledge, close to 40% of the PNAA respondents did not know that DNA sequences of two randomly selected healthy individuals of the same sex were 90-95% identical, or that a single gene variant caused most common diseases. Further, 47% of participants either did not know or not sure whether variations in human genome may be disease-causing or have no effect on health and disease. Additionally, 75% of participants did not know or were not sure that most common diseases such as diabetes and heart disease are not caused by a single gene variant (Table 4, page 53). These high numbers of wrong and unsure responses from survey participants related to genomics and genetics knowledge affirm that further education is necessary.

Perceptions

Majority of PNAA participants (77%) reported that both genetics and environment contribute to racial/ethnic and gender differences in health outcomes. Similarly, 63% perceived that absence of a family history for a given disease may reduce a patient's risk to below average, if the health status of the relatives is verified. Within the context of the influence of environment on disease, 56% of the sample perceived that environmental modifications (e.g., drugs, diet) are effective in helping prevent disorder.

Table 4. Knowledge Measures (Total N = 112)

Measure	*n* (%)
Common structural genetic variation (changes in the human genome, such as deletions, duplications and large-scale copy- number variants) is important in health and disease. (*n*=108)	
True	82 (76%)
False	4 (4%)
Don't Know	22 (20%)
All the genetic variation in an individual can be attributed either to spontaneous (i.e., de novo) or inherited changes in the human genome. (*n*=108)	
True	70 (65%)
False	13 (12%)
Don't Know	25 (23%)
The variation in the human genome includes both disease-causing gene variants and variants that have no effect on health and disease. (*n*=109)	
True	58 (53%)
False	25 (23%)
Don't Know	26 (24%)
The DNA sequences of two randomly selected healthy individuals of the same sex are 90-95% identical. (*n*=108)	
True	24 (22%)
False	42 (39%)
Don't Know	42 (39%)
Most common diseases such as diabetes and heart disease are caused by a single gene variant. (*n*=109)	
True	40 (37%)
False	27 (25%)
Don't Know	42 (38%)

Table 5. Perceptions Measures (Total N = 112)

Measure	*n* (%)
Do you think that genetic risk (e.g., as indicated by Family Health History) has clinical relevance for breast cancer? (*n*=106)	
Not at all	0 (0%)
Somewhat	21 (20%)
A Great Deal	85 (80%)
Do you think that genetic risk (e.g., as indicated by Family Health History) has clinical relevance for colon cancer? (*n*=106)	
Not at all	1 (1%)
Somewhat	24 (23%)
A Great Deal	81 (76%)
Do you think that genetic risk (e.g., as indicated by Family Health History) has clinical relevance for coronary heart disease? (*n*=104)	
Not at all	1 (1%)
Somewhat	21 (20%)
A Great Deal	82 (79%)
Do you think that genetic risk (e.g., as indicated by Family Health History) has clinical relevance for diabetes? (*n*=107)	
Not at all	1 (1%)
Somewhat	16 (15%)
A Great Deal	90 (84%)
Do you think that genetic risk (e.g., as indicated by Family Health History) has clinical relevance for ovarian cancer? (*n*=104)	
Not at all	1 (1%)
Somewhat	23 (22%)
A Great Deal	80 (77%)

Table 5 describes that majority of PNAA respondents perceived that genetic risks play a great deal of clinical relevance for most cancers. Further, majority of PNAA respondents also perceived that genetic risk has a great deal of clinical relevance for other chronic illnesses.

Genomic education

Although 41% of the sample indicated good understanding of genetics of common diseases, 60% had not attended any continuing education courses that included genetics as a major component since RN licensure, and 73% reported a lack of available genetic courses to take. In addition, 39% of PNAA respondents did not know if their senior staff members see genetics as an important part of a junior staff members' role, while 51% didn't know if their senior staff members see genetics as an important part of a senior staff's role.

Discussion

Responses obtained from the PNAA participants of the NCEMNA survey provide empirical evidence that Filipino-American nurses are in need of continuing education or necessary resources to improve their knowledge, perceptions, beliefs, and practice in handling genetic and genomic information. The fact that a large majority of

PNAA respondents want to learn more about genetics is a call for action for the PNAA leadership to address this need. These results are consistent with the responses from other minority nurses who participated in the parent NCEMNA survey. Majority of the parent survey respondents also felt that their understanding of genetics was poor or fair, and they overwhelmingly (94%) indicated their strong interest to learn more about genetics (Coleman et al., 2014). Further, the responses from PNAA participants were also very similar to a survey conducted by the American Nurses Association (ANA) (Calzone et al., 2013), affirming that our results demonstrated knowledge deficits in genetics, which is not unique to PNAA nurses, but seems to be echoed by all nurses, based on responses from both the NCEMNA and ANA surveys (Coleman, et a., 2014; Calzone et al., 2013).

Our findings support previous report that knowledge of genetic information among health care workers from different educational backgrounds, has been inadequate (Catz, et al., 2005; Singer, Antonucci & Hoewyk, 2004). One of these previous studies explored the attitudes and beliefs of New York patients and health workers towards genetics by conducting several focus groups (Catz et al., 2005). Regardless of cultural affiliations of focus group participants, most expressed desire for more information about genetics (Catz et al., 2005). However, Black American focus group participants expressed the most concern for possibly harmful use of genetic information, but still understand the importance of genetic testing as a preventative screening measure (Catz, et al., 2005). Another study involving African-American nurses also share similar concerns; however, these nurses do not believe that such risks should interfere with the integration of genetics and genomics in health care (Powell-Young & Spruill, 2013). Chinese and Latino focus group participants showed the least concern for the potential consequences of the use of genetic information (Catz et al., 2005).

Overall, there is a disconnect between genetics knowledge and its immediate implications for patient care among health care providers (Guttmacher, Porteous & McInerney, 2007). Although, it is important to educate health care professionals in genomics that can be used today, it is critical to teach the key underlying concepts and instill an appreciation of the future clinical importance of genomics in our health care students. Efforts to enhance nursing genomic competence began back in 2005 when the ANA partnered with the National Cancer Institute, the National Human Genome Research Institute, and the Office of Rare Diseases at the National Institutes of Health to develop nursing core competencies in genetics for nurses. The final document containing genetic and genomic core competencies for all nurses was entitled, "The Essential Core Competencies and Curricula Guidelines for Genetics and Genomics," which is endorsed by 49 nursing organizations, the Genetic Alliance, the March of Dimes, and the National Coalition for Health Professional Education in Genetics (NCHPEG) (http://www.nursingworld.org/genetics). The NCHPEG also issued its own core genetics competencies in 2007 to assist health care faculty members in incorporating genetics in their curriculum development and to provide individual health professional with additional genomic-specific resources (http://www.nchpeg.org/index.php?option=com_content&view=article&id=237&Itemid=84). Several educational strategies have been recommended and implemented since then in educational institutions and continuing education activities; however, major gaps are still evident as observed in our findings.

Genomic developments are rapidly changing health care. As such, the management of genomic information is no longer assigned to one specialty, but is relevant for all disciplines of the healthcare delivery system. Therefore, nurses are expected to meet this expanded role and must be competent in genomics to provide safe, cost-effective, quality health care (Calzone et al., 2010). The need was also identified in the recent Institute of Medicine (IOM) report on the future of nursing, which suggested enhancing the preparation of nurses for these expanded roles through timely changes in scope of practice and nursing education (IOM, 2011). Further, patients and families are protected from insurance and employment discriminations based on their genetic information as mandated by the Genetic Information Non-Discrimination Act (GINA), which was signed into law in the U.S. in May 2008. Assisting nurses to be aware of their knowledge, perceptions, beliefs, and practices on genetics and genomics, will allow them to provide a most unbiased and supportive care. In addition, this awareness equips nurses to better educate their

patients with relevant genetic and genomic information, and GINA-related resources to assist in making informed health decisions.

The NCEMNA survey was conducted to fill the gap identified by the nursing science blueprint proposed by the Genomic Nursing State of the Science Advisory Panel (Genomic, Nursing State of the Science Advisory Panel, 2013). The NCEMNA survey serves as a needs assessment and provides opportunities for each minority organization to assist in preparing their respective nurses to meet the goals proposed by the Consensus Panel on Genetic/Genomic Nursing Competencies (Consensus Panel on Genetic/Genomic Nursing Competencies, 2009). The efforts to analyze responses from PNAA participants of the NCEMNA survey are aimed to provide information to the national PNAA organization about the knowledge, perceptions, beliefs, and practices of PNAA members in handling genetic and genomic information, so gaps in knowledge can be addressed through educational activities, to assist PNAA nurses in providing genomically-competent care.

Although the PNAA members who responded to the parent NCEMNA survey were mostly women (89%), but the male PNAA respondents (11%) were higher than the total male NCEMNA survey participants (7%). Further, more PNAA respondents (66%) work in the hospital, compared to the overall NCEMNA respondents (49%), providing a better glimpse of the knowledge, perceptions, beliefs, and practices of minority nurses on genetics/genomics in the clinic. In addition, most of the PNAA nurses (68%) worked in the same clinical site since start of RN employment, higher than the NCEMNA respondents (50%). The PNAA respondents also held either a baccalaureate (50%) or master's degree (44%), a much higher rate than the total NCEMNA respondents (baccalaureate = 34%, master's degree = 39%, respectively). Nevertheless, PNAA respondents shared similar overall ratings related to knowledge, perceptions, beliefs, and practices on genetics/genomics as the overall NCEMNA survey respondents.

The Journal of Nursing Scholarship (JNS) recently published a special, virtual issue on genomics nursing (http://onlinelibrary.wiley.com/doi/10.1111/jnu.2013.45.issue-1/issuetoc). This JNS special issue provides education and a wide range of resources that can be useful for nurse clinicians and educators for clinical decision making and for curriculum integration of genetics/genomics, respectively. In addition to publicly available resources gathered from the JNS special issue articles, Table 6 lists educational resources gathered from review of literature and recommendations from nurse genomic experts from the NHGRI that can assist PNAA nurses to become knowledgeable in genetics and genomics.

