Fundamentals of Maternal and Child Health Nursing

NSG 223

University of Ibadan Distance Learning Centre
Open and Distance Learning Course Series Development

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Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfilment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Prof. Abel Idowu Olayinka

Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your computer skills by availing yourself the opportunity of training that the Centre's provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.

Professor Bayo Okunade

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Course Code: NSG 223
Course Title: Fundamentals of Maternal and Child Health Nursing
Course Designer's Name: Mrs Victoria F. Hanson

COURSE UNITS: 2 credit units

PRE-REQUISITE COURSES: you are expected have taken and pass all 200 level courses.
CON-CURRENT COURSES: All courses at the 300 level of the programme
SESSION: 2014/2015

COURSE AIM
The course introduces students to the rules and regulations governing Midwifery Practice. It highlights the concepts and principles that govern its practice and focuses on the roles of national and international organizations concerned with midwifery practice. It also reviews models for care in Maternal and Child Health Nursing.

COURSE OVERVIEW
The course introduces students to the Maternal and child health Nursing , the framework and philosophy of MCH care, The trends of maternal and child health care nursing rules and regulations governing Midwifery Practice. It highlights the concepts and principles that govern its practice and focuses on the roles of national and international organizations concerned with midwifery practice. It also reviews models for care in Maternal and Child Health Nursing. It is a 3 credit unit compulsory course.

Course objectives:
The objectives are to help students to understand, appreciate and be able to:

- Appreciate the history and developments in the field of maternal and child health nursing(MCHN).
- Acquire knowledge of the rules and regulations of MCHN practice.
- Appreciate the importance of rules and regulations in the maintenance of a high standard of MCHN practice.
- Interpret the roles and functions of National and International Organization as they apply to MCHN practice.

- Appreciate the legal and ethical issues pertaining to midwifery.
- Discuss the models of maternal and child health nursing

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Study Session 1: Introduction to Maternal and Child Health Nursing

Introduction

Nurses and midwives care for people, care about people, and use their expertise to help people care for themselves. This is the essence of nursing, for nurses who work for childbearing families or with children and their families; the reward that come from skilled nursing practice can be especially rich.

In this study session, you will be introduce to maternal and child health nursing, the trends of maternal and child health nursing and the historical perspective of modern medical services and midwifery.

Learning Outcomes

When you have studied this study session, you should be able to:

1.1 Discuss the introduction, framework and philosophy of maternal and child health nursing.

1.2 Explain the trends of maternal and child health nursing.

1.3 Describe the historical perspective of modern medical services and midwifery.

1.1 Maternal and Child Health Nursing

Maternal and child health nursing refers to the care of women during pregnancy, birth and postpartum, as well as the care of infants, children and adolescent. The care of childbearing and childrearing families is a major focus of nursing practice, because to have healthy adults you must have healthy children. To have healthy children, it is important to promote the health of the childbearing woman and her family from the time before children are born until they reach adulthood.

Both pre-conceptual and prenatal cares are essential contributions to the health of a woman and foetus and to a family's emotional preparation for childbearing and childrearing. As children grow, families need continued health supervision and support. As children reach maturity and plan for their families, a new cycle begins and new support becomes necessary.

Figure 1.1: *Mother and Child*

Source: healthsystem20202.org

The nurse's role in all these phases focuses on promoting healthy growth and development of the child and family in health and in illness. Although the field of nursing typically divides its concerns for families during childbearing and childrearing into two separate entities, maternity care and child health care, the full scope of nursing practice in this area is not two separate entities, but one: maternal and child health nursing.

The primary goal of maternal and child health nursing care can be stated simply as the promotion and maintenance of optimal family health to ensure cycles of optimal childbearing and childrearing.

In Text-Question

Maternal and child health nursing refers to……..

In Text-Answer

This is the caring of women during pregnancy, birth and postpartum, as well as the care of infants, children and adolescent.

The goals of maternal and child health nursing care are necessarily broad because the scope of practice is so broad. The ranges of practice which include pre-conceptual health care are:

- Care of women during three trimesters of pregnancy and the puerperium (the 6 weeks after childbirth, sometimes termed the fourth trimester of pregnancy)
- Care of children during the perinatal period (6 weeks before conception to 6 weeks after birth)
- Care of children from birth through adolescence
- Care in settings as varied as the birthing room, the paediatric intensive care unit, and the home. In all settings and types of care, keeping the family at the centre of care delivery is an essential goal.

In Text-Question

What is the primary goal of maternal and child health nursing care?

In Text-Answer

The primary goal of maternal and child health nursing care are promotion and maintenance of optimal family health to ensure cycles of optimal childbearing and childrearing.

1.1.1 Framework for Maternal and Child Health Nursing Care

Maternal and child health nursing can be visualized within a framework in which nurses, using nursing process, nursing theory, and evidence-based practice, care for families during childbearing and childrearing years through four phases of health care.

Examples of these phases of health care as they relate to maternal and child health are shown below in table 1.1.

Table 1.1: Phases of health care as they relate to maternal and child health

Term	Definition	Examples
Health promotion	Educating clients to be aware of good health through teaching and role modelling	Teaching women the importance of rubella immunization before pregnancy; teaching children the importance of safer sex practices
Health maintenance	Intervening to maintain health when risk of illness is present	Encouraging women to come for prenatal care; teaching parents the importance of safeguarding their home by childproofing it against poisoning
Health restoration	Promptly diagnosing and treating illness using interventions that will return client to wellness most rapidly	Caring for a woman during a complication of pregnancy or a child during an acute illness
Health rehabilitation	Preventing further complications from an illness; bringing ill client back to optimal state of wellness or helping client to accept inevitable death	Encouraging a woman with gestation trophoblastic disease to continue therapy or a child with a renal transplant to continue to take necessary medication

In Text-Question

Enumerate the four phases of health care.

In Text-Answer

The four phases of health care are as follows:

Health maintenance, Health promotion, Health restoration, and Health rehabilitation.

1.1.2 Philosophy of Maternal and Child Health Nursing

The philosophy of maternal and child health nursing can be seen as follows:

1. Family-centred. Assessment data must include a family and individual assessment.
2. Community-centred. The health of families depends on and influences the health of communities.
3. Research-oriented because research is the means whereby critical knowledge increases.
4. Both nursing theory and evidence-based practice provide a foundation for nursing care.
5. It serves as an advocate to protect the rights of all family members, including the foetus.
6. It includes a high degree of independent nursing functions.
7. Promoting health is an important nursing role because this protects the health of the next generation.
8. Pregnancy or childhood illness can be stressful and can alter family life in both subtle and extensive ways.
9. Personal, cultural, and religious attitudes and beliefs influence the meaning of illness and its impact on the family.
10. It is a challenging role for a nurse and is a major factor in promoting high-level wellness in families

1.2: Trends and Nature of Maternal and Child Health Nursing

At the beginning of the 20th century, the infant mortality rate in the United States (i.e., the number of infants per 1,000 births who die during the first year of life) was

greater than 100 per 1,000. In response to efforts to lower this rate, health care shifted from a treatment focus to a preventive one, dramatically changing the scope of maternal and child health nursing.

Research on the benefits of early prenatal care led to the first major national effort to provide prenatal care to all pregnant women through prenatal nursing services (home visits) and clinics. Today, thanks to these and other community health measures (such as efforts to encourage breast-feeding, increased immunization, and injury prevention), as well as many technological advances.

Figure 1.2: *A pregnant Woman*
Source: royaltime.com

Medical technology has contributed to a number of important advances in maternal and child health. Childhood diseases such as measles and poliomyelitis are almost eradicated through immunization. Specific genes responsible for many inherited diseases have been identified and stem cell therapy may make it possible in the next few years to replace diseased cells with new growth cells.

Figure 1.3: *A stethoscope*

New fertility drugs and techniques allow more couples than ever before to conceive and the ability to delay preterm birth and improve life for premature infants has

grown dramatically. In addition, a growing trend toward health care consumerism, or self-care, has made many child bearing and childrearing families' active participants in their own health monitoring and care.

Figure 1.4: *A Pregnant Woman tested using Medical Technology*

Health care consumerism has also moved care from hospitals to community sites and from long-term hospital stays to overnight surgical and ambulatory settings. Even in light of these changes, much more still needs to be done. National health care goals established in 2000 for the year 2010 continue to stress the importance of maternal and child health to overall community health (Department of Health and Human Services [DHHS], 2000).

Although health care may be more advanced, it is still not accessible to everyone. These and other social changes and trends have expanded the roles of nurses in maternal and child health care and, at the same time, have made the delivery.

In Text-Question

Medical technology has contributed to a number of important advances in maternal and child health. True/False

In Text-Answer

True, this is because childhood diseases such as measles and poliomyelitis are almost eradicated through immunization (medical technology).

1.2.1 Trends in the Maternal and Child Health Nursing Population

The maternal and child population is constantly changing because of changes in social structure, variations in family lifestyle, and changing patterns of illness. Trends in Maternal and Child Health Care and Implications for Nurses:

a. Families are smaller than in previous decades.

b. Single parents are increasing in number.
c. An increasing number of women work outside the home.
d. Families are more mobile than previously. There is an increase in the number of homeless women and children.
e. Abuse is more common than ever before.
f. Families are more health-conscious than previously.
g. Health care must respect cost containment.

1.3 Historical Perspective of Modern Medical Services and Midwifery

Comment [SM1]: Content not complete compared to the one submitted

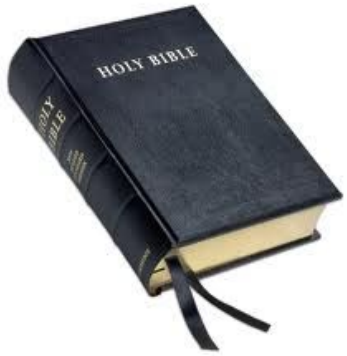
Midwifery is a long and aged profession. The word is derived from Mid-means "with" while wife means woman literally meaning a woman helping pregnant woman in pregnancy labour and in puerperium. Women who had previous knowledge practiced midwifery by making use of "birth stool" and this was handed over from hand and from one generation to another.

