**BACHELOR OF SCIENCE IN NURSING:**

**COMMUNITY HEALTH NURSING I**

|  |  |  |
| --- | --- | --- |
| **COURSE MODULE** | **COURSE UNIT** | **WEEK** |
| 1 | 5 | 5 |
| **OVERVIEW OF PUBLIC HEALTH NURSING IN THE PHILIPPINES** | | |
| **FAMILY NURSING & NURSING PROCESS** | | |

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* Read course and unit objectives
* Read study guide prior to class attendance
* Read required learning resources; refer to unit

terminologies for jargons

* Proactively participate in classroom/online discussions
* Participate in weekly discussion board (Canvas)
* Answer and submit course unit tasks

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At the end of this unit, the students are expected to:

**Cognitive**

* Discuss appropriate health care delivery system and actions holistically and comprehensively.
* Enumerate the phases of Family Nursing Process
* Enumerate the methods of Gathering Data

**Affective**

* Integrate relevant principles of social, physical, natural and health sciences and humanities in a given health and nursing situation in the community.
* Value the importance of the Family Nursing Process in gathering Data
* Relate the importance of Nursing Bag

**Psychomotor**

* Model professional behavior as a community health nurse.
* Participate actively during class discussions
* Express opinion and thoughts during class
* Be able to perform unit task of creating you own nursing care plan
* Be able to solve your own Family Health Problem Prioritization



**NURSING PROCESS**

**FAMILY NURSING PROCESS**

Is the blueprint of the care that the nurse designs to systematically minimize or eliminate the identified health and family nursing problems through explicitly formulated outcomes of care (goals and objectives) and deliberately chosen set of interventions, resources and evaluation criteria, standards, methods and tools.

**NURSING PROCESS**

Nursing Process is a problem-solving approach that enables the nurse to provide care in an organize and scientific manner. It is applicable to individuals, families and community groups at any level of health. It is adaptable to any practice setting or specialization and the components may be used sequentially or concurrently.

**Phases of Nursing Process:**

1. Assessment
2. Diagnosis
3. Planning
4. Implementation
5. Evaluation

**THE NURSING ASSESSMENT PHASE**

1. Collection of data
2. Comparison of data against the standard or norm

**Family Nursing Assessment:**

**Data Collection**

**Three Sources Of Data**

* First source - Health status of the family
* Second Source - Family’s status as a functioning unit
* Third Source - Family's environment

**Methods of Gathering Data**

1. Direct observation

* A method of data collection which is done through the use of all sensory capacities
* The nurse gathers information about the family’s state of being and behavioural responses.
* Presence of S/S
  + Physical make up of each member
  + Communication or language patterns expected and tolerated.
  + Role perception/task assumption by each member, including decision-making patterns.
  + Conditions in home and environment

2. Interviewing

* Productivity of interview process depends upon the use of effective communication techniques to elicit needed responses.
* Encourage verbalization of thought and feelings and offer needed support or reassurance.

3. Physical Examination

* Done through inspection, palpation, percussion, auscultation measurement of specific body parts and reviewing the body systems
  1. Review of Records
* Reviewing existing records and reports pertinent to the client
  1. Laboratory/ Diagnostic Tests
* Performing laboratory tests, diagnostic procedures or other test of integrity and function carried out by the nurse herself and /or health workers.

**5 Types of Data use as Initial Data Base for Family Nursing Practice**

1. Family structure and Characteristics

* 1. Members of the household and relationship to the head of the family.
  2. Demographic data- age,sex, civil status, position in the family
  3. Place of residence of each member - whether living with or elsewhere.
  4. Type of family structure - matriarchal, patriarchal, nuclear or extended.
  5. Dominant family members in terms of decision making in matters of health care.
  6. General family relationship - presence of any obvious/ready observable conflict between members; communication patterns among members.