Over half of PNAA participants preferred workshops, described as a combination of presentations and group activities, as the most helpful format to learn about genetics/genomics. This is important information for the PNAA organization to take into account in planning future continuing education activities, considering that 89% of PNAA respondents would encourage their national organization or local chapter to support a genetics/genomics awareness initiative, 86% believed that the PNAA should have a visible role in genetics/genomics awareness initiatives in local communities, and 83% would attend genetics/genomics training if offered during the PNAA annual educational conference.

An exhaustive review of available resources that the PNAA organization can tap is essential to respond to the genetic and genomic knowledge, perceptions, beliefs, and practice needs of its membership. The resources listed in Table 6 will further address the needs expressed by the PNAA participants of the NCEMNA survey, because 46% of the PNAA respondents also expressed that combined printed and web-based information is the second most helpful format to learn more about genetics/genomics. Most of the resources listed in Table 6, such as the case studies offered by the Global Genetics and Genomics Community (G3C) and the National Genetics and Genomics Education Centre of the United Kingdom's National Health Service, are web-based and provide options to print out transcripts of the case stories, which could be beneficial to both learners and educators. G3C is specifically useful because this resource offers bilingual collection of educational, disease-specific information that can be directly applied to clinical practice. These cases range from heart disease to diabetes, where recommendations are suggested to guide nurses on how to provide genetically/genomically appropriate care. Further, this resource analyzes one's responses to evaluation questions for each case study and determines the genetic/genomic competencies gained.

Resources listed in Table 6 can also be useful to novice and advanced learners in genetics/genomics. Novice learners can take advantage of the Genetics 101 short course for health professionals offered by NHGRI, which provides basic understanding of genetic and genomic information. The talking glossary of the same NHGRI website (http://www.genome.gov/) is also helpful to novice learners because it provides basic genetic terms that can help jumpstart one's understanding about the topic. Advanced learners can register at the Center of Disease Control and Prevention (CDC), Public Health Genomics website (http://www.cdc.gov/genomics/) to stay current on the issues related to genetics and genomics. The weekly CDC updates also list upcoming educational events and

Table 6. Genetic and Genomic Educational Resources

Resource	Uniform Resource Locator	Sponsor	Utility
Genetics/Genomics Competency Center for Education (G2C2)	http://www.g-2-c-2.org/	National Institutes of Health (NIH), NHGRI	Development of competency guidelines and curricula
Global Genetics and Genomics Community (G3C)	http://g-3-c.org/en	NIH, NHGRI	Bilingual collection of genetic/genomic case studies for students and practicing health care providers
NHGRI website	http://www.genome.gov/	NIH, NHGRI	1. Talking glossary of genetic terms 2. Genetics 101 short course for health professionals
Public Health Genomics website	http://www.cdc.gov/genomics/	Center of Disease Control (CDC) and Prevention	Weekly updates of the current evidence, conferences and funding opportunities.
Evaluation of Genomic Applications in Practice and Prevention (EGAPP™)	http://www.cdc.gov/genomics/gtesting/EGAPP/	CDC	Provide the highest level of evidence to issue recommendations for clinical practice
Physician Data Query (PDQ®)	http://www.cancer.gov/cancertopics/pdq/genetics	NIH, National Cancer Institute (NCI)	Provides latest evidence of genetics/genomics of different types of cancer, and the current recommendations for health professionals
Genetic Testing Registry (GTR)	https://www.ncbi.nlm.nih.gov/gtr/	NIH, National Center for Biotechnology Information	1. Can search for specific conditions to determine what genetic tests can be conducted and what laboratory perform those tests. 2. Provides reviews of different genes related to specific conditions. 3. Helps find a genetic professional.
National Genetics and Genomics Education Centre	http://www.geneticseducation.nhs.uk/	United Kingdom's National Health Service (NHS)	1. Case scenarios for faculty members. 2. Provides guidance in obtaining a health history, identifying patients, recommends a patient pathway for clinical management. 3. Provides guidance for workforce competencies.
Telling Stories website	http://www.tellingstories.nhs.uk/index.asp	NHS	1. Presents experiences of real patients. 2. The presentations are embedded with expert commentaries in educational platforms. 3. Can print out the transcripts of the stories.

funding opportunities. Further, the Evaluation of Genomic Applications in Practice and Prevention (EGAPP™) by the CDC establishes a very extensive and systematic mechanism to evaluate the highest level of evidence to issue recommendations for clinical practice (e.g., genetics of depression or genetic testing for colorectal screening). The Physician Data Query (PDQ®) on cancer genetics by the National Cancer Institute also provides latest evidence on the genetics and genomics of different types of cancer and the current recommendations for health professionals.

For nurse clinicians, the Genetic Testing Registry (GTR) by the National Center for Biotechnology Information can be useful to determine what genetic tests can be conducted for the selected condition and what laboratory perform those tests. In addition, the site also provides reviews of different genes related to specific conditions, as well as a way to find a genetic professional. These resources can provide basic, as well as advanced information necessary to improve one's knowledge about genetics and genomics. It is highly recommended that each PNAA member should assess his/her current level of genetic/genomic competency to determine what resources he/she needs. The NCEMNA survey instrument contains specific items that assess genetic/genomic competency of nurses (Calzone et al., 2012). This instrument is available for public use; hence PNAA members are encouraged to use this instrument to obtain baseline information of genetic/genomic knowledge, perceptions, beliefs, and practice. For nurses who prefer self-learning formats, the G3C website is a good resource to assess one's genetic/genomic competency level. More importantly, conducting PNAA-sponsored genetic/genomic workshops, which was reported by the PNAA members to be the most preferred format to improve genetic/genomic knowledge, should be supported by both leadership and general membership. In addition, patient support groups specifically organizations supporting patients and families with genetic conditions are also very good resource for clinical services, diagnostic laboratories, and innovative research available.

Limitations

This is the first study that describes the knowledge, perceptions, beliefs, and practice of PNAA nurses on genetics and genomics. However, the results of this study should be considered in light of its limitations. Similar to another study in this area (Calzone et al., 2013), this study used self-report and voluntary participation. Participants may have response bias from high levels of motivation to complete the survey, which could include concern about genomics or other influencing factors. Another limitation is the mean years of experience of PNAA survey participants which was 30 years, reflecting older generation of PNAA nurses, and the number of PNAA participants, which is <1% of the total PNAA membership. Therefore, findings cannot be generalized to the overall PNAA community. However, the data gathered should be useful in planning educational programs on genetics and genomics.

Implications

The findings of this survey confirm the existence of genomic knowledge deficits among Filipino-American nurses, a similar finding revealed in the parent study which reported similar genomic knowledge deficits among minority nurses (Coleman et al., 2014). Therefore, the recommendation is clear, that genomics education is needed by all nurses. The preparation of Filipino-American nurses with essential genetic and genomic competencies will help facilitate the effective use of genomic information in clinical care which can promote and protect the public's health. Overall, nurses can take a leading role in their institutions to assure that patients and families are provided with clinically relevant genetic and genomic information and protections to make informed health decisions. Nurses can also take advantage of the multiple educational resources to improve their knowledge of genetics and genomics and share appropriate educational resources with their patients. Once nurses can improve their knowledge in genetics and genomics, only then can we assure that in this genomic era of healthcare, nurses being an integral member of the workforce, are prepared to deliver responsible, effective, and accountable care.

Conclusion

The study findings described the knowledge, perceptions, beliefs, practice and genomic education of Filipino-American nurses. The findings provide empirical evidence that Filipino-American nurses are in need of educational opportunities to improve their knowledge on genetics and genomics, which should improve their clinical practice. This paper identifies a number of resources that can assist learners at every level to improve their knowledge about genetics and genomics. Additionally, findings from this study will assist PNAA in planning future educational programs that will incorporate topics on genetics and genomics.

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PHILIPPINE NURSES ASSOCIATION, INC.

Research Article

A Concept Analysis of Mentoring

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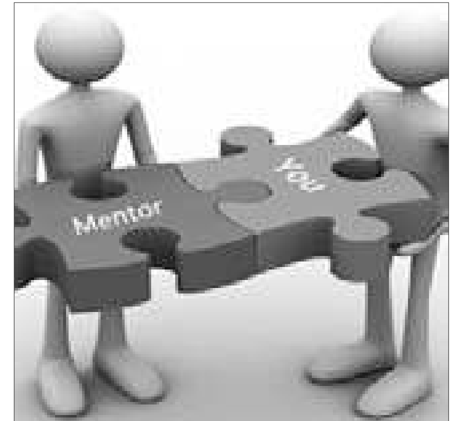
Abstract

The concept of mentoring is important in nursing. Mentoring allows opportunities for a mentor to transfer knowledge and expertise in both theory and practice and a mentee to improve performance. This concept analysis aims to clarify the meaning of 'mentoring'. Attributes, antecedents, consequences, and a model case are presented to clarify this concept further. Review of literatures was conducted by using databases which include EBSCO, MEDLINE, and Google scholar. Findings showed that mentoring allows personal and professional growth of mentees. Closing the gap between theory and practice is achieved through an expert supervision of a mentor to a mentee. Mentoring plays a central role in the development of novice nurses as they integrate theoretical concepts into their practice. The benefits of mentoring are illuminated in the increasing competency of nurses in performing their roles to be globally competitive.



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Key words: *Concept analysis, mentor, mentee, mentoring*

The gap between theory and practice raises concerns as it circles around nursing discipline. The existence of such dilemma reflects the lack of a mutual relationship between nurse practitioners and nurse scholars who dwell in theory development.

Such as in the case of a graduating student nurse and a novice registered nurse, the lack of experience in the clinical setting retracts them from executing their theoretical knowledge. Likewise, a senior and experienced nurse may administer care based on routinely practiced interventions that echoes non-observance of evidence-based practices. These exemplars posit the need for mentors who will act as catalysts to help bridge the gap between theory and practice. The ambiguity in the definition and roles of mentors, however, creates a confusion that warrants attention. The author, therefore, propose an exploration on the roles of mentors and its impact on the theoretical and clinical development of students and professional nurses. In this dissertation topic, the author aims to clarify the roles of mentors and showcase the outcomes they create. In this regard, a concept analysis of mentoring is deemed necessary to enhance understanding and guide theory development.