The eldest woman in the family is referred to as the "wise women", who supervises Labour. They are:

- Old women,
- Mother's
- In-law and
- Local birth attendant who attend to women in labour because of the experience they learnt over the years by the practice, though they had no formal training.

Biblical Reference- Genesis 35:17 showed that there is need for a midwife to attend to a woman in labor "And it came to pass, when she was in hard labor that the midwife said into her, fear not; for now you will have another son" also Exodus 1:16-21 refer to two Hebrews midwives ship rah and the other puah who attended to Egyptians women in labor and saved the lives of their male children.

The Bible



Source: holybible.ucoz.org

The Egyptians

The foundation has been laid down since ancient time. The Problems faced in obstetrics and Midwifery in the past; naturally influence current practice of maternity care. The Egyptians stated the early development of midwifery by testing for pregnancy and determine the sex of the foetus. Urine of pregnancy was used to water weed and barley, if the plants grow rapidly; it means that the woman was pregnant.

If the weed go taller that the barley it means they baby would be a boy, and if the barley grow taller than the weed it means a baby girl. They also started record keeping by using papyrus scroll. This formed the basis for the modern pregnancy test. What we got from the Egyptians form the basis for the modern pregnancy test. So we know that when the hormone in the pituitary gland is secreting well, then the baby will develop well in the uterus.

Modern day replication of the above practice is based on knowledge of pituitary and ovarian hormonal influence on growth e.g. Progesterone is a pregnancy maintaining hormone.

The Indians

The Indians are noted for the operative delivery e.g. destructive operations. Also in the early period, member of the family are allowed to stay during delivery, but there were traces of SPECIALTY CALL when there are problem of mal-presentation.

In Text-Question

The urine of pregnancy was used to water weed and barley; if the plants grow rapidly it means that…….

In Text-Answer

The woman was pregnant

The Greek Development

This scientific approach came from ancient GREECE. A Greek named HIPPOCRATES laid down the foundation for the medical model; he is referred to as the father of modern medicine.

The Factors of the medicine model are:

- Objectivity
- Cleanliness
- Respect
- Dignity

He believed there is an act to the practice of medicine therefore the following factors are to be considered.

a. The totality of the patient at that time.
b. The patient's way of life.
c. The natural process of life i.e. how the body functions.
d. Patient's nutrition and exercises were also stressed to makes that medical and surgical interventions are successful.

Examples of Scientific Approaches: During those days pregnant women would be attended to by a woman that has born children and has passed the child bearing age. The function performed included cervix and vagina.

They are forbade sexual relationship until 6 (six) weeks after delivery. But masters and Johnson (1996) said there is no reason to refrain from sexual act. Soranus also a Greek physician who specialized in gynecology and obstetrics was best known for his external podalic version".

European Development: The Europeans' development marked the transition from early to modern development, and this ended oral tradition. Some influential names in this respect are:-

a. AMBROSE PARE; A French physician. He used cervical dilators to induce labour in woman with bleeding. He proposed the use of nipple shield. He

shifted the responsibility of management of pregnancy and labour from physician to midwives.

b. PETER CHAMBER; He was credited for the invention of obstetric forceps and he kept it a family secret for a generation. SMELLIE LEURET disclosed the secret in 18th century.

Comment [SM2]: Source deleted

Figure 1.4: *Obstetric Forceps*

c. FRANCOIS MAUNCEAN (1637-1765). He was a French man. He observed puerperal fever, discovered the mechanism for breech and extraction, and introduced the use of beds rather that stools. He refuted the idea that public bones separated during labour, and advocated the suturing of tear.

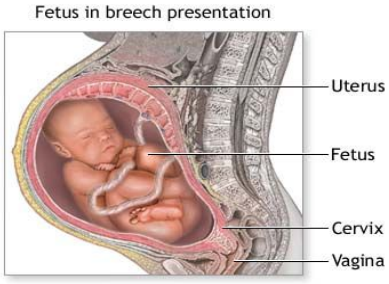


Figure 1.5: *Breech Delivery*
Source: healthkerman.org

d. HENDRICK VAN DEVENTER; He described the pelvic bones.

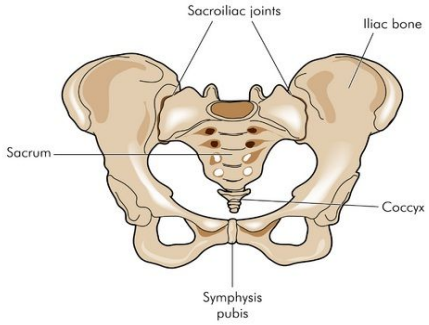


Figure 1.5: *The Pelvis*

Source: medicalpicturesinfo.com

e. WILLIAM SMELLIE: He made significant influences on obstetric studies. He contributed to the recording of mechanism of labour and also invented the curve and blunt Forceps. In the 19th century, significant advances e.g. Hospitals were built. Germs theories were established. Vaccinations were introduced. Records of vital statistics were established.

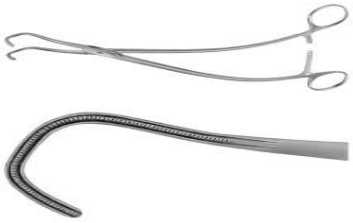


Figure 1.6: *A Curve and Blunt Forceps*

James Simpson administered Chloroform, first to a patient in labour and then to a child during surgery. Although anaesthesia was discovered, but its use was controversial. Though scientists accepted it as a means of relieving pain, religionist said it was a violation of biblical law until it was administered to Queen Victoria. As a result of this, James Simpson was home used with a knighthood

f. SMMELIE-VEIT; He used clinical observations. Also advanced the newly established germs theory and the two simple techniques to control infection i.e. techniques of prophlaxis and hand washing.

In Text-Question

The Factors of the medicine model are…….

In Text-Answer

Objectivity, Cleanliness, Respect, and Dignity

American Development

The practice of obstetrics reflects its base on the European development. Thus, relatives and neighbours help in the delivery. There was conflicting records as to when the first hospital was built. The date ranged from 1658-1736 when charity hospital was built in New Orleans.

DR J.W.BALLANTYNE was the first person to set aside hospital beds in 1901 for use of antenatal patients to study women during pregnancy and later established the antenatal clinic.

Summary

In this study session, you have learnt that,

1. The care of childbearing and childrearing families is a major focus of nursing practice, because to have healthy adults you must have healthy children. To have healthy children, it is important to promote the health of the childbearing woman and her family from the time before children are born until they reach adulthood.
2. Both pre-conceptual and prenatal cares are essential contributions to the health of a woman and foetus and to a family's emotional preparation for childbearing and childrearing.
3. The framework and philosophy of maternal and child health nursing as involving four phases which are Health promotion, Health maintenance, Health restoration and Health rehabilitation.
4. The history of midwifery in the pre-colonial era and in Nigeria specifically.

Self-Assessment Questions (SAQs)

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 1.1 (tests learning outcome 1.1)

What is pre conception care?

SAQ 1.2 (tests learning outcome 1.2)

What is the trend in the Maternal and Child Health Nursing Population?

SAQ 1.3 (tests learning outcome 1.3)

State the contribution François Mauncean (1637-1765). In the history of midwifery

Notes on the Self-Assessment Questions (SAQs)

SAQ 1.1

Pre conception health cares can be any of the following:

- Care of women during three trimesters of pregnancy and the puerperium.
- Care of children during the perinatal period.
- Care of children from birth through adolescence.
- Care in settings as varied as the birthing room, the paediatric intensive care unit, and the home.

SAQ 1.2

The maternal and child population is constantly changing because of changes in social structure, variations in family lifestyle, and changing patterns of illness. It involves the social changes that have occurred over the past 20 to 30 years that have altered health care priori-ties for maternal and child health nurses.

Today, client advocacy, a philosophy of cost containment, an increased focus on health education, and new nursing roles are ways in which nurses have adapted to these change

SAQ 1.3

In the history of midwifery a French man François Mauncean observed puerperal fever, and discovered the mechanism for breech and extraction. He introduced the use of beds rather that stools; also refuted the idea that public bones separated during labour, and advocated the suturing of tear.

Study Session 2: DEVELOPMENT OF FAMILY CENTRED MATERNITY CARE

Introduction

In the previous study session, you learnt about maternal and child health nursing, the trends of maternal and child health nursing and the historical perspective of modern medical services and midwifery.

The need for manpower training and for the development of indigenous skills in health care services was recognized quite early, first by the missionaries and later by the colonial government. In this study session, you will be introduced to development of family centred maternity care and the Nigeria-history of modern medical services.

Learning Outcomes

When you have studied this session, you should be able to:

2.1 Explain the development of family centred maternity care.

2.2 Discuss the Nigeria-history of modern medical services.

2.1 Development of Family Centred Maternity Care

The need for manpower training and for the development of indigenous skills in health care services was recognized quite early, first by the missionaries and later by the colonial government. The main reason for this was the fact that the missionary physicians, as is true for other missionaries, had a high rate of morbidity and mortality among their ranks resulting from the inclement weather and previously unfamiliar tropical diseases.

Since health care services had become a major part of evangelism, it became obvious that native Africans needed to be trained in all aspects of evangelical work, including health care delivery, in order to expand the missionary activities to the hinterland. The nearest place where this training was available was Britain. Several Africans were thus sponsored by missionary agencies to study in Britain there was increase in hospital delivery.

Childbirth took place in hospital, hospital rules became rigid, and there was isolation of maternity patient because of germs theory. Parents were separated

during labour and deliveries. Mother and baby are separated after birth. Feeding schedules were rigid, and formula feeding was introduce and aseptic in technique.