Ex.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Household Member | Age | Sex | Civil Status | Position in the Family | Place of Residence |
| RD | 24 | Male | Live-in | Father | Living with |
| JC | 23 | Female | Live-in | Mother | Living with |
| AL | 3 | Male | Single | Son | Living with |
| OJ | 2 | Female | Single | Daughter | Living with |

2. Socio-economic and Cultural Factors

1. Income and expense
   * Occupation, place of work and income of each working member
   * Adequacy to meet basic necessities (food, clothing and shelter)
   * Who makes decision about money and how it is spent
2. Educational attainment of its members
3. Ethnic background and religious affiliation
4. Significant others - roles they play in the family
5. Relationship of the family to the larger community-what is the participation of the family in community activities?

Ex

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Household Member | Occupation | Place of Work | Income | Educational Attainment | SO/ Roles in the Family |
| RD | Carpenter | QC | P9000/mo | Highschool Grad | Provider |
| JC | Housewife | - | - | College Grad | Keeper |
| AL | Children | - | - | - | Member |
| OJ | Baby | - | - | - | Member |

3. Environmental Factors

1. Housing
   1. Adequacy of living space
   2. Sleeping arrangement.
   3. Presence of insects and rodents.
   4. Adequacy of the furniture
   5. Food storage and cooking facilities
   6. Presence of accidents hazards
   7. Water supply-source, ownership, potability
   8. Toilet facility-type, ownership, sanitary condition
   9. Garbage/refuse disposal- type, sanitary condition
   10. Drainage system- type and sanitary condition
2. Kind of neighborhood- congested, slum, etc.
3. Social and health facilities available
4. Communication and transportation

Ex.

**Housing**

**- The family lives in a small room**

**- Inadequate living space**

**- They do not have beds and used to sleep in their floors, in a slanted position**

**- There is presence of breeding or resting sites of vectors of disease as manifested by an open-canal found outside their house.**

**- Presence of fire hazards due to the used of candle during night/sleep time**

**- Presence of fall hazards due to dark surroundings and un railed stairs**

**- They used to fetch water from the faucet of their neighbor**

**- Poor environmental sanitation due to poor drainage**

**- Poor environmental condition due to dirty toilet bowl and slippery toilet floor**

**- Poor environmental condition as manifested by pile of garbage found in their hallway**

4. Health Assessment of Each Member

1. Medical and Nursing History indicating past significant illness, beliefs and practices conducive to illness.
2. Nutritional assessment (specifically for vulnerable or at risk members)
   1. Anthropometric data- weight, height.
   2. Dietary history indicating quality and quantity of food intake per day
   3. Eating/feeding habits and practices
3. Current health status indicating presence of illness states (diagnosed/undiagnosed by medical practitioner)

5. Value Placed on Preventive Disease

1. Immunization status of children
2. Use of other preventive services

**Data Analysis**

* Comparison of the gathered DATA to the STANDARDS OR NORMS

Three Types:

1. Normal health of individual members
2. Home and environment conditions conducive to health development
3. Family characteristics, dynamics or level of functioning conducive to family development

**Health Problem**

* Is defined as situation or condition which interferes with the promotion and/ or maintenance of health and recovery from illness and injury.
* A health problem becomes a nursing problem when it can be modified through nursing interventions.

**Health Need**

* Exist when there is a health problem that can be alleviated with medical or social technology.

**THE NURSING DIAGNOSIS PHASE**

**Typology of Nursing Practice**

* the study or systematic classification of types.
* A tool or classification of a family nursing problems that reflects the family status and capabilities as a functioning unit.

**Health Problems and Family Nursing Diagnosis**

Typology of Nursing Problems in Family Nursing Practice

1. First level of assessment

I. Presence of health deficit, health threats, and foreseeable crisis/ stress points in the family.

A. Health Deficits

- Instances of failure in health maintenance and development

- Occurs when there is a gap between actual and achievable health status.

- diagnosed/suspected illness states of family members

-Sudden or premature or untimely death illness or disability and failures to adapt reality of life emotional control and stability

-Deviations in growth and development

-Personality disorders

Ex.