The concept of mentoring is vital to nursing. The notion of mentoring originated from Homer's Odyssey in ancient Greek mythology. In 1200 B.C., Odysseus was leaving for the siege of Troy and he appointed his friend, Mentor, to be a surrogate father to his son, Telemachum (Dorsey & Baker, 2004). Dorsey and Baker (2004) defined a mentor as a wise and trusted advisor, counselor, or teacher who has something to offer that meets the immediate needs and/or future needs of another. Mentoring is a strategy to assist beginning level practitioners to prepare for the complex health care context (Theobald & Mitchell, 2002). Similarly, McCloughen, O'Brien, and Jackson (2010) identified that mentoring is important to growing new or aspiring future nurse leaders.

The success of mentoring in developing less experienced nurses is widely recognized in the clinical

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practice (Saarikoski, 2003; McCloughen, O'Brien, & Jackson, 2010; Dorsey & Baker, 2004). A continuing debate concerning the elusive definition of the roles and functions of a mentor in nursing, however, produces conflict in practice (Murray &Staniland,2010). This dilemma, therefore, reflects the need to scrutinize and clarify the concept of mentoring to heighten nurses' understanding. This paper aims to analyze the concept of mentoring to elucidate its attributes, antecedents, consequences, and implications.

The concept analysis was initiated by identifying the concept of interest, which is mentoring, followed by a comprehensive review of literature. Internet based review of literature was conducted by searching databases which include EBSCO, MEDLINE, and Googlescholar. Retrieved literatures were examined and analyzed to identify the characteristics, similarities and variances of mentoring.

Attributes of Mentoring

In the review of literature, the author has found varied characteristics encompassing the concept of mentoring. Mentoring has been perceived according to the context to which it has been implemented. These contexts were evident in the student-teacher, student-nurse practitioner, and a novice professional nurse-expert nurse mentoring relationships. Consequently, mentoring exists at personal and professional levels.

At the personal level, mentoring is illuminated by a mentor's ability to reach out to a less experienced individual. Mentoring in the nursing profession is seen among mentors who are understanding, approachable and non-judgmental (Kopp & Hinkle, 2006). A nurse mentor is considered to be effective if the characteristics of a nurse are appreciated. These characteristics include the mentor's patience and caring attitude towards the mentee (Hockenberry-Eaton & Kline, 1995). Likewise, mentoring is deeply appreciated among mentors who are good communicators, trustworthy, enthusiastic, friendly, inspiring, committed, and have high confidence on the capabilities of their mentees (McCloughen, O'Brien, & Jackson, 2010; Andrews & Chitton, 2000).

At the professional level, mentoring is defined as the ability of the professional nurse to engage in expert practices and integrate theory and practice (vanEps, Cooke, Creedy, & Walker, 2006). Mentors are considered as experienced and knowledgeable supervisors who facilitate learning and develops expertise in a nurturing environment (Saarikoski, 2003, vanEps, Cooke, Creedy, & Walker, 2006; Hockenberry-Eaton & Kline, 1995). In the same way, mentoring is reflected by mentors who act as role models and leaders who are accessible, supportive, loyal, and supporters of change (Andrews &Chitton, 2000; Kopp & Hinkle, 2006; Theobald & Mitchell, 2002; Hockenberry-Eaton & Kline, 1995).Being attentive to cultural and gender differences also reveals high regards of mentoring in promoting sensitivity and justice (Kopp & Hinkle, 2006).

In terms of the working relationship, mentoring requires a collaborative effort between the mentor and a mentee. The involvement of a mentee in the activities shows the mentor's high confidence and trust in the mentee's abilities. Eventually, mentoring entails gradual withdrawalof supervision until a mentee exercises competence (Andrew &Chitton, 2000).

Antecedents of Mentoring

The relationship of a mentor and a mentee elucidates a two-way working partnership towards a positive outcome. This notion clearly suggests that mentor and mentee factors influence the process of mentoring.

Darling (1984) highlights that an effective mentor has three absolute requirements which are attraction (mutual), action (time and energy), and affect (mutual respect) (cited in Andrews & Chitton, 2000). In addition, Darling (1984) also highlights three basic mentoring roles: inspirer (attraction), investor (action), and supporter (affect) (cited in Andrews & Chitton, 2000).

The method of supervision has an influence on mentoring. Saarikoski (2003) found that the total satisfaction of students correlated most clearly with the method of supervision and that those satisfied students had a successful mentor relationship and frequently enough access to private supervision sessions with mentor. In this regard, mentoring requires the theoretical competency and expertise in practice of mentors. What appears to be vital in mentoring is the balance in meeting theory and practice (Andrews & Chitton, 2000).

A mentor's intrinsic traits and reputation have a big impact in mentoring (Kopp& Hinkle, 2006). Aside from the knowledge and expertise, the commitment of mentors has a significant influence in mentoring (Theobald & Mitchell,

2002). The commitment of mentors in assisting emerging nurse leaders by cultivating their flexibility, adaptability, judgment, and creativity also mirrors their willingness to honor and support colleagues (McCloughen, O'Brien, & Jackson, 2010; Kopp & Hinkle, 2006).

On the other hand, a degree of self-motivation by the mentee is integral to the success of the mentoring partnership (Theobald & Mitchell, 2002). Nelson, Godfrey, and Purdy (2004) suggests that a mentee needs to display a strong desire to learn, a commitment to the mentoring program, and have the ability to take initiative to become successful. This notion highlights the participation of a mentee to a mentor's objectives in meeting the desired outcomes of mentoring. Further, the effective communication and personal commitment on the part of the mentee and mentor is critical to the fundamental success of the partnership (Theobald & Mitchell, 20002).

Consequences of Mentoring

Individuals who are involved in mentoring benefit from the supportive and nurturing environment it creates. The mentees achieve a sense of control over their capabilities and achieve development of intuition and skills in handling patients. Saarikoski (2003) points that a mentoring relationship is the most important element of clinical experience of nursing students.

The learning opportunities are more likely to be planned and meaningful which helps mentees to be successful (Gray & Smith, 2000). Similarly, mentoring enable institutions to recruit and retain the brightest graduate students (Nelson, Godfrey, & Purdy, 2004). This outcome reflects that the career progression of mentees is a part in strengthening institutional stability.

In the perspective of professional nurses, mentoring results to an enhanced job satisfaction, reduced turnover, and demonstration of leadership behaviors (Kopp & Hinkle, 2006).Likewise, mentoring empowers nurses to be productive and progress in their careers (Dorsey & Baker, 2004; Theobald & Mitchell, 2002). The contribution of mentored nurses has become significant as they engage in professional socialization and expand professional knowledge (Dorsey & Baker, 2004).

The transformation of a mentee to be a future mentor appears to be a climax in the process of mentoring as it fosters continuity of the process. Kopp and Hinkle (2006) emphasized a “ripple effect” in an effective mentoring. This effect demonstrates that mentees are likely to pave the way, and in turn, their mentees will follow and leave their own imprints or legacies.

These discussions illuminate the impact of mentoring in the development of professional nurses in their individual careers and in honing their capabilities to be contributors in the advancement of the nursing profession.

Identifying a Model Case

To provide an exemplar, the author refers to his own experience which exemplifies the concept of mentoring.

Five years ago, I started to teach student nurses in Saint Louis University- School of Nursing with limited experience in teaching. Although my credentials have met the qualifications of a nurse educator, I encountered a dilemma on how to effectively teach what I know. I struggled to be at par with the performance of other educators but slowly I realized that I am becoming desperate to be an “instant expert educator”. I felt academically exhausted and almost gave up because I was not contented with the results.

In one of our conferences, a group of senior lecturers known to be experts in their own field offered their intent to assist newly hired faculty members in implementing effective teaching strategies. At that point, I started to acquaint myself with one of the expert lecturers. I was openly accepted and he treated me like a brother. I never felt degraded because of my limitations. He believed in my capabilities to improve because he constantly exposed me to trainings or seminars where I need to analyze and share my ideas.

I keenly observed my mentor in his classes, jotting down his techniques in opening the class, facilitating discussion, delivering the subject matter, and implementation of his teaching styles. Constant communication was evident as my mentor always inquire the outcomes of my lectures and gives feedback on my strengths and weaknesses. His criticisms were given constructively that enabled me to exert more effort in delivering my teaching style. My mentor became my friend and his wife and kids added in my support system.

My mentor has continuously shared his experiences in the clinical area and in teaching emphasizing the do's and don'ts in achieving something. His influence in my personal and professional growth is second to none. After a year, the senior faculty already involved me in planning the course syllabus and subject modules. I have witnessed how the senior faculty consolidates brilliant ideas of other lecturers and execute them successfully. Eventually, I felt that my competency in teaching has greatly improved as evidenced by higher scores in the evaluation and good feedback from the department heads and students. I felt so empowered and more confident in teaching. Indeed, I gained competence from the supervision of my mentor.

Now, as I enter my 6th year in teaching, I engage myself in actively supporting newly hired faculty members. This act is not to satisfy self-interest but to communicate that I also started somewhere and was nurtured appropriately. When the time comes, they will also contribute in the development of new faculty members.

Conclusion

Mentoring is a way of advancing the nursing profession by strengthening its members. The benefit gained from mentoring occurs at personal, institutional, and societal levels. At a personal level, students and novice nurses are equipped with the necessary knowledge, skills, and attitude. Being competent in implementing nursing practice reflects the quality of services provided by the institutions where they belong. Collectively, the positive outcomes achieved by institutions illuminate the capability of nurses to be globally competitive.

Lack of mentoring opportunities may play a central role in the stagnation of nursing knowledge and dissatisfaction of nurses in their practice. Consequently, the productivity of nurses will be decreased and the consumers of care suffer the consequences.

Nurses who portray expertise in theoretical knowledge and clinical practice play an important role for the next generations of nurses. As leaders, their role in directing nurses towards excellence will greatly advance the nursing profession. Bridging the gap between theory and practice is inculcated in the roles of mentors as they transcend their expertise to less experienced nurses. This outcome will be close to reality as nurse leaders continuously engage in transforming nursing through research and evidence-based practice.