Figure 1.6: *Family-Centred Maternity Care*

The turning point came in 1940 when parents themselves began to resist the rigid rules. As parent were reacting, social scientists also analysing the effect of these practices on family, personal and individual maternity care. Parents argue that maternal bonding is very important in child development as well as for the emotional security of the mother and the infant.

In Text-Question

The need for manpower training and for the development of indigenous skills in health care services was recognized first by…….. and …….

a. The Military government and later by the Nigerian government
b. The National government and later by the colonial government
c. The missionaries and later by the colonial government
d. All of the above

In Text-Answer

The missionaries and later by the colonial government.

As a result of this, it became necessary that more personalized and individual hospital oriented care be developed. This led to the development of certain concepts. These are:

a. Natural childbirth
b. Rooming-in
c. Maternal Deprivation

a. **Natural Childbirth**: Classes are given to expectant mothers on normal pregnancy and labour, relaxation exercise, what to anticipate before, during and after labour. It was ordered that the husband or important neighbour stays with the patient to give assurance and support to the woman.
b. **Rooming In**: This was introduced by Arnold Gesel. This concept was introduced as a way of satisfactory adjustment of the mother to the child. Rooming-in means the new-born infants stay with their mother instead of taking them to the nursery. This method focuses its attention on the family where father and the mother attend to the infant.
c. **Maternal Deprivation**: John Prowlby described the effect of maternal deprivation on children and mental health of both mother and child. This study has great impact on health care. Thus the focus on the family was essential and from then the concept of parent centred was stressed. He concluded that the care now is more personalized more comprehensive and more family centred.

In Text-Question

Who first described the pelvic bones?

a. Peter Chamber
b. Smellie Leuret
c. Hendrick Van Deventer
d. Francois Mauncean

In Text-Answer

Hendrick Van Deventer

2. 2 Nigeria-History of Modern Medical Services

Western medicine was not formally introduced into Nigeria until the 1860s, when the Sacred Heart Hospital was established by Roman Catholic missionaries in Abeokuta. Throughout the ensuing colonial period, the religious missions played a major role in the supply of modern health care facilities in Nigeria.

The Roman Catholic missions predominated, accounting for about 40 percent of the total number of mission-based hospital beds by 1960. By that time, mission hospitals somewhat exceeded government hospitals in number: 118 mission hospitals, compared with 101 government hospitals.

Figure 2.1: *Western Medicine*

Mission-based facilities were concentrated in certain areas, depending on the religious and other activities of the missions. Roman Catholic hospitals in particular were concentrated in the south-eastern and mid-western areas. By 1954 almost all the hospitals in the mid-western part of the country were operated by Roman Catholic missions.

The next largest sponsors of mission hospitals were, respectively, the Sudan United Mission, which concentrated on middle belt areas, and the Sudan Interior Mission, which worked in the Islamic north. Together they operated twenty-five hospitals or other facilities in the northern half of the country. Many of the mission hospitals remained important components of the health care network in the north in 1990.

In Text-Question

Western medicine was not formally introduced into Nigeria until the……..

a. 1861
b. 1860
c. 1960
d. 1680

In Text-Answer

1860

The missions also played an important role in medical training and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe, for many of the first generation of Western-educated Nigerian doctors.

In addition, the general education provided by the missions for many Nigerians helped to lay the groundwork for a wider distribution and acceptance of modern medical care. The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centres in the 1870s.

Unlike the missionary facilities, these were, at least initially, solely for the use of Europeans. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there.

In Text-Question

In 1954 almost all the hospitals in the mid-western part of the country were operated by……

a. Western-educated Nigerian doctors
b. Roman Catholic missions
c. Nigerian medical assistants
d. University College Hospital

In Text-Answer

Roman Catholic missions

World War I had a strong detrimental effect on medical services in Nigeria because of the large number of medical personnel, both European and African, who were pulled out to serve in Europe. After the war, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established.

Nigerian physicians, even if trained in Europe, were, however, generally prohibited from practicing in government hospitals unless they were serving African patients. This practice led to protests and to frequent involvement by doctors and other medical personnel in the nationalist movements of the period.

After World War II, partly in response to nationalist agitation, the colonial government tried to extend modern health and education facilities to much of the Nigerian population. A ten-year health development plan was announced in 1946. The University of Ibadan was founded in 1948; it included the country's first full faculty of medicine and university hospital, still known as University College Hospital.

A number of nursing schools were established, as were two schools of pharmacy; by 1960 there were sixty-five government nursing or midwifery training schools. The 1946 health plan established the Ministry of Health to coordinate health services throughout the country, including those provided by the government, by private companies, and by the missions.

The plan also budgeted funds for hospitals and clinics, most of which were concentrated in the main cities; little funding was allocated for rural health centres. There was also a strong imbalance between the appropriations of facilities to southern areas, compared with those in the north.

By 1979 there were 562 general hospitals, supplemented by 16 maternity and/or pediatric hospitals, 11 armed forces hospitals, 6 teaching hospitals, and 3 prison hospitals. Altogether they accounted for about 44,600 hospital beds. In addition, general health centers were estimated to total slightly less than 600; general clinics 2,740; maternity homes 930; and maternal health centers 1,240.

Ownership of health establishments was divided among federal, state, and local governments, and there was privately owned facilities. Whereas the great majority of health establishments were government owned, there were a growing number of private institutions through the 1980s.

By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospital beds); 3,023 owned by state governments (47 percent of hospital beds); 6,331 owned by local governments (11 percent of hospital beds); and 1,436 privately owned establishments (providing 14 percent of hospital beds.

2.2.1 Midwifery in Nigeria

The care of pregnant women and babies is lagging behind in Nigeria that that of many developed countries due to inadequate human and material resources- doctors, midwives, hospital, health centre and maternity homes.

The first two Nigerian registered midwives trained abroad in 1912- are late Mrs. Ore Green and Mrs. Abimbola Gibson. Later, three more midwives are trained – Mrs. peregrino, Mrs. Franklin and Mrs. Adebisi. They were referred to as state certified midwives.

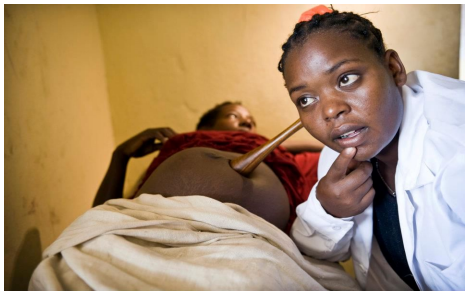


Figure 2.5: *A Traditional Midwife*

Source: womennetwork.net

African midwives belong to a truly noble profession. They use their skills, experience and dedication to preside over the gift to humanity of a new life. The first Nigeria registered midwife qualified in July 1927 at General Hospital, Ijebu-ode then called African Hospital Ijebu-Ode Her name was Miss Josephine Durojaiye.

From 1928 more ladies were trained in the art of delivery. In 1930, the first midwife Ordinance came into being and was published on the 1st of April 1931-see the midwife Ordinance- under Nursing and Midwifery Council Decree.

In Text-Question

The care of pregnant women and babies is lagging behind in Nigeria than that of many developed countries due to……..

In Text-Answer

Inadequate human and material resources

Lots of midwives were later trained in Massy Street, Lagos as Grade Midwives. All other Midwives Trained outside Lagos are referred to as Grade II midwives; this was abolished in 1968, Iyienu Hospital, Anambra started training Grade 1 midwives in 1968, later on in Nigeria more hospitals were built, more nurses and midwives were trained and more training schools were set up.

Today in Nigeria there are 62 midwifery schools training midwives for post basic training who after passing the Final Nursing and Midwives Qualifying Examinations are registered as Registered Midwives (R.M) with three yearly renewable licenses to practice.

In Text-Question

Who is the first Nigeria registered midwife qualified in July 1927 at General Hospital, Ijebu-ode……..

In Text-Answer

Miss Josephine Durojaiye

Summary

In this study session, you have learnt that,

1. Health care services had become a major part of evangelism. It became obvious that native Africans needed to be trained in all aspects of evangelical work, including health care delivery, in order to expand the missionary activities to the hinterland.
2. Several Africans were thus sponsored by missionary agencies to study in Britain because there was increase in hospital delivery.
3. Childbirth took place in hospital, hospital rules became rigid, and there was isolation of maternity patient because of germs theory. Parents were separated during labour and deliveries. Mother and baby are separated after birth. Feeding schedules were rigid, and formula feeding was introduce and aseptic in technique.
4. The history of midwifery in the pre-colonial era and in Nigeria specifically.
5. The care of pregnant women and babies is lagging behind in Nigeria that that of many developed countries due to inadequate human and material resources- doctors, midwives, hospital, health centre and maternity homes.

Self-Assessment Questions (SAQs)

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 2.1 (tests learning outcome 2.1)

a. If health care services had become a major part of evangelism, it became obvious that native Africans needed to be trained in all aspects of evangelical work (including health care delivery), in order to expand the missionary activities to the hinterland. True/False

b. What do you understand by the word Rooming-in?

c. The Midwives trained outside Lagos are referred to as……

   a. Grade I midwives
   b. Grade II midwives
   c. Grade Midwives
   d. None of the above

SAQ 2.2 (tests learning outcome 2.2)

a. The Sacred Heart Hospital was established by Roman Catholic missionaries in…….
    a. Lagos
    b. Abeokuta
    c. Calabar
    d. Port Harcourt

b. In……..the first midwife Ordinance came into being and was published on the 1st of April……..
    a. 1930 and 1931
    b. 1929 and 1930
    c. 1931 and 1930
    d. 1830 and 1930

Notes on the Self-Assessment Questions (SAQs)

SAQ 2.1

a. Rooming-in means the new-born infants stay with their mother instead of taking them to the nursery. This method focuses its attention on the family where father and the mother attend to the infant.

b. True

SAQ 2.2

a. Abeokuta

b. 1930 and 1931

c. Grade II midwives

Study Session 3: Regulations and Organizations of Midwifery Practice

Introduction

In the last study session, you learnt about development of family centred maternity care. The Nursing and Midwifery Council of Nigeria is a category B parastatal of the Federal Ministry of Health established by Decree No. 89, 1979 now known as Nursing and Midwifery (Registration etc.) act. Cap. N143, Laws of the Federation of Nigeria, 2004.