* Illness regardless whether it is diagnosed
* Failure to thrive or inability to develop according to normal rate.
* Disability arising from illness, whether transient/temporary
* e.g.

TEMPORARY

* + Aphasia or temporary paralysis after CVA

PERMANENT

* + Leg amputation secondary to DM, blindness from measles, paralysis from polio.

B. Stress Points/ Foreseeable Crisis Situation

- Anticipated periods of unusual demand on the individual or family in terms of adjustments/family resources.

Ex.

* Marriage
* Pregnancy, labor, puerperium
* Parenthood
* Additional member-newborn, lodger.
* Abortion
* Entrance at school
* Adolescence
* Loss of job
* Death of a member
* Resettlement in new community
* Illegitimacy

C. Health Threats

- Condition that are conducive to diseases, accidents or failure to realize one’s health potential.

Ex.

1. Health history of specific condition/disease-
   1. family history of DM
2. Threat of dross infection of CD case
3. Family size beyond what resources can adequately provide
4. Accident Hazards
   1. Broken stairs
   2. Pointed sharp objects, poison and medicine improperly kept
   3. Fire hazards
   4. Fall hazards.
5. Nutritional
6. Inadequate food intake both in quantity and quality
7. Excessive intake of certain nutrients
8. Faulty eating habits
9. Stress Provoking Factors
10. Strained marital relationship
11. Strain parent-sibling relationship
12. Interpersonal conflicts between family members.
13. Poor Environmental Sanitation
14. Inadequate living space
15. Inadequate personal belongings/utensils
16. Lack of food storage facilities
17. Polluted water supply
18. Presence of breeding places of insects and rodents
19. Improper garbage/refuse disposal
20. Unsanitary waste disposal
21. Improper drainage system
22. Noise pollution
23. Air pollution
24. Unsanitary Food Handling and Preparation
25. Personal Habits/ Practices
26. Frequent drinking of alcohol
27. Excessive smoking
28. Walking barefooted
29. Eating raw meat/fish
30. Poor personal hygiene
31. self-medication
32. Use of dangerous drugs or narcotics
33. Sexual promiscuity
34. Engaging in dangerous sports
35. Inherent personal characteristics- short temper
36. Health history which may precipitate the occurrence of health deficit-previous history of difficult labor.
37. Improper role assumption-child assuming mother’s role, father not assuming his role.
38. Lack of/ inadequate immunization status of children
39. Family disunity
40. Self-oriented behaviour of members
41. Unresolved conflicts among members
42. Intolerable disagreements

II. Inability to recognize presence of problem

III. Inability to make decisions with respect to taking appropriate health action

IV. Inability to provide adequate nursing care to the sick, disabled, dependent or vulnerable/at risk member of the family.

V. Inability to provide a home which is conducive to health maintenance and personal development due to:

VI. Failure to utilize community resources for health care

**Nursing Diagnosis**

Two Parts:

1. General
   * the statement of the unhealthful response
2. Specific
   * the statement of factors which are maintaining the undesirable response and preventing the desired change

Ex:

GENERAL:

* + Inability to utilized the community resources for health care due to

SPECIFIC

* + Lack of adequate family resources, specifically,
    - 1. Financial
      2. Manpower
      3. Time

**THE NURSING PLANNING PHASE**

**Family Nursing Care Plan**

A Family Nursing Care Plan is the set of actions the nurse decides to implement to be able to resolve identified family health and nursing problems.

**Characteristics Family Nursing Care Plan**

* 1. The nursing care plan focuses on actions which are designed to solve or minimize existing problem.
  2. The nursing care plan is a product of deliberate systematic process.
  3. The nursing care plan, as with all other plans, relates to the future.
  4. The nursing care plan is based upon identified health and nursing problems.
  5. The nursing care is a means to an end, not an end in itself.
  6. Nursing care plan is a continuous process not a one-shot deal.

**Desirable Qualities a Nursing Care Plan**

1. It should be based on a clear definition of the problems.
2. A good plan is realistic.
3. The nursing care plan should be consistent with the goals and philosophy of the health agency.
4. The nursing care plan is drawn with the family.
5. The nursing care plan is best kept in a written form.