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“Good words are worth much, and cost little.”

George Herbert, Jacula Prudentum
(19610; cited in Bartlett, 1968, p. 324a; Roper & Shapira, p. 39)

PHILIPPINE NURSES ASSOCIATION, INC.

Case Study

Utilizing Levine's Conservation Model in the Care of Patient with Lithium Toxicity: Caring Beyond the Symptoms[1]

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Introduction

Health professionals are trained to recognize and address cues which endanger the client's survival. In critical situations, we focus on ensuring the airway, breathing and circulation (ABC) in order to sustain life. Oftentimes, we feel great in performing dramatic interventions and save our patients from the brink of death. But is this enough? Does our role end here? Is this only how we define good nursing care?

This is the case of DL, a 39 year old female who, upon admission to the pay ward in Philippine General Hospital, presented with respiratory distress, as evidenced by dyspnea and oxygen desaturation, necessitating intubation. Health history revealed the client as a diagnosed case of Bipolar I Disorder for 21 years. The goal of providing holistic care to a patient with a mood-affective disorder presenting with a medical emergency, like DL, poses a crucial challenge - the challenge in going beyond what meets the eye and focusing on human responses and not just the disease process. This case was then selected to serve as a reminder and a learning opportunity that we should not be limited to symptom management, but more importantly, to recognize the totality of the human being, which is the true essence of nursing care.

Assessment

DL is a 39-year old single female who resides in Sto. Tomas, Batangas. She is the eldest among her three siblings and used to live with her grandparents, who spoiled her, until she was 30 years old. She was also considered an achiever and had above-average grades until high school. DL was reported to have difficulty adjusting to her college life. At 18 years old, she started isolating herself from others, lavishly spending money and shouting without any apparent reason. She also had difficulty sleeping. After her family sought psychiatric help for her, she was diagnosed with Bipolar I Disorder. However, DL had poor compliance with her therapeutic regimen. Also, her caregivers had difficulty monitoring DL's compliance to medications. Eight years later, Lithium Carbonate was added to DL's list of medications.

The patient had her menarche only when she was 18 years old. She did not have any close friends, nor did she belong to any social group. She only had one known romantic relationship. Although she had close relationship with her siblings, DL was reported to be manipulative towards her mother. She wasn't known to be expressive of her problems. Her family had diffucuity in her manic attacks and when her manic symptoms would break out, they would immediately resort to admitting her to a private mental health care faility.

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Two weeks prior to admission, DL had a fight with her mother, causing her to be uncooperative, agitated and restless. On the following days, she stopped taking her medications so she was brought to a private mental health care facility. After a week in the facility, she had episodes of loose bowel movement (LBM) and undocumented fever, with cough and colds. She was also observed to have increasing sleeping time. She then refused to eat and drink, so her family was contacted and she was eventually admitted to a tertiary hospital where she was treated for amoebiasis. Due to the persistence of signs and symptoms, coupled with incoherence and difficulty cooperating, DL's family decided to transfer patient to PGH last February 4, 2011.

The physical assessment of this patient focused on the patient's sensorium, respiratory status and parameters of kidney function. DL was drowsy with a Glasgow Coma Scale (GCS) score of 8 (E2V2M4), with signs of respiratory distress, disoriented and with no regard. Upon inspection, patient had pale conjunctiva and nail beds. She was tachypneic, with apparent use of accessory muscles. Upon auscultation, patient had crackles at bibasal lung fields and rhonchi on upper lung fields. Patient also had productive cough with whitish thick secretions. She was also febrile (T=38.5oC). Patient also presented with fair turgor. She also had indwelling foley catheter, with tea-colored urine.

Baseline Laboratory and Radiologic Exams were taken to assess the client's status. Complete Blood Count showed anemia and leukocytosis which are consistent with sepsis. Arterial Blood Gas shows metabolic acidosis, and blood chemistry revealed electrolyte imbalances and high creatinine levels, highly suggestive of kidney injury. Fecalysis done at previous hospital showed presence of Entamoeba Histolytica. Patient's chest X-Ray showed Pneumonia. Other diagnostic exams were unremarkable.

Discussion

Problem Identification and Nursing Interventions

In caring for this patient, Myra Levine's (1967) Conservation Model served as the basis of the nurses. This model views the person as a holistic being, responding wholly and completely to every alteration in his or her life pattern. Therefore the goal of nursing is to promote adaptation and maintain wholeness using the principles of conservation (Energy, Structural Integrity, Personal Integrity and Social Integrity).

The significant findings were indicative of inadequate oxygenation thus requiring immediate interventions. Patient's history and physical examination led to the admitting impression of Encephalopathy probably secondary to Severe Sepsis secondary to Aspiration Pneumonia. Due to the effects of electrolyte imbalances, client had a decrease in sensorium predisposing her to aspiration. This then eventually led to pneumonia. Pneumonia is defined as the inflammation of the lung parenchyma (Porth, 2005). This inflammatory reaction produces exudates that interfere with the diffusion of oxygen and carbon dioxide, causing a ventilation-perfusion mismatch (McCance and Huether, 2014). Thus the nursing problem of ***Impaired Gas Exchange related to ventilation-perfusion imbalance secondary to Pneumonia*** was selected. This encompasses interventions that address not only problems with gas-exchange, but also with airway and ventilation. Priority was given to this problem because ensuring respiratory function is a primary nursing task critical in sustaining life (Kozier, 2008). Our goal was to establish adequate oxygenation and resolve aspiration pneumonia. Ultimately, this would prevent development of complications. An improvement of oxygenation and ventilation as evidenced by absence of respiratory distress, normal blood gas levels and oxygen saturation, and improvement in sensorium was warranted for our client DL.

After incubation and consequent interventions on Ventilation Assistance, our nursing interventions focused on addressing and preventing complications of pneumonia. This was done through Airway Management and Respiratory Monitoring. Antibiotics were given as ordered, to treat lung infection causing sputum production, addressing her impairment in gas exchange. Our responsibility here is to understand the rationale for these medications. Her response to the interventions was then observed and vital signs were continuously monitored.

So, initial septic management was done. However, despite aggressive antibiotic therapy, the patient remained febrile with persistence of other symptoms. So what exactly is happening to DL? The health care team was then faced with the challenge to identify and address other possible etiologies.

Remember that DL was diagnosed with Bipolar I Disorder and took Lithium for about a year prior to admission, with poor compliance and without any lithium

level monitoring done. It was only during the admission at a previous health facility that she was able to regularly take lithium. Patient also had episodes of loose bowel movement which led to loss of fluid and electrolytes. As reabsorption of lithium increases in individuals who are hyponatremic or volume-depleted, as in DL's case, lithium level was obtained. And indeed, her serum lithium was elevated. With lithium's very narrow therapeutic index, toxicity is very likely to occur (Jasleen Gill, 2003; Lee, 2010). Lithium salts bind to the receptor sites and are absorbed more by the kidneys instead of the lost electrolytes, causing build-up of lithium. Lithium also decreases water resorption and increases sodium and potassium elimination (Lederer, 2012) thereby forcing the body to compensate by decreasing blood flow to the kidneys, leading to kidney injury.

Based on the cues, the diagnosis most appropriate to address these problems is ***Potential Complication: Renal Failure***. Lithium Toxicity is a medical emergency that warrants collaboration with physicians and other members of the health care team (Smeltzer et al, 2010). A potential complication is Renal Failure and measures must be taken to prevent it. This can be achieved through addressing Lithium Toxicity, thereby improving renal function, as evidenced by normal fluid balance and normal serum electrolyte levels.

While the problem on gas exchange was being addressed, interventions on Fluid and Electrolyte Management were also done. DL's intake and output were accurately monitored to determine fluid loss and need for replacement. Furthermore, to correct fluid and electrolyte imbalance and facilitate excretion of excess lithium in blood, intravenous fluid therapy was administered per physician's orders. In theory, forced diuresis using normal saline should increase lithium clearance by decreasing proximal reabsorption (Glen Markowitz, 2000). While administering normal saline, free water flushing was given per nasogastric tube to prevent hypernatremia.

Gradually, her symptoms were resolved. After two weeks, she was able to tolerate weaning and was eventually extubated. In addition, her electrolyte levels normalized. Her sensorium had also greatly improved. But do we stop here? Another challenge then arises for us, how do we ensure that history will not repeat itself?

To address this challenge and taking Levine's Conservation Model in mind, the patient's personal and social integrity must be focused on. And in order to provide holistic care for DL, our nursing care focused on three goals: how to address the crisis she faced, how to prevent further complications of the cause of the crisis, and how to prevent all of this from happening again. And this is where the challenge lies. The mental illness will require its own treatment and management, but the focus must be on what we can do. Therefore, as nurses, we can help address the problem of ***Ineffective Therapeutic Regimen Management (Individual and Family) related to (1) Knowledge Deficit, (2) Complexity of Therapeutic Regimen.***

We must focus in the long-term goal in that she and her family would be able to integrate a program for the treatment of her Bipolar disorder into her daily living pattern and family process. The goal was for them to develop skills, knowledge and attitudes that would enable them to perform effective therapeutic management at home. Health teaching was then done with the client's significant others about medications. This aimed to broaden their knowledge and enable them to anticipate and detect possible problems and early signs and symptoms of drug toxicity that may necessitate readmission. In addition, collaboration with DL's doctors was done to ensure that the client will receive psychotherapy regularly after discharge. Also, assessment of the involvement of other systems such as social services, health care facility and providers was done. A written health commitment contract, signed by the doctor, nurse, client and responsible caregiver/s to reinforce adherence to plan of care was also devised.

Evaluation and Recommendations

After further nursing and medical interventions, the patient was discharged on room air, ambulatory, voiding freely with a positive fluid balance, conscious and coherent with a GCS score of 15, has optimal level of functioning and good outlook in life. Last we heard, she is tending to the family's sari-sari store and goes to her follow-up with her psychiatrist.