It is the only legal, administrative, corporate and statutory body charged with the performance of specific functions on behalf of the Federal Government of Nigeria in order to ensure the delivery of safe and effective Nursing and Midwifery care to the public through quality education and best practices. The Council is mandated by Law to regulate the standards of Nursing and Midwifery Education and Practice in Nigeria and to review such standards from time to time to meet the changing health needs of the society.

In this study session, you will be introduced to the origin, establishment, functions of the nursing and midwifery council of Nigeria and the roles of various national and international organizations involved in health care services.

Learning Outcomes

When you have studied this session, you should be able to:

3.1 Discuss the origin, establishment and functions of the nursing and midwifery council of Nigeria.

3.2 Describe the roles of various national and international organizations involved in health care services.

3.1 Nursing and Midwifery Council of Nigeria

The Nursing and Midwifery Council of Nigeria is a category B parastatal of the Federal Ministry of Health On 28th Day of September 1979, the Federal Military Government established by Decree No. 89, 1979 a body to be known as the ”Nursing and Midwifery Council of Nigeria of the Nursing”.

Figure 3.1: *Nursing and Midwifery Council of Nigeria logo*

Source: .nmcnigeria.org/portal/images/banner.jpg

(Hereafter in this Decree referred to as "the Council") and Midwifery which shall be a body corporate with perpetual succession and a common seal and may sue and be sued by name aforesaid. It is now known as Nursing and Midwifery (Registration etc.) act. Cap. N143, Laws of the Federation of Nigeria, 2004. The Council is a body Corporate with perpetual succession and a common seal.

The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession. The Council has its headquarters in Abuja with Zonal Offices in Sokoto, Kaduna, Bauchi, Enugu, Port-Harcourt and Lagos.

Origin

Nursing as a profession, came into existence as early as human existence. It is the foremost caring profession. It rested, savoured and consolidated its position through the ages by developing its own language, rituals, arts and sciences from the physical, psycho-social and spiritual needs of the patients.

The history of Nursing Education and Practice in Nigeria is closely interwoven with the history of nursing as a universal profession, the history of education and the history of Nigeria itself. Modern Scientific Nursing started with the crusading efforts of Miss Florence Nightingale (1820-1910) during and after the Crimean¬ War (1854-1856).

She combined Christian ideals, strict discipline and a sense of mission to open the door for what is known today as the "Nursing Profession". Nursing was the first profession in the health industry to form an international organization - the International Council of Nurses formed in 1899. In 1916, the Royal College of

Nursing was founded, while in 1919 the General Nursing Council for the England and Wales came into existence.

The early missionaries who arrived in Nigeria in the early nineteenth century, had the strong belief that Jesus Christ is the spiritual King, the greatest Nurse and Physician capable of caring for and healing whatever affects the body, mind and soul. They combined their missionary work with the provision of medical and nursing care to the sick.

With the Amalgamation of the Colony and the Protectorates of Nigeria into one country in 1914, Nigeria became a colony of Britain. Nursing like all other professions developed and witnessed rapid changes to meet the changing needs of the society it serves. The first and second world wars also had impact on the growth and development of the nursing profession.

Establishment

The Nursing and Midwifery Council of Nigeria is a category B parastatal of the Federal Ministry of Health On 28th Day of September 1979, the Federal Military Government established by Decree No. 89, 1979 a body to be known as the "Nursing and Midwifery Council of Nigeria of the Nursing"

(Hereafter in this Decree referred to as "the Council") and Midwifery which shall be a body corporate with perpetual succession and a common seal and may sue and be sued by name aforesaid.

The Council is a body Corporate with perpetual succession and a common seal. It is the only legal, administrative, corporate and statutory body charged with the performance of specific functions on behalf of the Federal Government of Nigeria in order to ensure the delivery of safe and effective Nursing and Midwifery care to the public through quality education and best practices.

The Council is mandated by Law to regulate the standards of Nursing and Midwifery Education and Practice in Nigeria and to review such standards from time to time to meet the changing health needs of the society.

The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession. The Council has its headquarters in Abuja with Zonal Offices in Sokoto, Kaduna, Bauchi, Enugu, Port-Harcourt and Lagos.

The Council is headed by a Secretary General/Registrar and is assisted by other professionals and non-professional staff. They are responsible to a Board headed by a Chairman with members drawn from various institutions and zones in the country

In order to assist the Federal Government in achieving its Health-Care Reform Agenda, the Council has close working relationship with other sister organizations under the Federal Ministry of Health. These include the Medical and Dental Council of Nigeria, Pharmacist Council of Nigeria and other health parastatal. The aim of creating this rapport is to work as a team in assisting the Government in actualizing its objectives in the health-care sector.

The Council also works in partnership and collaboration with national and international non-governmental organisations such as WHO, UNICEF, USAID, The British Council, International Council of Nurses, International Council for Midwives, Institute of Human Virology, Nigeria (IHVN), International Centre for AIDS Care and Treatment Programs (ICAP),West African Health Organization (WAHO), IPAS, Netherlands Leprosy Relief Organisation, JSI/MMIS-Nigeria, Family Health International, GHAIN, PATHS, NACA, Pathfinder International, Society For Family Heath etc, in developing and implementing various health programmes, projects, workshops/seminar etc., aimed at uplifting the standards of Nursing and Midwifery Education and Practice in the country.

The Council also maintains close relationship with National Board of Technical Education (NBTE), National Universities Commission (NUC), Federal and State Universities, Polytechnics, Joint Admission and Matriculation Board (JAMB), Administrative Staff College of Nigeria, Centre for Management Development, Federal Training Centres (for academic and professional training programme for staff)

The lawyer's logo

Source: www.eofdream.com

In Text-Question

What are the primary objectives of the Nursing and Midwifery Council of Nigeria?

In Text-Answer

They are:

i. To ensure high quality of Nursing and Midwifery education in Nigeria.
ii. Maintain high standard of professional nursing.
iii. Midwifery practice and enforce discipline within the profession.

3.1.1 Functions of the Nursing and Midwifery Council of Nigeria

The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession.

Broadly, the Council's functions are related to those of designing, implementing and evaluating various nursing and midwifery educational programmes, of indexing, examination, registration, certification, licensure of professional nurses and midwives and monitoring standards of nursing and midwifery practice in the Country.

Specifically, the Council's functions are as follows:

1. Index all categories of nursing and midwifery students on commencement of their training.
2. Develop and review periodically, the different curricula utilized for the education of all categories of Nurses and Midwives.
3. Co-operate with recognized bodies interested in conducting new schemes for Basic and Post Basic Education of Nurses and Midwives such as: National Universities Commission, World Health Organization, etc.
4. Accredit all training institutions and clinical practice areas utilized for the education of all categories of Nurses and Midwives in Nigeria.
5. Conduct Professional Examinations for all categories of Nurses and Midwives in Nigeria.
6. Establish and maintain Registers of all persons qualified to practice the discipline of Nursing and Midwifery in Nigeria.

7. Conduct Registration interviews for Nurses and Midwives trained outside Nigeria who are seeking to practice in Nigeria.
8. Issue and update Professional Practicing Licenses every three years to all cadres of qualified Nurses and Midwives.
9. Issue Professional Certificates to all cadres of Nurses and Midwives at the end of their training.
10. Revoke and/or Restore Professional Certificates as applicable.
11. Determine and maintain standards of knowledge and competencies in Nursing and Midwifery Education and Practice in Nigeria.
12. Organize and Conduct Mandatory Continuing Professional and Educational Development Programmes for all cadres of Nurses and Midwives.
13. Conduct and Promote Research in relevant areas of Nursing and Midwifery.
14. Maintain discipline within the Nursing and Midwifery profession in Nigeria through the Nurses and Midwives Tribunal.
15. Prosecute illegal Training Institutions.
16. Regulate and control the practice of Nursing and Midwifery in all its ramifications.

In Text-Question

State four nursing and midwifery regulation act.

In Text-Answer

1. Conduct and Promote Research in relevant areas of Nursing and Midwifery.
2. Maintain discipline within the Nursing and Midwifery profession in Nigeria through the Nurses and Midwives Tribunal.
3. Prosecute illegal Training Institutions.
4. Regulate and control the practice of Nursing and Midwifery in all its ramifications.

3.1.2 Council Structure

The Nursing and Midwifery Council of Nigeria has a Governing Council/Board. The Board of the Council is made up of nineteen (19) members, appointed by the Federal Government, on the recommendations of the Federal Ministry of Health. The Board formulates policies' that brings improvement to Nursing education and Nursing practice in Nigeria.

The Secretary General/Registrar, who is the Chief Executive of the Council, gives effect to the policy decisions of the Council. The Secretary General/Registrar is responsible for the day to day administration of the organization. She is also the Accounting officer of the organization. The Registrar is assisted by four Directors who are head of the Council's four major departments, other cadres of Nursing officers and a multidisciplinary team of staff. There is presently 203 staff on the nominal roll of the Nursing and Midwifery Council of Nigeria.

In the year 2001, the Council, after critical review of its activities by a team of Management experts from the Presidency, was upgraded from category 'C' to category 'B' Federal Health Parastatal. The new status of the Council has given rise to the creation of four major departments, namely, Education, Inspectorate, Planning, Research and Statistics, Human Resources, Finances and Accounts.