**Importance of Planning Care**

1. They individualized care to clients
2. The nursing care plan helps in setting priorities by providing information about the client as well as the nature if his problem.
3. The Nursing care plan promotes systematic communication among those involve in the health care effort.
4. Continuity of care is facilitated through the use of nursing care
5. Nursing care plans facilitate the coordination of care by making known to other members of the health team what the nurse is doing.

**Four Criteria for Determining Priorities**

1. Nature of condition or problem
   * + Categorized into wellness state/ potential, health threat, health deficit of foreseeable crisis.
2. Modifiability of the Problem

- refers to the probability of success in minimizing, alleviation or totally eradicating the problem through nursing intervention

1. Preventive Potential
   * refers to the nature and magnitude of future problems that can be minimized or totally prevented if intervention is done on the problem under consideration.
2. Salience
   * refers to the family’s perception and evaluation of the problem in terms of seriousness an urgency attention needed.

**Scale for Ranking Family Health Problems according to Priorities**

|  |  |  |
| --- | --- | --- |
| **CRITERIA** | **SCORE** | **WEIGHT** |
| 1. **NATURE OF THE PROBLEM PRESENTED** |  |  |
| **SCALE:** |  |  |
| * **Health Deficit** | **3** |  |
| * **Health Threat** | **2** | **1** |
| * **Foreseeable Crisis** | **1** |  |
| **2. MODIFIABILITY OF THE PROBLEM** |  |  |
| **SCALE:** |  |  |
| * **Easily Modifiable** | **2** |  |
| * **Partially Modifiable** | **1** | **2** |
| * **Not Modifiable** | **0** |  |
| **3. PREVENTIVE POTENTIAL** |  |  |
| **SCALE:** |  |  |
| * **High** | **3** |  |
| * **Moderate** | **2** | **1** |
| * **Low** | **1** |  |
| **4. SALIENCE** |  |  |
| **SCALE:** |  |  |
| * **A serious problem, immediate action needed** | **2** |  |
| * **A problem but not needing immediate attention** | **1** | **1** |
| * **Not a felt need/problem** | **0** |  |
| **TOTAL/HIGHEST SCORE** |  | **5** |

**Scoring**

1. Decide on a score for each of the criteria.
2. Divide the score by the highest possible score and multiply by the weight.

SCORE/HIGHEST SCORE X WEIGHT

Sum up the scores for all the criteria. The highest score is 5, is equivalent to the total weight.