Our duty to our patients does not end upon the resolution of their symptoms. The essence of our care should extend beyond their hospital stay. Our presence should be felt in home care through our reminders and instructions which we give prior to discharge. Therefore, we would like to suggest the following: (1) Revision of the discharge instructions form for the patient and the family, which will be accomplished by every member of the health team and will consolidate each service's home instructions; (2) Development and utilization of Commitment Health Contract, to be signed by the patient, relative, nurse and

doctor which aims to reinforce adherence to therapeutic management; (3) Establishment of a psychiatric nurses' core group and (4) Conduction of trainings and seminars to improve the nurses' skills in providing holistic care towards quality of life.

Often we take this for granted but it is through proper health education and the nurses' skill to anticipate potential problems at home that we prevent the same problems from arising again. Through health education, we empower our patients and their family to take control of their condition and move forward towards the improvement of their lives.

In this age of modernity where we are predominated by medical breakthroughs, we appeal to each and every one of you to go back to our roots. Let us remind ourselves, what is really the essence of nursing? Is it the complexity of our interventions? True and effective nursing care comes from the heart. It can only be through genuine concern and compassion that we can make a difference in their lives. Nursing is seeing the human in our patients. And though they come to our aid broken, hurt and ill, we nurses can help make them whole – because we, nurses, are the fulcrum of multidisciplinary care. This is the challenge we face: to emulate care that transcends enough to make a mark in our patient's life.

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About the Author: *Carlo Paul C. Sana*, MAN, RN, is a Professor, Research and Extension Coordinator, and Accreditation Coordinator of Virgen Milagrosa University Foundation – Graduate School. He is a Research enthusiast and is an active member of various research institutes and organizations. He has also received several awards relative to the conduct, presentation, and publication of this study, notably the Platinum Award for having the Best Research Paper, and the Best in Multimedia Presentation Award during the 10th Dr. Martin Posadas Memorial Research Forum; the aforementioned study also garnered 3rdplace – Best in Oral Presentation during the Region I Health Research and Development Consortium(R1HRDC) Regional Research Contest & Research Dissemination Forum in July 2014. At present, he is working on a number of researches intended for national development.

> “By increasing emotional intelligence, nurses raise their awareness so they can make better choices in the future. This process enhances nurses' abilities to have emotional intelligence inform their practice.”
>
> Sherwood & Horton-Deutsch, 2012, p. 23

PHILIPPINE NURSES ASSOCIATION, INC.

Case Study

The Champion: Conquering the Challenges of Bipolar Disorders[1]

Marian T. Villanueva, RN, **Maria Angela A. Mabale,** RN,
John Bernard F. Bernardo, RN, **Paolo Niccolo V. Bruno,** RN
and **Roderick P. Lorenzo,** MAN, RN

Bipolar Disorder has been one of the leading psychiatric conditions here in the Philippines. . It is characterized by mood swings from profound depression to extreme euphoria (mania), with intervening period of normal mood (euthymia). The frequency, duration, and severity of manic and/or depressive episodes varies and is unique to each individual (Haber, 1997). In general, there are five in every 100 Filipinos who are suffering from some form of depression, and other may have a different reaction such as hyperactivity or swinging from depression to euphoria, unable to function normally, and in real danger of hurting themselves and others. Sadly, many of those with bipolar illness are left undiagnosed and, consequently, untreated. This case study presents how nurses play a role in helping patients overcome the challenges of having a psychiatric illness particularly those with Bipolar Disorder.

Client Profile

Client JCR is a 31 year old Filipino male who lives in Antipolo City. This patient was diagnosed with Bipolar Disorder in 2013 when he started to manifest with depressive behaviors because his father and friends rejected him for his expression of homosexuality. These depressive behaviors alternated with elation, hyperactivity, irritability, and grandiose behaviors. His first admission in a psychiatric facility was when he drank a glass of Monosodium Glutamate out of his depression. He did not experience any untoward physical symptom after the incident but he was brought to the hospital due to the behavioral changes. He was then started on unrecalled medications and the symptoms resolved after a week but the patient was no longer able to go back to work. He stayed at home for several years and the symptoms would recur warranting admission to different psychiatric institutions. Due to financial constraints, the patient's family consulted at Philippine General Hospital in 2012. He was admitted at Ward 7 when the same symptoms recurred after he stopped his medications and resorted to herbal pills. At this time, he was started on Clozapine and Divalproex Sodium as maintenance medications. He was discharged improved after a month and was again functional at home.

Four months prior to admission, the patient became active in a religious organization where one member told him to stop taking his medications believing that only faith will heal him. The patient stopped his medications and after several weeks, his symptoms recurred. He was noted to have decreased need for sleep and frequent anger outbursts. He was disruptive and incessantly talks about irrelevant and unrealistic things. During the Holy Week, he went on a station of the cross around their village and even invited strangers to eat in their house. He would roam around their neighborhood at night and would not

[1] *Ms. Angelita H. Dimaano, RN, Chief Nurse and Ms. Maria Cecilia E. Palomeno, Head Nurse of the Psychiatric Unit advised the group who presented this case study.*

sleep. He strongly refused to take his medications and would always start a fight whenever being reprimanded for his activities. Because of this, he was brought to PGH-OPD for consult and was advised readmission to Ward 7.

On the initial mental status examination, the patient looked kempt and well-groomed and was wearing sleeveless shirt, shorts, and slippers that were appropriate for his age and sex. He had poor concentration and easily gets distracted with the environment. He was hyperactive as he paces and roams around the ward and he refused to stay on his bed. He is cooperative while talking with the nurses but tends to be manipulative when the topic was about his hospitalization. He demanded a lot of things about his stay in the hospital and threatened to sue the staff for not giving his needs adequately. He became irritable and argumentative every time his father joins the conversation. He was able to maintain good eye contact. He had loud and pressured speech of normal quality but speaks mostly in English. His mood was manic and his affect was appropriate. In terms of his thought process, he denied presence of any form of hallucination. His responses were relevant to the question asked but he tend to have a loosening of association and flight of ideas when narrating events. He had delusions of grandeur as he claimed that he is a certain celebrity and that he is the most intelligent when he graduated from many universities. He also had bizarre delusions about "Ina Magenta" and other fictitious characters which he claimed to come into his life. He was also preoccupied about religious teachings. He denied presence of suicidal ideations. He would verbally threaten to harm people but no attempt was done. In terms of insight about his illness, he knew that he has Bipolar Disorder but denied that he needs admission and medications. He made confabulations about the events that transpired prior to his hospitalization. His judgment for real life situation was also impaired.

With all the abovementioned symptoms, the question now is how did all these symptoms come about? Bipolar disorder as defined by biological theories is an imbalance of dopamine and norepinephrine in the brain wherein an excess would lead to mania and a deficiency would lead to depression. (Townsend, 2008) However, in dealing with maladaptive behaviors, we also have to look on psychosocial or environmental factors that may have brought about such behaviors and symptoms as basis for our interventions. Figure 1 *(page 70)* explains the psychodynamic paradigm of the patient's maladaptive behaviors.

The nursing care for this patient is focused on three major problems including Disturbed Thought Process related to unresolved intrapsychic conflicts; Defensive Coping related to fear of rejection; and Chronic Low Self Esteem related to perceived lack of affection and acceptance from others. (Fortinash, 2003)