Board members

1. THE CHAIRMAN, who is appointed by the Honourable Minister of Health.
2. THE HEAD OF NURSING SERVICES at the Federal Ministry of Health.
3. FOUR NURSES each of whom shall be a Head of Nursing Services in the State Ministry of Health from the Four Health Zones on rotation among the States within each Zone.
4. FOUR NURSES each of whom shall be an Educator in Nursing, Midwifery, Public Health Nursing and Psychiatric Nursing who will serve on rotation from the four Health Zones.
5. TWO NURSES to represent the National Association of Nigeria Nurses and Midwives.
6. TWO PEOPLE to represent Public Interest.
7. TWO NURSES to represent Universities offering Degree Programmes in Nursing.
8. ONE REGISTERED MEDICAL PRACTITIONER who shall be an Obstetrician and Gynaecologist.
9. THE SECRETARY TO THE BOARD who is the Secretary-General/Registrar of the Council.

The Council conducts its affairs through Standing Committees, which under the auspices of the Secretary-General, meet to deliberate on vital Professional, Educational and Administrative matters and make necessary recommendations to the Board.

The Standing Committees include:-

a. Education Committee
b. Examination Committee
c. Registration Committee
d. Finance and General Purposes Committee
e. Standards and Accreditation Committee
f. Appointment, Promotion and Disciplinary Committee
g. Nurses and Midwives Disciplinary Tribunal

3.1.3 Midwives Legal Coverage

Ignorance is no defence in law. It is unacceptable under the law to do anything that is illegal and use ignorance as an excuse, thus a registered midwife must be licensed to practice. A lecture on the midwife and the law is not supposed to make midwife and nurses lawyers, but to make them aware of the legal aspects of questions that may arise at any time, particularly during the course of their career as Midwives or nurses.

Is there absolute justice in Nigeria? 'Access to justice' is a much-vented value (boastful talk) in most legal systems of the word (including Nigeria), but only a few really have this access. What justice is there in a system where the majority of the populace is ill informed about its rights and obligations under law, or where those who even have a smattering idea of their legal right cannot afford the means of its enforcement?

It is the desire to increase awareness about legal rights and obligations of the midwives that necessitated the inclusion of this lecture on the Midwifery curriculum in Nigeria. Midwifery/Nursing has the backing of the law-for example, there is: Nursing and midwifery (Registration) Decree No. 89 of 1979 Law of the Federal Republic of Nigeria.

It is under the laws of the Federal Republic of Nigeria to regulate the conducts of Nurses and Midwives. The first relevant legislation to be examined is the Nursing and Midwifery (Registered etc.) Decree No. 89 of 1979 which is an important law in nursing activities in Nigeria as it brings under one general umbrella the registration of Nurses and Midwives.

Under section 1 (1) of this Decree, is established a body to be known as the Nursing Council of Nigeria. Functions conferred upon this body are clearly stated in the Nursing and Midwifery Decree as follows:

- To determine who are Nurses and Midwives
- To determine what standards of knowledge and skills are to be attained by person seeking to become members of profession of Nursing and Midwifery.

3.2 Roles of National and International Organization in Midwifery Practice

Midwifery, like nursing is a profession that is guided by rules and regulations of the profession regulations. Accordance to International Confederation of Midwives (1996) a professional regulation could simply be described as the means by which order, consistency and control are brought to a profession and its practice.

In Nigeria, the Nursing and Midwifery Council of Nigeria regulate midwifery practice while UKCC is the regulating body for United Kingdom. However, the International Confederation of Midwives (ICM) is one of the foremost actors in the global arena working to improve maternity services through the empowering of midwives and promotion of good practice.

Apart from the already mentioned profession bodies, other national and international organizations, which play important roles in the practice of midwifery, are:

1. Nursing and Midwifery Council of Nigeria
2. World Health Organization (WHO)
3. The united Nations Children Emergency Fund now renamed United Nations Children Fund (UNICEF)
4. West African College of Nursing
5. United Nations Economic Development Program (UNEP)
6. United Nations Development Program (UNDP)
7. United Nations of American International Development Agency (USAID)

3.2.1 International Confederation of Midwives (ICM)

The International Confederation of Midwives (ICM) is a non-governmental organization, which came into being in 1919 as the International Midwives union. According to Bennett and Brown (1999), the purpose was to improve the services available to child bearing women through campaigning for a stronger, better educated and properly regulated midwifery profession' (ICM 1994 P.I). The United Nations accredited ICM in 1960.

Figure 3.3: *The International Confederation of Midwives (ICM)*

It has more than 75 member associations that cover approximately 66 countries. ICM's office is situated in London, England. This office welcomes both visitors and enquiries from midwives and midwifery organizations from anywhere in the world. The ICM collaboratively with other agencies thereby contributing to the increase acceptance of the midwife as a key provider of quality maternity care.

For example, the ICM worked with WHO and the International Federation of Gynaecologists and Obstetrician (FIGO) to develop the international definition of the midwife.

Roles of ICM

- Improvement of the services available to childbearing women through campaign for a stronger, better educated and coordinating of the International Day of the Midwife annually.
- Assisting midwives and midwifery association to unite under a central banner to promote the role and responsibilities of the midwife under a specific theme.
- Bringing together group of midwives from different countries for workshops, seminars and triennial congress. The triennial congress is valuable because it has been a useful vehicle for promoting midwives and midwifery in the host country.

The triennial congress is valuable because it has been a useful vehicle for promoting midwives and midwifery in the host country. Through the action orientation of the pre-congress workshops, midwives from a variety of countries developed plans and activities for improving midwifery services to women nationally and globally. For example, the 1990 congress in Kobe, Japan took its theme, midwifery education for safe motherhood and it was at the pre-congress workshop that the midwifery modules for safe motherhood initiative (WHO 1996) were first formulated

The ICM triennial congress 1990 was preceded by a workshop to discuss safe motherhood. The results of the workshop were:

(i) Recommendations for action to strengthen the curriculum for midwives

(ii) Making the curriculum more community based and including management of selected obstetric emergencies.

3.2.2 The United Kingdom Central Council for Nursing Midwifery and health visiting (ukcc)

The UCKK (Now NMC) is the regulatory body for nursing, Midwifery and health visiting in the United Kingdom. The statutory control of the practice, education and supervision of midwives became the responsibility of the UKCC, National Boards of Nursing, Midwifery and Health Visiting Boards on 1st July 1983 (Bennett and Brown 1999).

Roles of UCKK (Now NMC)

1. To maintain register for qualified nurses, midwives and health visitors.
2. To set standards for Nursing, midwifery and health visiting education practice and conduct.
3. To provide advice for Nurses, midwives and health visitors on professional standards.
4. To consider allegations of misconduct or unfitness to practice due to ill health.

The UKCC (1992a) Publishes a booklet entitled 'The scope of professional practice' to guide practitioners in judging when this scope may appropriately be adjusted:

- To protect the public from unsafe practices
- Registration and protection of title
- To confer accountability, identity and status upon the midwife
- To ensure quality care.

3.2.3 The Nursing and Midwifery Council of Nigeria

The Nursing and Midwifery Council of Nigeria is a category B parastatal of the Federal Ministry of Health now known as Nursing and Midwifery (Registration etc.) act. Cap. N143, Laws of the Federation of Nigeria, 2004. The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing

and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession.

Roles

1. Index all categories of nursing and midwifery students on commencement of their training.
2. Develop and review periodically, the different curricula utilized for the education of all categories of Nurses and Midwives.
3. Co-operate with recognized bodies interested in conducting new schemes for Basic and Post Basic Education of Nurses and Midwives such as: National Universities Commission, World Health Organization, etc.
4. Accredit all training institutions and clinical practice areas utilized for the education of all categories of Nurses and Midwives in Nigeria.
5. Conduct Professional Examinations for all categories of Nurses and Midwives in Nigeria.
6. Establish and maintain Registers of all persons qualified to practice the discipline of Nursing and Midwifery in Nigeria.
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10. Revoke and/or Restore Professional Certificates as applicable.
11. Determine and maintain standards of knowledge and competencies in Nursing and Midwifery Education and Practice in Nigeria.
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14. Maintain discipline within the Nursing and Midwifery profession in Nigeria through the Nurses and Midwives Tribunal.
15. Prosecute illegal Training Institutions.
16. Regulate and control the practice of Nursing and Midwifery in all its ramifications.

3.2.4 The World Health Organization (WHO)

The World health Organization was founded in 1947 and it now has 154 member states. Its headquarters are located in Geneva, Switzerland and it has six regional offices (Lucas and Gilles, 1998).

These regional Offices and their locations are as follows:

- African Regional offices (AFRO) – Brazzaville Congo.
- Regional Office for the Americans (AMRO) – Washington, D.C. U.S.A
- European Regional Office (EURO) – Copenhagen Denmark.
- South East Asia Regional Office (SEARO) – New Delhi, India.
- West Pacific Regional Office (WPRO) – Manila, Philippines.

Its Roles

1. Launching of midwifery education modules for safe motherhood in 1996.
2. Funding of workshop and seminar on midwifery practice including Research. WHO (1994) produced the mother-baby package: a practical guide to implement safe motherhood in various countries (WHO 19094b) in the package the following recommendations were made:
3. Appropriately trained midwifery personnel living and working in the community is recognized as the key to successful safe motherhood.
4. Countries should give priority to developing the midwifery skills of their health personnel especially those proving community based care.
5. Strengthening of midwifery skills in all aspects of maternity care- provision that must include the immediate management of selected obstetric emergencies such as haemorrhage prolonged and obstructed labour, puerperal sepsis and hypertension in pregnancy.
6. Provision of technical information through the publication of World Health Bulletin
7. Sponsoring training of various Cadres of maternal and child workers
8. Planning of Expanded programs on immunization.
9. WHO works collaboratively with the ICM and FIGO to formulate internationally accepted definition of a midwife.

3.2.5 The UNICEF

The United Nation's children emergency fund now renamed United Nations children fund is an International Organizational financed almost entirely by voluntary contributions from government, private foundations and public donations. It is particularly concerned with the well-being of children in developing societies.