|  |  |  |  |
| --- | --- | --- | --- |
| **SCABIES AS A HEALTH DEFICIT TO THREE PRE-SCHOOL MEMBERS OF THE FAMILY** | | | |
| **CRITERIA** | **COMPUTATION** | **ACTUAL SCORE** | **JUSTIFICATION** |
| **NATURE OF THE PROBLEM**   * **HEALTH DEFICIT** | **3/3 X 1** | **1** | **A health deficit that requires immediate attention and adequate management to reduce likelihood of transfer of the disease to the rest of the family members.** |
| **MODIFIABILTY**   * **PARTIALLY MODIFIABLE** | **½ X 2** | **1** | **The family does not have adequate resources to solve the problem. Inadequacy of living space and water supply are barriers to achievement of good personal hygiene, which is important in the management and prevention of scabies**. |
| **PREVENTIVE POTENTIAL**   * **HIGH** | **3/3 X 1** | **1** | **Transfer of scabies to other family members is reduced or eliminated if the problem is managed adequately as soon as possible.** |
| **SALIENCE**   * **A PROBLEM BUT NOT NEEDING IMMEDIATE ATTENTION** | **1/1 X 1** | **1** | **The family recognized it as a problem. It consulted the health personnel a month ago, however, it does not see the problem as needing immediate action.** |
| **TOTAL SCORE** |  | **4** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **IMPROPER REFUSE DISPOSAL** | | | |
| **CRITERIA** | **COMPUTATION** | **ACTUAL SCORE** | **JUSTIFICATION** |
| **NATURE OF THE PROBLEM** | **2/3 X 1** | **0.67** | **It is a health threat** |
| **MODIFIABILITY** | **2/2 X 2** | **2** | **Resources are available and interventions are feasible** |
| **PREVENTIVE POTENTIAL** | **3/3 X 1** | **1** | **Communicable disease transferred by insects and rodents can be prevented** |
| **SALIENCE** | **0/2 X 1** | **0** | **The family does not perceive this as a health problem** |
| **TOTAL SCORE** |  | **3.67** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MALNUTRITION** | | | |
| **CRITERIA** | **COMPUTATION** | **ACTUAL SCORE** | **JUSTIFICATION** |
| **NATURE OF THE PROBLEM** | **3/3 X 1** | **1** | **It is a health deficit that requires immediate management to eliminate untoward consequences.** |
| **MODIFIABILTY** | **2/2 X 2** | **2** | **The problem is easily modifiable since the nurse’s resources are available, she can help the family on effective budgeting of money and scheduling of time. she can develop skills of other members to achieve good nutrition – proper food selection and preparation, and feeding practices. The nurse can also educate the family to utilize the backyard by planting nutritious vegetables.** |
| **PREVENTIVE POTENTIAL** | **3/3 X 1** | **1** | **Susceptibility to other diseases and infections can be prevented if malnutrition is eliminated; normal growth and development can thus be achieved.** |
| **SALIENCE** | **2/2 X 1** | **1** | **A serious problem needing immediate action and attention** |
| **TOTAL SCORE** |  | **5** |  |

**Summary**

The list of health problems ranked according to priorities is presented:

1. MALNUTRITION 5
2. SCABIES 4
3. IMPROPER REFUSE DISPOSAL 3.67

**Formulation Of Goals And Objectives Of Nursing Care**

Establishment of Goals

* Goals
  + Is a general statement of condition or state to be brought about by specific courses of action.
  + It is the end towards which all efforts are directed.

Example:

after nursing intervention, the family will be able to take care of the premature infant competently.

* Goals relate to health mater
  + specifically the alleviation of disease conditions.
  + And health problems that intertwined with other problems like socio-economic ones.

Example 1:

at the end of nursing intervention, the family will be able to start a piggery business.

Example 2:

at the end of nursing intervention, the family will be able to start litigation proceedings against landlord.

* A cardinal principle in goal setting states that goals must be set mutually with the family.
* Basic to the establishment of mutually acceptable goals is the family’s recognition and acceptance of existing health needs and problems.
* Goals set by the nurse and the family should be realistic or attainable.
* Goals are best stated in terms of client’s outcomes, whether at the individual, family, or community levels.

**Barriers to Joint Goal Setting Between the Nurse and the Family**

1. Failure on the part of the family to perceive the existence of the problem.
2. The family may realize the existence of the health condition or problem but is too busy at the moment.
3. Sometimes the family perceives the existence of the problem but does not see it as serious enough to warrant attention.
4. The family may perceive the presence of the problem and the need to take action. It may however refuse to face and do something about the situation.

* Reasons to this kind of behavior:

1. Fear of consequences of taking actions.
2. Respect for tradition.
3. Failure to perceive the benefits of action.
4. Failure to relate the proposed action to the family’s goals.
5. A big barrier to collaborative goal setting between the nurse and the family is the working relationship.

**Formulation Objectives of Nursing Care**

Objectives -refer to more specific statements of the desired results or outcomes of care.

It can either be nurse-oriented based on activities of the nurse or client-oriented stated in terms of outcomes.