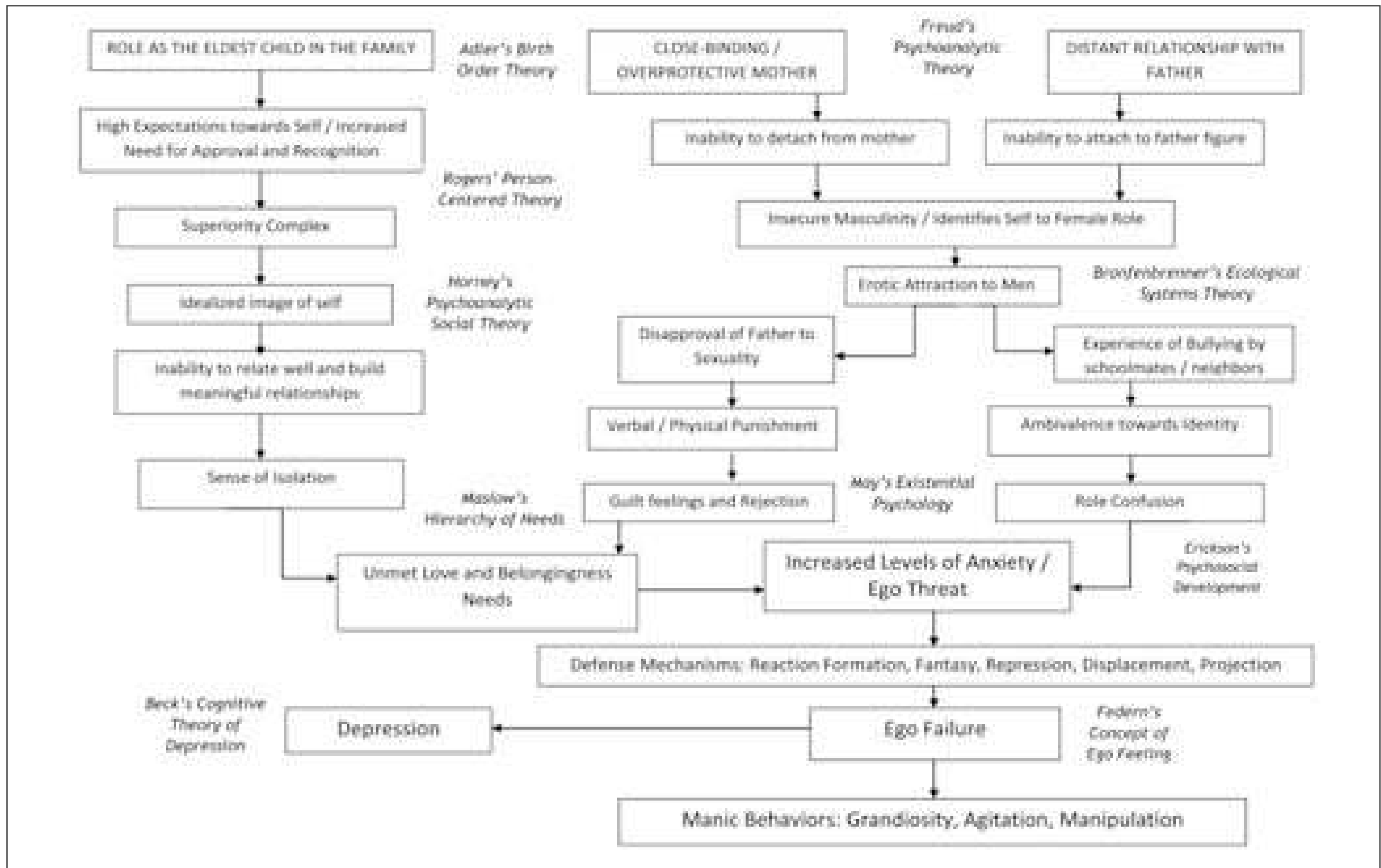
NURSING INTERVENTIONS

In addressing these problems, the nurse utilized the nurse-patient interaction as the main tool in providing interventions. Through this, the nurse was able to address physical needs, teach necessary knowledge and skills, provide support, and assist the patient towards change. (Townsend, 2008) For this patient, the objectives of the interaction were directed towards reality orientation, management of delusions, improvement of judgment and insight, effective communication, self awareness and improvement of self-concept, and development of adaptive coping skills. The nurse-patient interaction was conducted daily while the patient was admitted to monitor the patient's progress. The objectives of each interaction depend on the patient's needs as well as his readiness for interventions.

Art therapy was also utilized as an effective intervention for this patient. It utilized the creative process of art making to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. One example of an activity done for this patient was the Draw a Person Test which was used for self-expression and personality analysis. Outputs of this patient reflected that he was seriously disturbed and had poor self-concept. The fact that the patient drew the opposite sex first described strong attachment or dependency on parent of opposite sex and possible sexual identification conflict, which the patient really experienced. The big head on his drawing was interpreted as preoccupation with fantasy or the person wished he was smarter or better able to achieve. His drawing also showed high standard for achievement, expansive and grandiose tendencies, feelings of inadequacy, emotional tendencies, and femininity. (Moschini, 2005)

Another nursing intervention provided is the promotion of his involvement in group activities. These activities included Patient Government Meetings to facilitate self determination and decision making,

Figure1. PSYCHODYNAMIC PARADIGM



communication skills training to improve relationships with people, self-awareness activities, stress management, and recreational activities. The patient was also involved in Psycho-education Sessions on Bipolar Disorder and its management, Relaxation Techniques, and Coping Strategies.

FAMILY THERAPY

Emotional symptoms or problems of an individual may also be an expression of problems in the family. According to Goldenberg (1996), individual behavior is better understood as occurring within a family social system wherein the identified patient is viewed as merely a representative of a system in disequilibrium. Therefore, the family can be viewed as a unit of treatment. More importantly, the family, as the basic unit of the society, was considered a significant part of the patient's coping and recovery. Filipinos highly value the presence, love, acceptance and support of the family more than anything. So, on this particular case, it was deemed necessary to conduct family education and family therapy sessions in order to address the patients conflicting relationship with father and to strengthen family involvement in the care of the client. The family underwent five (5) family therapy sessions. On their initial session, each member of the family was able to express their needs with regards to the care of the client. Trust and rapport was established between the nurse therapist and the family members. The present role and relationship patterns were determined as well as the aspects of care that needs to be strengthened and improved. The goal for the whole family therapy session was established which is to resolve relational conflicts within the family, to engage all the family members in the treatment regimen and to promote open communication within the family. During the succeeding sessions, the family was able to discuss issues concerning the psychiatric illness and treatment regimen of client JCR. The family was also able to enumerate symptoms of bipolar disorder and ways to deal with manipulative and disruptive behaviors. They were able to discuss most of the guide pointers for caregivers of people with mental illness and also expressed the importance of their involvement in the

decision making process especially those that are related to the management of illness. They explored ways of dealing with family issues and problems with focus on increasing effective communication and were able to determine each family member's strengths and weaknesses with regards to effectively communicating feelings towards client and with other family members. On the last family therapy session with the family, each member was able to set realistic personal and family goals for the next five years. They were able to identify the modifications needed on the family's present treatment approach on the client's illness and they agreed to help and support one another in overcoming their personal and family concerns specially those challenges related to the client's condition.

EVALUATION

After the nursing interventions, the patient demonstrated ability to execute complex mental processes as evidenced by the ability to communicate clearly with others, comprehend the meaning of daily situations appropriately and make appropriate decisions when given hypothetical situations. He was able to recognize changes in behavior and thinking by identification of delusional thoughts from reality and verbalization of understanding of causative factors/stressors related to illness. He also demonstrated behaviors and lifestyle changes to prevent or minimize changes in mentation by ignoring delusional thoughts and asking significant others for validation of reality. During the later part of his admission, the client displayed absence of delusions during nurse-patient interactions. Moreover, he expressed feelings of being in control over concerns regarding homosexuality and family issues. He demonstrated an increased level of emotional responsiveness by attempts to avoid unduly stressful situations and practice of deep breathing exercises whenever necessary. The client was able to utilize appropriate, constructive, and effective coping strategies while in the ward. He discussed coping strategies that he has practiced in the past, identified effective coping strategies appropriate to present problems and verbalized a feeling of increased psychological comfort. Consequently, the patient expressed positive feelings about self and what he can do despite his homosexuality. He was able to enumerate his strengths and weaknesses and verbalized presence and acceptance of self limitations. He demonstrated behaviors congruent with increased self esteem by avoidance of negative self-statements and validation of thoughts from others. He also verbalized willingness to call on his parents and siblings for help and was able to settle conflicting relationship with father. Lastly, he was able discuss ways to promote effective communication within the family and recognized the value of the support given by family members on conquering his mental illness.

INSIGHTS

It was such a humbling experience for us, the psychiatric nurses, to be able to care for our patient and invite him to be part of our case presentation. Even though we provided psychiatric nursing care to this patient, we think that we have gained more from the client and his family. We have considered our client a CHAMPION for we have witnessed how he became empowered and tried his best to overcome Bipolar Disorder. We consider the family as CHAMPIONS for they have chosen not to give up on the patient but instead, they have showered him with more love, forgiveness and acceptance. Moreover, they became actively involved in the care for the patient. And lastly, we consider ourselves, the psychiatric nurses as CHAMPIONS because of the appreciation by the client and his family for the nursing care given. This gave us more than enough reason to be grateful for all that we have shared and learned from this case presentation. Life is indeed a wonderful journey to take despite the trials and difficulties so in whatever path that we have to face as nurses, we must claim ourselves to be **CHAMPIONS**, giving out our best for our patients, not giving up and moving forward as stronger and better individuals.

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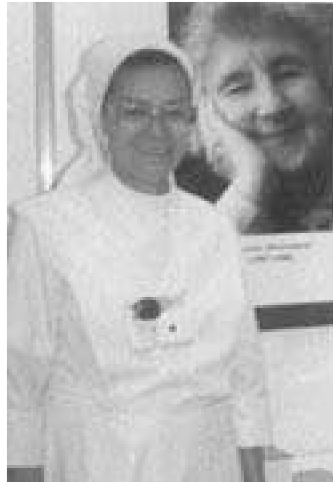
PHILIPPINE NURSES ASSOCIATION, INC.

Feature Article

Sister Remy Angela Junio, SPC: A Model of Faith and Exemplary Leadership

Marian G. Santos, RN



Sr. Remy during her trip in Canada for the PBL Training. This training opened the opportunity for the emphasis of lifelong learning skills in the curriculum and in the training of students in the university.

Sr. Remy is a visionary leader. Even before the call to prepare for ASEAN 2015, Sr. Remy had been promoting Philippines nursing education to people outside the country. She has convinced Chinese, Indonesians, Thai, East Timor students to be educated in the Philippines.

To perpetuate the legacy of Anastacia Giron Tupas, the founder of the Philippine Nurses Association, the Anastacia Giron Tupas Award is given annually to remind Filipino nurses of their distinction as creative and inspiring leaders who are brave, compassionate, and skillful in their relentless pursuit of ways to alleviate pain and suffering that is experienced by people around them. For such were the exemplary traits portrayed by the late Founder Tupas herself during hard times in Philippine history. Two of the yardsticks she had set in the selection of deserving recipients are Service and Universality that have been broken down into the following criteria: Proven leadership (35%), Personal traits (25%), Exemplary competence (30%) and Exemplary contributions (10%).

Having been chosen as the 32nd Anastacia Giron Tupas Awardee, Sister Remy Angela Junio, SPC was once an ordinary nurse who rose from the ranks due to her simplicity, sincere heart for service, and innovativeness. It was during her first employment in the Manila Doctor's Hospital where she became the Director of Nursing Services that she found her calling to the religious life and from thereon blazed a trail of impeccable and soulful leadership in other organizations such as the St. Paul College of Manila where she became Assistant Dean and eventually Dean of the College of Nursing, St. Paul College of Iloilo where she became Dean of the College of Nursing, and finally, St. Paul University Tuguegarao where she became Dean of the College of Nursing, Vice President for Academics, and University President for ten years.

According to Sister Junio, her experiences in the said organizations "tested her leadership, creativity, innovative ideas, and vision for the nursing profession." She also humbly attributes all of her achievements to God who she believes had blessed her with the best people to support and enhance the talents, leadership abilities and opportunities that were given to her. In addition, she mentioned, in her audio-visual acceptance of the AGT award, that her desire to make a difference further extended not only in plans and programs for St. Paul University Tuguegarao--- but also in education and policy guidelines governing nursing practice in general through her stint as the elected President of the association of deans of the different colleges in Nursing.

Her message to nurses is "to continue touching lives and sustain a passion to help all nurses in efforts to innovate and discover what is new from what is ordinarily seen."