Its Roles

- Assisting countries to establish accelerated program of immunization
- Sponsoring of workshops and seminars on children's welfare
- Promotion of awareness through jingles through the electronic media and posters.
- Promotion of children well-being through growth monitoring, oral rehydration, breast feeding, immunization and family planning.
- Sponsoring of female literacy programmed and supplementary feeding.

In Text-Question

When was the nursing and Midwifery council of Nigeria established?

In Text-Answer

28th of September 1979

3.2.6 The West African College Of Nursing (WACN)

This body was inaugurated in April 1981 in Banjul, Gambia as one of the special agencies of the West African Health Community (WAHC). They assist in pursuance of the goal of nursing and midwifery education at the basic and post basic level. They maintain standards of practice of nurses and midwives within the community.

Roles

1. Sponsoring of in-service educational programs
2. Assisting in providing facilities for nursing and midwifery education.
3. Encourage and promote research in the field of nursing and midwifery.
4. Production of textbooks and journal on current issues in nursing and midwifery practice.
5. Disbursement of research fund to member states.
6. Assisting in the formation of nursing and midwifery education program and to support the management and funding of such program in accredited institution in the member state.

7. Promote interaction among nurses and midwives by organizing workshops and seminars to disseminate information for client better care.

Others Are:

UNEP – United Nations Environmental Program is concerned with matters affecting the environment.

UNDP – United Nations Environmental program co-ordinates UN activities in the area of development.

USAID – Makes provision for funds and commodity for operational research.

THE PATHFINDER – sponsors family planning program through provision of commodities and funding of family planning education program

Summary

In this study session, you have learnt that,

1. The Nursing and Midwifery Council of Nigeria is a category B parastatal of the Federal Ministry of Health On 28th Day of September 1979, the Federal Military Government established by Decree No. 89, 1979 a body to be known as the ”Nursing and Midwifery Council of Nigeria of the Nursing”.
2. Nursing as a profession, came into existence as early as human existence. It is the foremost caring profession.
3. The primary objectives of the Nursing and Midwifery Council of Nigeria are to ensure high quality of Nursing and Midwifery education in Nigeria, maintain high standard of professional nursing and midwifery practice and enforce discipline within the profession.
4. Midwifery, like nursing is a profession that is guided by rules and regulations of the profession regulations. Accordance to International Confederation of Midwives (1996) a professional regulation could simply be described as the means by which order, consistency and control are brought to a profession and its practice.

Self-Assessment Questions (SAQs)

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 3.1 (tests learning outcome 3.1)

State the decree that established the Nursing and Midwifery Council of Nigeria.

SAQ 3.2 (tests learning outcome 3.2)

Write briefly on WACN.

Notes on the Self-Assessment Questions (SAQs)

SAQ 3.1

Two decree that establish the Nursing and Midwifery Council of Nigeria are

The council shall be charged with the general duty of:

a.) Determining who are Nurses and midwives for the purpose of this Decree

b.) Determining what standard of knowledge and skill are to be attained by persons seeking to become member of the profession of nursing and midwifery

SAQ 3.2

This body was inaugurated in April 1981 in Banjul, Gambia as one of the special agencies of the West African Health Community (WAHC)

They assist in pursuance of the goal of nursing and midwifery education at the basic and post basic level. They maintain standards of practice of nurses and midwives within the community.

ROLES

a. Sponsoring of in-service educational programs
b. Assist in providing facilities for nursing and midwifery education.
c. Encourage and promote research in the field of nursing and midwifery.
d. Production of textbooks and journal on current issues in nursing and midwifery practice.
e. Disbursement of research fund to member states.
f. Assist in the formation of nursing and midwifery education program.
g. Support the management and funding of such program in accredited institution in the member state.
h. Promote interaction among nurses and midwives by organizing workshops and seminars to disseminate information for client better care.

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Study Session 4: Ethical Concepts in Nursing

Introduction

In the last study session, you learnt about the origin, establishment, functions of the nursing and midwifery council of Nigeria and the roles of various national and international organizations involved in health care services.

Ethics are rules or principles that govern right conduct. Ethical practice refers to the moral behavior and decision regarding ethical dilemmas. Ethics is about the use and abuse of power, the ability of persons states and system to change lives and events for good. Professionals have special responsibilities to be sensitive to the way in which the power conferred on them by their professional standing are used, maintain and improved.

Professional codes of ethics are largely designed to protect the clients and to ensure that the inherent inequality in the client-care giver relationship is not abused. It is therefore necessary that nurses understand the ethics of nursing, internalize it so as to use it in all aspects of their practice. In this study session, you will learn about the concept of ethics, types of ethics, purposes of professional code of ethics, and nursing codes of ethics.

Articles 1 A & B of the International Code of Ethics for Midwives (ICM, 1993) envisages midwifery care as a partnership, concept that embraces equality and dialogue establishing real treat between clients and midwives.

1A: Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcomes of her choice.

B: Midwives work with women, supporting their right to participate actively in decisions about their care and empowering women to the health of women and their families in their culture/society.

Learning Outcomes

When you have studied this session, you should be able to:

4.1 Describe the concept of ethics, law and professional code of nursing practice

4.2 Discuss the Rights and Responsibilities in Client Care.

4.3 Describe the legal Roles of the Nurse.

4.4 Explain Informed Consent.

4.1 Concept of Ethics, Law and Professional Code of Nursing Practice

Ethics has several meanings in common use. It is:

- A method of inquiry that helps people to understand the morality of human behaviour. Remember an earlier discussion that morality refers to the requirements necessary for people to live together.
- The practices or beliefs of a certain group e.g. nursing ethics, medical ethics etc. Remember that beliefs are interpretations or conclusions that people accept to be true.
- The science relating to moral actions and one's value system
- The expected standards of moral behaviour of a particular group as described in the group's formal code of professional ethics.

Many authors agree that ethics and morals convey the same meaning but there are some that contend that ethics refers to publicly stated and formal set of rules or values, while morals are values or principles to which one is personally committed. For the professional nurse, however, both the publicly stated and formal sets of rules and values and the personally committed principles interact to shape the nurses moral behaviour.

Ethics is not confined to nursing. It is part and parcel of everyone's life in a civil society. No individual is born with a set of ethical standards; rather they are acquired through life.

4.1.1 Law and Ethics

Ethics relates to rules of conduct. It is similar to law. Both are based on understanding principles of right and wrong of acting in a democratic society. However, legal issues differ significantly from ethical issues. This is shown in the

Table 4.1.

Table 4.1: Differences between Law and Ethics

S/N	Law	Ethics
1	Law is defined as society's formal rules of conduct or action, recognized as enforceable by a controlling authority such as federal or state government.	Ethics refers to a set of moral principles or values that informally govern individuals in a society.
2	Laws are the regulations established, and usually written, by a governing power.	Ethics are the morals of a culture, and often times, they inform the laws that are made.
3	Laws are rules that people must obey in order to be legally proper. The legal view to an issue implies that legal obligations co-exist with rights. These rights are described as welfare rights and have been granted by law.	Ethics are rules that people ought to obey so that their conduct is morally proper and their conscience clear. Ethical rights involve no legal guarantees.
4	Law sets the types of repercussions that should occur should it be broken.	Ethics do not have any associated punishments when broken.

For example, right to health care is an ethical right as no one is obligated by law to provide and enforce it. A client may choose not to request for care when ill or to be treated by a particular kind of healer, orthodox or unorthodox. Health professionals do however feel obliged to provide health care to those seeking it.

As soon as a client willingly submits to be cared for by you, a contract of care is established and you must practice within certain legal constraints that ensure safe and effective care.

Failing to do this, you will become liable to prosecution by the legal authority of the society. Thus, whereas legislative duties are mandatory and must be fulfilled, some of the ethical duties might be fulfilled, so long as professional standards are upheld, dropped or disregarded at will.

This may lead some people to think their ethical requirements are of less importance than legal requirements. On the country, ethical codes usually have higher requirements then legal standards and they are never lower than the legal standards of the profession.

Figure 4.1: *The Anchor*

4.1.2 Types of Ethics

There are two main types of ethics governing an individual's life in a society. They are: Personal and the professional ethics.

a. Personal ethics: This refers to a person's moral principles and values acquired as the person develops and matures through the life span. An individual's personal code of behaviour might include:

- The "ought to do" things such as being honest, spending time in worthwhile activities, helping and being kind to people and
- The "ought not to do "things like, not stealing, not cheating other people or organization, or consciously causing harm to others.

Personal ethics are influenced by family, religion, education, peer group etc. and therefore vary from one individual to another. Personal ethics may change or be modified as a result of age, environmental or situational influence.

b. Professional Ethics: This refers to the formal or informal moral responsibilities peculiar to a profession which are not shared by members of the society. The informal professional ethics are unwritten while the formal ones are the written ethical codes.

Members not only agree to subscribe to the ethical codes to govern their conduct but also monitor other member of the profession to ensure conformity to them as well. Failure to conform may earn the individual a dismissal from the profession or suspension.

In Text-Question

Differentiate between Law and Ethics?

In Text-Answer

Laws are rules that people must obey in order to be legally proper but ethics are rules that people ought to obey so that their conduct is morally proper and their conscience clear.

4.1 3 Code of Professional Conduct

The Code of Professional Conduct places the client/patient at the center of nursing activities. Nursing code of ethics is a formal statement of the ideals and values of nursing and ethical principles that serve as standards for nurses' actions. It concerns the behaviour that is normally right for a nurse in professional situations. The need for an ethical code of practice for nursing was perceived in the 19th century.

Some religious communities prepared code of practice for their nurses in consonance with the "religious orders" rule of life. Among the earliest evidence of that perceived need in the secular world was the **Florence Nightingales** pledge formulated by a group of nurses in 1893. It was based on Hippocratic Oath and contained all the expectations from a nurse in that era.

The Florence Nightingale Pledge of 1893

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully.