**Nurse Oriented VS, Client Oriented**

|  |  |
| --- | --- |
| **Nurse-Oriented** | **Client-Oriented** |
| Nurse-oriented objectives will not tell if the nurse’s activities produced some beneficial results; they only indicate what the nurse did and in qualitative evaluation, how well she performed them.  Example:   * + during the home visit, the nurse will discuss the importance of immunization.   + during the second nurse-family contact, the nurse will show the different types of fertility-regulating methods. | Stating objectives in terms of client outcomes will indicate during the evaluation phase whether the desired changes in the problem situation resulted from the nurse’s action.  Example:   * + after the nursing intervention, the malnourished pre-school member of the family will increase their weights by at least one pound per month.   + after the nursing intervention, there will be improved relationship among family members.   + after the nurse’s visit, the family will bring the pre-school members to the well-baby clinic the following day. |

**General VS. Specific Objective**

|  |  |
| --- | --- |
| **General Objective** | **Specific Objective** |
| After the nursing intervention, the family will utilize community resources for health care.  After the nursing intervention, the family will be able to take care of the mentally challenged child competently. | After the nursing intervention, the family will bring the pregnant member to the health center regularly for check ups  The family will also consult the health center on every episode of illness among members.  Define the criteria for evaluation  Example:   * After the nursing intervention, the family will be able to feed the mentally challenged prescribed quantity and quality of food. * They will be able to teach the child simple skills related to activities of daily living and * The family will be able to apply measures taught to prevent infection in the mentally challenged child. |

**Objective Time Frame**

|  |  |  |
| --- | --- | --- |
| **SHORT-TERM**  **OR IMMEDIATE OBJECTIVES** | **MEDIUM-TERM**  **OR INTERMMEDIATE OBJECTIVES** | **LONG-TERM**  **OR ULTIMATE OBJECTIVES** |
| **problem situations which require immediate attention** | **are those which are not immediately achieved and are required to attain the long term ones.** | **require several nurse-family encounters** |
| **Results can be observed in a relatively short period of time.** |  | **The nature of the outcomes sought requires time to demonstrate** |
| **They are accomplished with few nurse-family contacts and relatively less resources.** |  | **Investment of more resources** |

**Example of Nursing Goal / Objective**  
The family will cope effectively with the threat of pulmonary tuberculosis.

* Short Term -The infant and preschool members of the family will be immunized with BCG.
* Medium Term-All members of the family will have a complete physical check-up to rule out pulmonary tuberculosis.
* Long Term-All members of the family will participate in the care of the sick members and apply preventive measures against the spread of infection.

**THE NURSING IMPLEMENTATION PHASE**

**Selecting Appropriate Nursing Actions**

The choice of nursing intervention is highly dependent on two major variables:

1. The nature of the problem

-resolve around the family’s assumption of the health tasks.

2. Resource available to solve the problem

-aimed at minimizing or eliminating the possible reasons for or causes of the family’s inability to do these tasks.

**Goals and Objectives**

**S –** Specific

**M –** Measurable

**A** – Attainable

**R** – Realistic

**T**- Time Bound

**Principles of Nursing Actions**

* To stimulate recognition and acceptance of health needs and problems
* The nurse can work on the family’s failure to decide on taking appropriate health actions
* The nurse can increase the family’s confidence in providing nursing care to its sick, disabled and dependent member through demonstrations on nursing procedures utilizing supplies and equipment’s available in the home.
* The nurse should involve the patient and family in order to motivate them to assume responsibility for their own care.
* The nurse also explains and clarifies doubts thus the role of the nurse shifts direct care giver to that of a teacher.
* She can explore the ways to minimize or prevent threats to the maintenance of health and personal development among family members
* She can utilize intervention measures involving environmental manipulations through improvements on the physical facilities in the home either by construction of needed ones or modifying existing ones.
* To minimize or eliminate psychological threats in the home environment, the nurse can work closely with the family to improve its communication patterns, role assumptions and relationships and interaction patterns.

**Types of Resources**

1. FAMILY RESOURCES- physical and psycho-social strengths and assets of individual members, financial capabilities, physical facilities and the presence of support system provided by relatives and significant others.
2. NURSE RESOURCES- knowledge about family health and her skills in helping family manage them. These skills may range from simple nursing procedure to complicated behavioural problems such as marital disharmony. Availability of time and logistical support are also part of resources of the nurse.
3. COMMUNITY RESOURCES- include existing agencies, programs or activities for health and related needs/problems and community organization for health actions.