Feature Article

Tita Rillorta[1] & Her Life of Service

Erlinda Castro-Palaganas, PhD, RN

Tita with the healing touch of her acupuncture needles.

Hailing from the humble plains of Isabela, Tita Rillorta is a nurse who has been practicing acupuncture since 1985. She graduated with a degree in Nursing and passed the board exam with impressive statistics. One would expect someone as talented, resourceful and idealistic as her to be working abroad, especially after her training and experiences in Japan, China and Indonesia. But she is still back home, extending her services to those who need it the most. Like she said, “My goal when I was younger was to move abroad and earn dollars and give my family the life they deserve. Later in life I discovered, it is a much better goal to think of the larger good, to think of a bigger family to serve: my community. And I have not looked back since.”

Not only is she one of the region's most well-known acupuncturist, and one of the very few selects of the country to be awarded a certificate of being a certified acupuncturist by the PITAHC, but she is also a leader and organizer. She has been working in Ilagan's CBHP for three decades now. Organizing trainings, medical missions in the far flung sitios and barangays, and passing on all of the knowledge and experiences she has gained over the years to young health workers willing to learn and help the community, especially those who receive less of what they are promised and deserve when it comes to basic health services.

When asked about what inspires her with her brand of work, she simply tells the story of her family: "I came from a family who had little. I saw how my parents struggled to provide for us and seeing this, I told myself that one day, I will give back to everyone who has little and needs a lot of help. My inspiration are the hardships I had to experience, these pushed me to become who I am: a dedicated nurse with a passion for service.”

On a personal note, it was during the start of my career as a community health nurse that I met Tita. I worked with her every time I would be in Isabela, traversing rice fields and rivers during our field work. We trained community health workers in the rural communities of Isabela. I remember clearly the times we rode the boat cruising the swollen Cagayan River to hacienda Sta. Isabel and hacienda San Antonio. These communities then were highly militarized because of land issues by the farmers and landlords of Isabela. But the people in the communities protected us and so we were able to conduct our Community Health Worker's training in peace. I have had a close look into Tita's dedicated work in the community. I have visited her home and her family in Quirino, and definitely, with her caliber, she could have been driven by her family's condition to join the caravan of nurses going to the US and other countries, which at that time was almost what every nurse was doing and aspiring to do. Unknowingly, she inspired me to be as good a community health nurse as she is. She has touched so many lives of people in the community and my life as well. She is a great model of dedication to community service and much more.

Aside from dedicating her time and passion to the plight of community health service, Tita also entered the academe and served as a teacher and clinical instructor for 10 years in Our Lady of Pilar College. Her passion has not once wavered. She has inspired many of her students to serve the people. She resigned her secured position recently to dedicate all of her time to serving her community. She has set aside her dreams of studying again and pursuing a doctorate degree in the meantime to fully focus on the state of her community's health. Clients and friends are in awe when they described her dedication to serve, “she goes to our house to treat my ailing father but would sometimes even refuse any form of monetary payment I give her; she is an angel to all of us”, a dear friend who has been Tita's client for many months now once said.

Despite not reaching the required number of points to be awarded this respected Huwarang Nars title, to the people Tita dedicated her life to, she is their Huwarang Nars. No title can ever replace the respect and love the people of her community is giving her. True to form, service asks for no recognition. Tita has long since been her community's Huwarang Nars.

[1] *Tita Rillorta is the sole nominee of 2014's Huwarang Nars Award.*

News Feature

PNA Gears for Transformation: To be a Trade Union or Not?

Jossel I. Ebesate, RN

Marian G. Santos, RN

Salaries below the Nursing Law-prescribed salary grade level in the public sector, wages below the prescribed minimum wage in many private hospitals nationwide, understaffing and poor working conditions, non-payment of mandatory benefits, and lack of job opportunities are only some of the numerous challenges that had been hounding nurses all over the Philippines for years.

In almost a century of existence by the Philippine Nurses Association and its forerunner the Filipino Nurses Association, the recognized accredited nurses organization have been advocating and campaigning for the welfare of the Filipino nurses year-in year out such as. This include among others, the increase in salaries and wages of nurses, payment of prescribed benefits, adequate staffing in public hospitals and public health facilities, provision of adequate employment opportunities both local and international and adequate enforcement of regulatory protection for employed nurses in order for us nurses to deliver the best possible nursing care for our patients and to the public in general. But not so distant and recent events have proven, such issues and corresponding campaigns have not been fully addressed by the government and the private sector.

For example, the issue of lack of employment opportunities for nurses and the inadequate staffing in government hospitals and public health institutions amidst an overwhelming oversupply of registered nurses who are either unemployed or employed in non-nursing jobs, that until recently are estimated to have reached the 500,000 mark are only given scant attention by our government. Add to this, based on a study published in the UP Manila Journal in 2000, only 15% of about 178,000 employed nurses are employed locally, during that period.

In a message delivered by Hon. Leah Primitiva Paquiz, Ang NARS Partylist Representative, she explained that efforts to realize the passage of House Bill 151 - An Act Providing For Comprehensive Nursing Law Towards Quality Health Care System, Repealing For This Purpose Ra 9173 Known As The Philippine Nursing Act Of 2002, now pending in the Philippine Congress, will come to fruition only if nurses can negotiate through a "tripartism and bipartism agreement with the government and potential employers." In other words, success or fulfillment of PNA's pleas for nurses can be achieved through a nurses' trade union.

Founded by the late Anastacia Giron Tupas as Filipino Nurses Association on September 02, 1922 and incorporated in 1924, PNA has been recognized locally and abroad as a professional organization that advocates the continuous development and utmost welfare of Filipino nurses. To date, however, nursing leaders who convened for the General Assembly in the recent PNA National Convention held at the Tent City, Manila Hotel on October 21 to 23, 2014, have begun to discuss and to consider the possibility of giving their organization dual functions: one as a professional organization and the other as a collective bargaining and negotiating organization representing the nurses. PNA Governor Gloria Almariego stressed the importance of studying this transformation to gain easier access to key government officials, *"Kapag tayo po ay worker's organization, lahat po tayo kahit sa anong dulo ng Pilipinas ay kaya po natin kausapin pati mga governos at tsaka mga mayors ninyo."* In addition, Dean Clarita Curato of NCR Zone 1 clarified the negativity associated with being a union or a workers' organization, *"Akala nila kapag union leftist na. Pagunion eh palaban na yung lalabanan na yung gobyerno. No. It's not that. But we have to understand what unionism is all about. Ano ba yung ah aim natin dito? Ano ba yung tinutumbok natin dito? Ito ay papalakasin natin because it is a tripartrite agreement every time we want something from the government or from the institution we are connected with. Tripartite yun palagi. Para tayo ay pakinggan, nandyan ang government, nandyan ang administration, nandyan ang union. Kaya itong tatlong ito ang maguusap-usap."*

Mr. Jossel Ebesate, Chair of the of the PNA's Department of Nurses Welfare, urged nurses to study the following Resolution which was vetoed during the deliberations in the House of Delegates of the PNA. Nurses need to be more involved in matters affecting them . As the challenge goes, "Kung hindi tayo, sino? Kung hindi ngayon, kailan pa natin ipaglaban ang nararapat?"

"Resolution Authorizing the Department of Nurses Welfare to Conduct a Nationwide Campaign Aimed to Create Awareness thereby Pushing Public Pressure for Relief and Reform of Policies Aimed at Resolving the Flight of Unemployed, Misemployed and Underpayment of Nurses; and Chronic Understaffing in Public Health and Public Hospitals and Eventually Make Health Care More Equitable and Accessible

Whereas, estimate of unemployed and misemployed nurses nationwide now stood at 200,000 and 300,000, respectively. Misemployed nurses are registered nurses that pursued employment other than nursing because of the lack of employment in the nursing field nationwide.

Whereas, the number of unemployed and misemployed nurses are increasing annually not because of the lack of needs for nursing services but primarily because of the lack of prioritization by the government to create additional regular plantilla items for nurses nationwide in spite of increasing demand. The demand for additional nurses is imperative considering the increasing population that now stood at 100,000,000.

Whereas, the demand for increased nurses and the lack of priority or focus by the government to provide health care is palpable in the following statistics: 7 out of 10 Filipinos died without being seen by a health professional; 60% of over-all health spending is out of pocket; 94,000 hospital bed capacity out of the WHO recommended of 200,000 beds for our 100,000,000 population (2 hospital beds/1,000 population); 100,000 health workers out of the WHO recommended of 230,000 health workers (2.3 health workers/1,000 population).

Whereas, an NIH study in 2000 (Lorenzo, et. al.) estimated that there are 27,000 existing nurse position in the country. To say the least, we need at least 33,000 additional regular nurses position in the country to approximate the WHO recommendation of 2.3 health workers/1,000 population, based on our existing health structure.

Whereas, while laudable, the government's response on the massive unemployment of nurses in spite of our people's increasing demand for health care have been, to say the least, "band-aid" in character and not a lasting solution to both problems of nurse-unemployment and lack of health care, such as NARS Program, RN-HEALS, and lately, the Nurse Deployment Program (NDP), "Band-aid" in the sense that at the latest, under the NDP, 12,500 nurses are only hired as contractual staff for two (2) years, no regular plantilla items are created.

Whereas, until now, the entry level Salary Grade for nurses in the government, only stood at SG 11, far from the SG 15 prescribed under Section 32 of Republic Act 9173 or the Nursing Act of 2002. While in the private sector, there are still nurses that received P180.00 daily compensation even here in the NCR in spite of the fact that the current daily minimum wage in the private sector, already stood at P466.00.

Whereas, in spite of repeated appeals to concerned government agencies, specifically the Department of Budget and Management (DBM) and the Department of Health (DOH), no concrete steps have been done to implement the prescribed starting salary of SG 15 for nurses in the public sector; and in spite of complaints to the Department of Labor and Employment, no corrective measures have been done for erring private hospitals in implementing the minimum wage.

Whereas, our public health care have been saddled with understaffing with one public health nurse serving 40,000-60,000 population in spite of the DOH prescribed of one (1) nurse per twenty thousand (20,000) population, while public hospitals have a staffing ratio of one (1) nurse to 30-80 patients in minimal care units, far from the DOH prescribed of one nurse/12 patients.