I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug.

I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling.

With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care.

Source: (Fowler, Marsha, D. in Anarado, A. N; 2002)

The pledge was formulated based on the acquiescent nature of nursing that was operational at the time when it was not in agreement with social relevance to the 21st century context of nursing, it was replaced with the Nurses' Pledge which is recited by students of most schools of nursing at the beginning or at the completion of their training.

The purposes of the Code of Professional Conduct are to:

Inform Professional Nurses of the Standards of Professional Conduct required of them in the exercise of their professional accountability and practice.

- Inform the public, other professions and employers, of the standard of Professional Conduct that they can expect of a Registered Practitioner.

4.2 The Professional Nurse and the Health Care Consumer

A Nurse is a person who has received authorized education, acquired specialized knowledge, skills and attitudes, and is registered and licensed with the Nursing and Midwifery Council to provide promotive, preventive, supportive and restorative care to individuals, families and communities, independently, and in collaboration with other members of the health team. The

Nurse must provide care in such a manner as to enhance the integrity of the profession, safeguard the health of the individual client/patient and protect the interest of the society.

The Nurse must:

a. Provide care to all members of the public without prejudice to their age, religion, ethnicity, race, nationality, gender, political inclination, health or social economic status.
b. Uphold the health consumer's human rights as provided in the constitution.
c. Ensure that the client/patient of legal age of 18 years and above gives informed consent for nursing intervention. In case the health consumer is under aged, the next of kin or the parents can give the informed consent on his behalf.
d. Keep information and records of the client confidential except in consultation with other members of the health team to come up with suitable intervention strategies or in compliance with a court ruling or for protecting the consumer and the public from danger.
e. Avoid negligence, malpractice and assault while providing care to the client/patient.
f. Relate with a consumer in a professional manner only.
g. Not take bribe or gifts that can influence you to give preferential treatment.
h. Consider the views, culture and Beliefs of the client/patient and his family in the design and implementation of his care/treatment regimen.
i. Know that all clients/patients have a right to receive information about their condition.
j. Be sensitive to the needs of clients/patients and respect the wishes of those who refuse or are unable to receive information about their condition.
k. Provide information that is accurate, truthful and presented in such a way as to make it easily understood.
l. Respect clients and patients' autonomy, their right to decide whether or not to

undergo any health care intervention even where a refusal may result in harm or death to themselves or a foetus, unless a court of law orders to the contrary.

m. Presume that every patient and client is legally competent unless otherwise assessed by a suitably qualified practitioner. A patient or client who is legally competent can understand and retain treatment information and can use it to make an informed choice.
n. Know that the principles of obtaining consent apply equally to those people who have a mental illness.
o. Ensure that when clients and patients are detained under statutory powers (e.g. Mental Health Act), you know the circumstances and safeguards needed for providing treatment and care without consent.
p. Provide care in emergencies where treatment is necessary to preserve life without clients/patients consent, if they are unable to give it, provided that you can demonstrate that you are acting in their best interests.

4.2.3 Professional Nurse and Professional Colleagues

The Nurse must:

a. Work cooperatively and collaboratively with professional colleagues and other members of the health team for ethical procedure **ONLY.**
b. Exhibit 'Espirit de corps' in all situations except when it involves fraudulent and unethical practices.
c. Delegate functions and responsibilities to subordinates according to their abilities and competencies, supervising them accordingly.
d. Not ridicule professional colleagues and especially NOT in the presence of Clients/Patients or other members of the health team.

The Nurse must:

a. Be personally accountable for the care that she provides to clients/patient
This means that she is answerable for her actions and omissions regardless of advice or directives from other health professionals.
b. Be punctual to duty and hand over, patients and equipment physically after duty.
c. Switch off her telephone/handsets when providing care to clients/patients and when teaching in the classroom.

d. Avoid the use of self in the advertisement, promotion or sale of commercial products, services and illicit trade such as trafficking in hard drugs.
e. Reject any form of gift, favour or gratification which might appear to have undue influence or advantage towards obtaining preferential treatment.
f. While providing care, ensure that use of technology and scientific advance are compatible with the safety, dignity and rights of clients/patients.

4.2.4 The Professional Nurse and the Public

The Nurse must:

a. Protect the public against danger or harmful agents
b. Have regard to the environment of care and its physical, psychological and social effects on the client/patient.
c. Access the adequacy of resources and make known to appropriate persons and authorities, any circumstances which could place clients/patients in jeopardy or which militate against safe standards of practice.
d. Contribute to policy making.

4.2.5 The Professional Nurse and the Global Health Organization

The Nurse must:

a. Implement global health initiatives and instruments to which the country, the Nursing and Midwifery Council of Nigeria, National Association of Nigeria Nurses and Midwives (NAMMN) are signatory.
b. Participate actively in International and National Conferences and Conventions and contribute her quota to the development of Nursing Sciences.

Summary

In this study session, you have learnt that,

1.The Code of Professional Conduct highlighted in this document is intended to empower the Professional Nurse Practitioner to provide effective care to individuals, families and communities.

2. The Nursing and Midwifery Council of Nigeria subscribes to the fact that Nursing is an inalienable right of citizens and as such the professional Nurse has the responsibilities of assisting them to attain the optimal level of health.

3. The Nursing and Midwifery Council of Nigeria believes that this Code of

Professional Conduct will serve as a springboard for providing effectivenursing Care in Nigeria.

Self-Assessment Questions (SAQs)

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 4.1 (tests learning outcome 4.1)

What is ethics?

SAQ 4.2 (tests learning outcome 4.2)

Distinguish between ethics and law

SAQ 4.3 (tests learning outcome 4.3)

Differentiate between the types of ethics

SAQ 4.4 (tests learning outcome 4.4)

Describe the professional nurse and the public

Notes on the Self-Assessment Questions (SAQs)

SAQ 4.1

Ethics is the belief that helps people to understand the requirements in terms of conduct, attitudes and standards that are necessary for people to live together.

SAQ 4.2

Differences between law and Ethics:

a. Law is Society's formal rules of conduct or action, recognized as enforceable by a controlling authority such as federal or State government, while ethics refers to a set of moral principles or values that informally govern individuals in a society.
b. The locus of legal control is external, whereas that of ethics is mostly internal in the person's conscience.
c. Laws are rules that people must obey in order to be legally proper but Ethics are rules that people ought to obey so that their conduct is morally proper and their conscience clear.
d. The legal view to an issue implies that legal obligations co-exist with rights. These rights are described as welfare rights and have been granted by law. In contrast ethical rights involve no legal guarantee.

e. Legislative duties are mandatory and must be fulfilled whereas some of the ethical duties might be fulfilled or not, so long as professional standards are upheld.

SAQ 4.3

a. Personal ethics refers to a person's moral principles and values acquired as the person develops and matures through the life span.
b. Professional Ethics refer to the formal or informal moral responsibilities peculiar to a profession which are not shared by members of the society. The informal professional ethics are unwritten while the formal ones are the written ethical codes.

SAQ 4.4

THE PROFESSIONAL NURSE AND THE PUBLIC

The Nurse must:

- Protect the public against danger or harmful agents
- Have regard to the environment of care and its physical, psychological and social effects on the client/patient.
- Access the adequacy of resources and make known to appropriate persons and authorities, any circumstances which could place clients/patients in jeopardy or which militate against safe standards of practice.
- Contribute to policy making.

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Study Session 5: Rights and Responsibilities in Client Care

Introduction

In the last study session, you learnt about the concept of ethics, types of ethics, purposes of professional code of ethics, and nursing codes of ethics.

The clients that enter health care institutions come with some rights, needs and expectations. The nurse by education is prepared to take her place in the health team and contribute to meeting the needs and expectations of clients.

How effective the nurse becomes will depend on her understanding of what the rights needs and expectations of the client are and her responsibility in meeting these. In this study session, you learn about the concept of right, the rights of the client in health care, nurses' responsibilities in health care and ways in which the nurses respect clients' rights in client care.

Learning Outcomes

At the end of this session, you should be able to:

5.1 Explain the concept of right.

5.2 Outline the rights of client in health care.

5.3 Explain the nurse's responsibilities in health care delivery.

5.4 Explain client's bill of rights as applied to nursing care.

5.1 Concept of Right

Right is a claim to a particular privilege. For example people who have paid their electric bill have a right to have electricity. Similarly a person who has paid for a particular health care has a right to that health care. Rights can be legal or ethical. Legal right is that which a person is entitled to; that is, the right to do something, or to receive from another person whose duty is imposed within the limits of the law.

This implies that legal rights co-exist with obligation. Obligations is willingness to accept the burden of a given task for whatever reward, as the result of success or risk as a result of failure one may see in the situation. For example, the worker who has the obligation to perform certain services for an employer has the right to receive the agreed salary but will also cope with the difficulties or loses that may go with the job.

Violation of a legal right may subject the individual to a civil or criminal liability. Ethical rights impose on the professionals the obligation to provide services to those who seek such services. Ethical rights do not involve legal guarantee because no

authority exists to enforce the right. For example, the right to work and the right to health care are ethical rights.

There is no law in Nigeria that stipulates that one must be employed by government or private sector. For this reason, people seek for job anywhere. Also people can seek medical care from anywhere- herbalist, orthodox or prayer home. Health care is an ethical obligation because no one is obligated by law to provide it.

However, health care professionals feel obligated to provide health care to those who seek it and have paid for it. For example, a client with a wound who had paid for dressing has a right to have the dressing done. Violation of an ethical right may result in reprimand, censure, suspension or expulsion from the profession.

Society today is looking closely at the moral and ethical quality of its actions and motive. This trend has resulted in a closer scrutiny of what may be considered as morally right or wrong in our relationships with others. This has led to the formulation of bills of right. There are many bills of rights. E.g. Human rights bill, the rights of the child, patients' bill of rights etc.

In Text-Question

Rights can be legal, why?