**Methods of Intervention**

Family-Nurse Contact

* Home-Visit
* Home visit is a professional, purposeful interaction that takes place in the family’s residence aimed at promoting, maintaining and restoring the health of the family or its members.
* Clinic- Visit
* takes place in a private clinic health center, barangay health station.
* Major advantage is the fact that a family member takes the initiative of visiting the professional health worker, usually indicating the family readiness to participate in the health care process.
* Because the nurse has greater control over the environment, distraction are lessened and the family may feel less confident to discuss family health concerns.
* Group Approach
* appropriate for developing cooperation, leadership, self-reliance and or community awareness among group members.
* The opportunity to share experiences and practical solutions to common health concerns is a strength of this type of family-nurse contact.
* Telephone Conference
* Written Communication
* used to give specific information to families, such as instructions given to parents through school children.
* School Visit or Conference
* Industrial or Job Site Visit

**The Nursing Bag**

* Frequently called the PHN bag is a tool used by the nurse during home or community visits to be able to provide care safely and efficiently.
* Serves as a reminder of the need for hand hygiene and other measures to prevent the spread of infection.
* Nursing bag usually has the ff. contents:
* Articles for infection control
* Articles for assessment of family members
* Note that the stethoscope and sphygmomanometer are carried separately.
* Articles for nursing care
* Sterile items
* Clean articles
* Pieces of paper

**Use of the Nursing Bag**

* Bag technique helps the nurse in infection control.
* Bag technique allows the nurse to give care efficiently.
* It saves time and effort by ensuring that the articles needed for nursing care are available.
* Bag technique should not take away the nurse’s focus on the patient and the family.
* Bag technique may be performed in different ways, principles of asepsis are of the essence and should be practiced at all times.

**THE NURSING EVALUATION PHASE**

* The determination of whether the objectives set were attained or to what degree they were attained.
* Evaluation is always related to objectives.
* Evaluation when address to the result or outcome of care answers the question “did the intended results occur?”
* There is always an element of subjectivity in evaluation; the process involves value judgement which is subjective
* Evaluation also involves decision-making

**Dimensions of Evaluation**

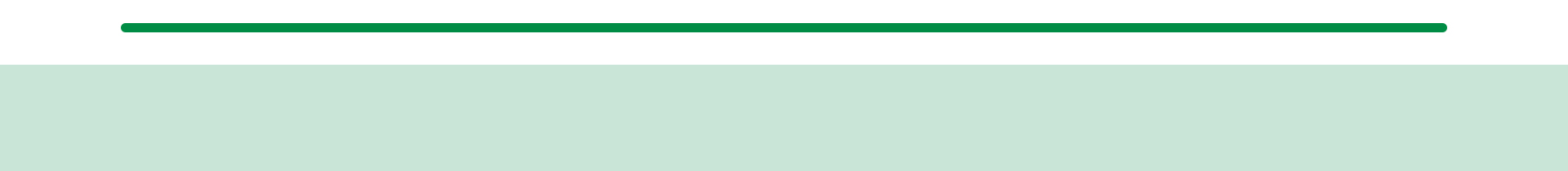
* + EFFECTIVENESS- focus is attainment of the objectives
  + EFFICIENCY- relates to cost whether in terms of money, time, effort, or materials
  + APPROPRIATENESS- ability to solve or correct existing problem situation, a question that involves professional judgement.
  + ADEQUACY- pertains to its comprehensiveness whether all necessary activities were performed in order to realize the intended results.

**Criteria and Standard**

* CRITERIA- refer to the signs or indicators that tell us if the objective has been achieved. They are names and description of variables that are relevant indicators of having attained the objectives. They are free from any value judgement and are independent to time frame.
* STANDARD- once a value judgement is applied to a criterion; it acquires the status of a standard. It refers to the desired level of performance corresponding with a criterion against which actual performance is compared. It tells us what the acceptable level of performance or state of affairs should be for us to say that the intervention was successful.