Now, therefore, upon representation by the Department of Nurses Welfare, and upon motion duly moved and seconded, resolved as it is hereby resolved that the Philippine Nurses Association, with the support of all the Board of Governors, and in coordination and active participation of all chapters, the House of Delegates hereby authorizes the Department of Nurses Welfare to Conduct a Nationwide Campaign Aimed to Create Awareness thereby Pushing Public Pressure for Relief and Reform of Policies Aimed at Resolving the Flight of Unemployed, Misemployed and Underpayment of Nurses; and Chronic Understaffing in Public Health and Public Hospitals and Eventually Make Health Care More Equitable and Accessible.

Resolved further that the Executive Committee and the National Office to provide funding and manpower support, accordingly, in order to carry out the said campaign.

Resolved further that the Department of Nurses Welfare to make and carry out a campaign plan and coordinate, with all national and international chapters to ensure a nationwide and sustained campaign.

Resolved further that all chapters to conduct sustained localized campaign activities as coordinated by the Department of Nurses Welfare.

Resolved finally that copies of this resolution be furnished to the Board of Governors, The Executive Committee, the National Office through Executive Director, the Department of Nurse Welfare and all national and international chapters through their respective Chapter President."

The Chairman of the Board of Governors, Governor Noel Cadete, concluded the discussion on the matter by informing his colleagues that the Board of Governors will create a taskforce on unionism. He invited all PNA members who would want to be part of it.

Two Nurses from the Philippines Attended the 1st Congress of the Global Nurses United

Mr. Jossel Ebesate and Ms. Jocelyn Andamo, Chairpersons of the PNA's Department of Nurses Welfare and Committee on Positve Practice Environment, respectively attended the First Global Congress of the Global Nurses United (GNU) held on September 26, 2014 at the Planet Holywood Hotel, Las Vegas, Nevada, USA.

Leaders of affiliated health workers and nurses unions from 17 other countries of the international trade union federation of nurses also attended the historic meeting. National Nurses United - the largest trade union of nurses in the United States hosted the daylong event. The nurses and health workers shared stories of what's happening in their respective countries. They talked about efforts to combat austerity measures, privatization of health services and erosion of patient care standards. Other discussions focused on the need for mandated nurse-to-patient ratios, healthcare for all and how the climate crisis is impacting our health.

GNU, which was created in June 2013, welcomed its newest members: Greece, Uruguay, Kenya, Taiwan and Paraguay. The federation now has 18 countries represented. Jossel I. Ebesate, RN

News Feature

PNA hosts the 1st Nurse Consultant Training on PMDT

Gerelyne R. Reboroso, RN

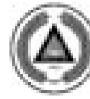
The 1st Nurse Consultant Training on Establishing a Patient-centred Approach to Programmatic Management of Drug-resistant-TB (PMDT) was held in Quezon City, Philippines on November 17-21, 2014. This training was jointly sponsored by the Global Drug Resistance Initiative, the International Council of Nurses (ICN) and the Philippine Nurses Association (PNA). It enjoined nurses involved in managing patients with Drug-Resistant Tuberculosis (DR-TB) from Latvia, Thailand, China, Cambodia, Laos, Vietnam, South Africa, Ethiopia, Papua New Guinea, and Philippines participated.

A Global priority of scaling up the PMDT to ensure universal access to rapid, effective MDR-TB diagnosis and treatment requires a massive and coordinated effort on the part of countries, technical agencies, and donors. The GDI Taskforce on Establishing a Patient-centred Approach to PMDT believes that the clinical and programmatic scale-up requires a patient-centred approach in order to ensure its success, thus requiring technical consultants with this expertise.

This training aims to prepare nurse consultants to address some of the key practical challenges associated with achieving a patient-centred approach to PMDT-TB (DR-TB). It focuses on the practical aspects of care delivery along the patient pathway from diagnosis to the end of treatment. It covered clinical aspects of DR-TB, professional issues such as management, training and regulation, practical aspects of applying a patient-centred approach to PMDT and the role of the nurse consultant.

The programme included lecture-discussions, group discussion, workshops and onsite visits to the Lung Center of the Philippines, Toro Hills Batasan Health Center and one TB-DOTS Center in Caloocan City. The expert facilitators include Ms. Virginia Williams (immediate former TB Director in ICN), Ms. Carrie Tudor from U.S.A (current TB Director of ICN), Dr. Mamel Quelapio (DOH) and Ms. Nona Rachel Mira (Nurse Consultant for the Western Pacific Regional GLC).

The trained nurse consultants were tasked to contribute ideas and propose plans on how to disseminate important information and skills among nurses and other front-line health workers in their respective home countries. They will become a valuable resource in building the capacity of nurses in their home countries to improve care for people affected by DR-TB. They eventually departed with much confidence and optimism in their continuing campaign towards TB eradication.



Philippine Nurses Association, Inc.

Training Site for American Heart Association's BASIC LIFE SUPPORT (BLS) and ADVANCED CARDIAC LIFE SUPPORT (ACLS)

EKG & PHARMA	BLS	ACLS
January 8	January 10	January 10 &11
February 12	February 14	February 14 & 15
March 12	March 14	March 14 &15
April 8	April 11	April11 & 12
May 7	May 9	May 9 & 10
June 11	June 13	June 13 &14

Note: Dates subject to change without prior notice.

Time: EKG & Pharmacology **(8:00AM - 5:00PM)**
BLS **(7:30 AM - 2:00 PM)**
ACLS **(1st Day - 2:00-5:00PM/ 2nd Day - 8AM -5:00PM)**
Venue: **J. V Sotejo Hall, 1663 F.T Benitez St. Malate, Manila**

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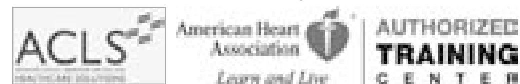

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Look for ***Ms. Sherell Tabafunda*** *or* ***Ms. Gerelyne Reboroso*** *for inquiries and registration.*

GUIDELINES FOR AUTHORS

The Philippine Journal of Nursing, a peer reviewed journal, is the official publication of the Philippine Nurses Association published biannually. It considers original articles written for Filipino nurses at all levels of the health care organization and in various settings. The Philippine Journal of Nursing will serve as:

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2. Source of updates on policies and standards relevant to Nursing practice and Nursing education, and
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Manuscript Preparation and Submission

1. Manuscripts are voluntary contributions submitted for exclusive review for publication in the PJN. Manuscripts containing original materials are accepted for consideration if either the article or any part of its essential substance, tables, or figures has been or will be published or submitted elsewhere before appearing in PJN.
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3. For additional information about manuscripts and queries about submitting manuscripts, please contact the editor:
   E-mail: ***philippinenursesassociation@yahoo.com.ph.***

The information below indicates the required presentation of manuscripts.

Format and Style

1. The PJN follows the Publication Manual of the American Psychological Association (APA) 6th edition with respect to manuscript preparation. Authors are encouraged to refer to the manual, whenever possible. Alternatively, the following internet resource may be used: Angeli, E., Wagner, J., Lawrick, E., Moore, K., Anderson, M., Soderlund, L., & Brizee, A. (2010, May 5). *General format*. Retrieved from http://owl.english.purdue.edu/owl/resource/560/01/
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3. Manuscripts should be 12 font, double-spaced with standard margins (about 1 inch). Fancy typefaces, italics, underlining and blooding should not be used except as prescribed in the APA 6th edition guidelines.

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The content of a typical manuscript includes:

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Title
Should indicate the focus of the article in as few words as possible. It should not contain a colon or other complex structure. Manuscript titles should not exceed 15 words.

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(b) Title or position, institution and location; to whom correspondence should be sent, with full address, phone and fax numbers, and e-mail address: provide e-mail address for all coauthors.

Acknowledgements
Briefly state name of funders, grant number and name of mentors/people with significant contribution.

Abstract
A structured abstract with headings should be included as part of the manuscript. The abstract denotes: (a) purpose of the article, without detailed background; (b) design, including type of study, sample, setting, ethics review board approval, dates of data collection, if applicable; (c) methods, such as interventions, measures, type of analysis; (d) findings; and (e) conclusions.
For manuscripts focused on review or theoretical analysis, a structured abstract is still required but the organizing construct may be stated instead of a design.

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A few words that are recommended for use in indexing should be listed at the end of the Abstract.

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- Conclusions

The text should indicate the characteristics of the setting in which the study was conducted. The review of literature and the discussion, interpretation and comparison of findings should include reference to relevant works published in other countries, contexts and populations.

Systematic Reviews

Authors considering to submit a systematic review must adhere to the PRISMA Statement. Such submissions must be accompanied by a PRISMA 2009 Checklist. Further information about the PRISMA Statement and the PRISMA 2009 Checklist can be obtained from the following link:
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Authors must adhere to APA 6th edition Form and Style; list of references should include only those references that are important and cited in the text. References should be the most current on the topic.

Tables and figures/photos

1. Each table and figure should be presented on a separate page and uploaded separately. Placement of each table or figure should be noted in the text. The PJN does not use addenda, appendices and colors.
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1. The average time from manuscript submission to the author's receipt of the editor's decision about publication is approximately 3 months. During that time, each manuscript undergoes rigorous double-blind peer review. During this period, peer reviewers may request additional information including but not limited to electronic copies of raw data for the purpose of verifying and gaining a better understanding of the manuscript. Such requests will be within the limits allowed by standard ethical guidelines.
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   a. accept, with editing to follow immediately;
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6. All accepted manuscripts are subject to editing.
7. Authors will receive a complimentary copy of the issue in which their respective articles appear.

The PJN is now indexed in the Western Pacific Region Index Medicus (WPRIMP, a project of the World Health Organization Western Pacific Regional Office in collaboration with several institutions in its Member States. All journals must be approved by the Regional Journal Selection Committee before inclusion of any articles or abstracts in the WPRIM database. The PJN was officially accepted for inclusion on August 15, 2014, in a meeting held in Ulaan Bataar, Mongolia.

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