**Activity and Outcome**

* ACTIVITIES- are actions performed to accomplish an objective. They are the things the nurse does in order to achieved a desired result or outcome. Activities consume time and resources. Examples are health teachings, demonstration and referrals.
* OUTCOME- is the results produced by activities. Where activity is the cause, outcome is the effect. They can also be immediate, immediate or ultimate outcomes. Patient care outcomes can be measured along three broad lines:
* PHYSICAL CONDITION- decreased temperature or weight and change in clinical manifestations
* PSYCHOLOGICAL OR ATTITUDINAL STATUS- decreased anxiety and favourable attitude towards health care personnel.
* KNOWLEDGE ON LEARNING BEHAVIOR- compliance of the patient with instructions given by the nurse.





**Submit:** Word File

**Points:** 100 pts

**Situation:**

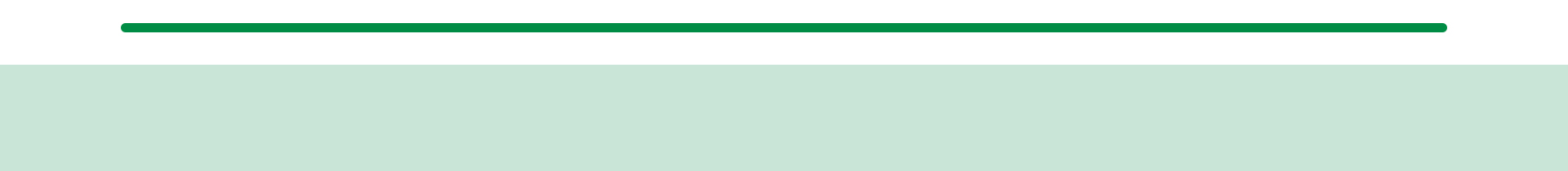
Josefina Rivera is a public Health Nurse at the Rural Health Unit. She met 26-year-old Susan Yap, married, 6 months pregnant with her first child, in a Garantisadong Pambata (outreach health services) visit at an ambulatory clinic in the barangay where the Yap family was residing.

Josefina found out that Susan never had a prenatal consultation. She also noted that Susan was underweight, with a weight of only 48kg and a height of 155 cm. When Josefina asked her where she plans to deliver her baby, she replied that she would probably have a home delivery under the care of the local “hilot” because professional attendance would be too expensive for them. Susan explained that she came to the ambulatory clinic upon the prodding of her husband who heard about the health workers’ visit to the barangay. To assess the Yaps’ home situation and teach Susan health practices related to her pregnancy, Josefina asked Susan if she could make a home visit. Seemingly pleased with Josefina’s attention, Susan agreed with Josefina on a home visit schedule, stating that she wanted to learn more from Josefina to prevent problems with her pregnancy and delivery.  
  
 When Josefina made the home visit, she noted that Susan lived with her 32-year-old husband Mario, who was at work at the time of the visit. He was the sole breadwinner of his family – a construction weoker earning the daily minimum wage. Susan described her husband as hardworking. They lived in a rented shack of mixed materials with a bedroom, a bathroom and toilet, and a small multipurpose room (living and dining room and kitchen). Susan’s activities consisted mainly of household chores. Sometimes, Susan would spend time at the homes of some friends and relatives residing in the neighborhood.  
  
 In the course of the interview, Josefina found out that Susan had inadequate knowledge about community health services, prenatal nutrition, preparation for childbirth, and infant care. Susan said that she and her friends and relatives sometimes talk about such matters, but the information given was confusing and conflicting. Aside from palmar pallor and underweight, other findings during physical examination were normal. When asked about her diet, Susan told Josefina that she limited her food intake because she did not want to have a caesarian section, which may be needed if baby grew too big.

**Question :** With this given scenario, create the 5 phases of Family Nursing Process.



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