In Text-Answer

This is because legal right is that right which a person is entitled to i.e. the right to do something, or to receive from another person whose duty is imposed within the limits of the law. This implies that legal rights do co-exist with obligation.

5.2 Rights of Clients in Healthcare

The movement for client's right in health care arose in the late 1960s.The broad goals of the movement were to improve the quality of health care and to make the health care system more responsive to clients' needs because of knowledge explosion and technological advances.

Today's clients are more knowledgeable and indicating desire to participate in the decision that concerns them when they are ill thus raising issues of patient's rights.

In response to this, patients' bill of rights emerged. The American Hospital Association (AHA) in 1973 published a patient's bill of rights to protect the rights of hospitalized clients. This was revised in 1992.

Comment [SM3]: right picture from original

Source: allinhealth 30.com

5.2.1 Principles of Patients' Rights and Responsibilities

Principles of Patients Rights' and Responsibilities was developed and Approved by the National Health Council Board of Directors, January 1995 1 (Directors 1995).

a) **All patients have the right to informed consent in treatment decisions, timely access to specialty care, and confidentiality protections:** Patients should be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to:

- Coverage for qualified second opinions,
- Timely referral and access to needed specialty care and other services,
- Confidentiality of their medical records and communications with providers; and,
- Respect for their legal advanced directives or living wills.

b.) **All patients have the right to concise and easily understood information about their coverage:** This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain health care providers, prescription drugs, and "experimental" treatments).

Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.

c). **All patients have the right to know how coverage payment decisions are made and how they can be fairly and openly appealed:** Patients are entitled to information about how coverage decisions are made, i.e., how "medically necessary" treatment is determined, and how quality assurance is conducted.

Patients and their family caregivers should have access to an open, simple, and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.

d). **All patients have the right to complete and easily understood information about the costs of their coverage and care:** This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, co-payments, and additional premiums), and any catastrophic cost limits.

Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.

e.) **All patients have the right to a reasonable choice of providers and useful information about provider options:** Patients are entitled to a reasonable choice of health care providers and the ability to change providers if dissatisfied with their care.

Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain providers. The latter should include information about whether and how a patient can remain with a provider who leaves or is not part of a plan network.

f)**. All patients have the right to know what provider incentives or restrictions might influence practice patterns:** Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules (e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) which could affect provider practice patterns.

In Text-Question

What are the broad goals of the movement for client's right in health in Nigeria?

In Text-Answer

The broad goals of the movement for client's right in health in Nigeria are as follows:

a. To improve the quality of health care.
b. To make the health care system more responsive to clients' needs because of knowledge explosion and technological advances.

5.2.2 The Responsibility of Patients

It is recognized that patients may suffer significant physical and/or mental conditions which may limit their ability to fulfil these responsibilities. Therefore all patients have the responsibility to:

1. Pursue healthy lifestyles.

Patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.

2. Become knowledgeable about their health plans.

Patients should read and become familiar with the terms, coverage provisions, rules, and restrictions of their health plans. They should not be hesitant to inquire with appropriate sources when additional information or clarification is needed about these matters.

3. Actively participate in decisions about their health care.

Patients should seek, when recommended for their age group, an annual medical examination and be present at all other scheduled health care appointments. They should provide accurate information to providers regarding their medical and personal histories, and current symptoms and conditions.

They should ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives. Where appropriate, this should include information about the availability and accessibility of experimental treatments and clinical trials. Additionally, patients should also seek and read literature about their conditions and weigh all pertinent factors in making informed decisions about their care.

4. Cooperate on mutually accepted courses of treatment.

Patients should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side

effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

5.2.3 Patient or client right:

a. To be treated in a professional, courteous, and caring manner that respects and appreciates differences related to race, ethnicity, national origin, gender, sexual orientation, religion, personal values, age, disability, and economic or veteran status.
b. To request the health care provider of your choice or change your health care provider, as well as to request a second opinion or referral.
c. To receive complete information regarding diagnosis, treatment, and prognosis of your health concern in language you can understand. We will provide confidential interpreters when needed.
d. To receive information you need to participate in decisions about your care, and to give consent before any diagnostic or treatment procedure is performed.
e. To decline treatment, to the extent permitted by law, and to be informed of the consequences of making this decision.
f. To expect that your personal privacy will be respected and confidentiality protected to the greatest extent permitted by law.
   We do not release information outside of Gannett (including to parents, professors, potential employers) without your written permission, except upon court order, as required by law (as in the case of certain communicable diseases and reports of child abuse), or as required, in our judgment, to protect you or others from physical danger.
g. To review any health records created and maintained by Gannett regarding your care and treatment.

As a patient or client of Gannett, you have the responsibility:

1. To provide accurate and complete information about current and past health issues, medications (including over-the-counter products and dietary supplements), and allergies or sensitivities, and other matters pertaining to your health.

2. To ask questions to make sure you understand your diagnosis, treatment, expected outcome, and any instructions.
3. To follow through on the treatment plan you and your health care provider make together, including completing medications and returning for follow-up appointments.
4. To keep your appointment, or change or cancel it in a timely manner, to allow others in need to have access to a health care provider.
5. To inform your health care provider about any living will, medical power of attorney, or other directive that could affect your care.
6. To provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your health care provider.
7. To have health insurance that meets Cornell's requirements, understand what your insurance does and does not cover, and provide information about your insurance as needed for processing claims.
8. To use services wisely, be aware of costs, and accept personal responsibility for paying all charges billed to you that are not covered by your insurance.
9. To be respectful of others, including Gannett staff, volunteers, patients and clients.
10. To communicate with your health care provider, a patient advocate (607 255-3564), or any Gannett staff member if you have concerns or suggestions about the care you receive here, so we can work together to provide you with the best possible service in the future. You may report any unresolved grievances to the Accreditation Association for Ambulatory Health Care (AAAHC).
11. The patients' bill of rights with the following objective
12. To reaffirm the importance of a strong relationship between clients and their health care professionals.
13. To reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health care. The principal areas of rights and responsibilities include:
    a. Information disclosure
    b. Choices of providers and plans
    c. Access to emergency service
    d. Participate in treatment

e. Respect and non-discrimination
f. Confidentiality of health information
g. Complaints
h. Consumer
i. Full copy of the patients' bill of right

5.3 Nurses Responsibilities in Healthcare

Responsibility is an obligation on the part of a person to perform some act for which he/she becomes accountable. The nurses' responsibilities are embedded in the code of ethics for nurses. The ICN code outlined the four fundamental responsibilities of nurses as follows: to promote health, to prevent illness, to restore health, and to alleviate suffering.

These responsibilities are to all people irrespective of age, colour, creed, culture, illness, disability, gender, nationality, politics, race or social status. This implies that you must make decisions on aspects of client's health and take steps to implement the decisions. To be effective, you must carry out comprehensive assessment of the client to identify his/her needs and problems, plan and implement to meet the needs and solve the problems.

The ICN code went further to outline nurses responsibilities specific to people, the nursing profession, co-workers and for nursing practice. For you to be able to assume the major role in determining and implementing acceptable standards of clinical practice, you must:

- Engage in continual learning.
- Attend workshops, conferences and update courses that form basis for re-licensing for practice.
- Be aware of social and technological changes that impact on the needs and expectations of the consumers of nursing care, advances in nursing knowledge that improve standards and quality of nursing care and apply them in a manner that is compatible with the safety, dignity and right of people.

Armed with this knowledge, you will be able to assess clients well enough to identify their needs and problems, plan and implement evidence – based care that is geared toward solving the problems of the clients, meeting their needs, ensuring satisfaction of the consumers of health care and thereby increasing the consumers' confidence in the nursing profession.

It is also your responsibility to maintain personal and environmental hygiene, protect yourself from danger in the work place, rest, exercise and engage in all other activities that promote health and prevent illness. In all these responsibilities, the nurse is accountable for her actions and neglect or carelessness in carrying out any of the responsibilities may expose the nurse to liability.

Accountability implies being answerable and responsible for one's conduct. As a nurse you have a duty to provide care for clients according to law and you will be held responsible for your actions. There are four areas of accountability identified for nurses in the code of ethics. They include:

a. Accountability to society – whatever you do impact on society so society will hold you responsible.
b. Accountability to the employer under a contract of employment.
c. Accountability to the client under existing law provision
d. Accountability to the profession.

Professional accountability means using your professional judgement and being answerable for it. This implies decision making and an obligation to explain and justify actions taken. As a nurse you are:

- Privileged to be allowed to make decisions about areas of care based on your knowledge, skills and experience. These quite often are life – saving decisions or decisions that have huge potential impact on your client.
- Expected to be able to justify the basis on which your decisions were made if required to do so. This implies that there is both a right and a duty attached to professional accountability. In recognition of your autonomy in the responsibility of providing nursing care, there is a concomitant responsibility to act in the best interests of the client.

Student nurses cannot be professionally accountable because they are not entered on the professional register, but they are accountable in the other three areas. For example, a registered nurse may delegate the task of dressing a wound to a student. The student is accountable or answerable for any harm he/she causes the client and therefore, should not do the dressing if he/she does not feel competent to do so.

The registered nurse, however, retains the professional accountability in terms of ensuring the correct materials are used for the dressing and for ensuring that the student is, in the registered nurse's opinion, competent to carry out the dressing.

In Text-Question

What are the four areas of accountability identified for nurses in the code of ethics?

In Text-Answer

They include:

a. Accountability to society.
b. Accountability to the employer under a contract of employment.
c. Accountability to the client under existing law provision
d. Accountability to the profession.

5.3.1 Application of Clients' Bill of Rights in Nursing Care

The nurse who knows that her fundamental responsibilities are to promote health prevent illness, restore health, and alleviate suffering and that the client has the right of access to appropriate high quality health care will educate the clients on activities they will engage in to promote their health and prevent illness. It is important that you know these activities and use every opportunity to inform the clients of them.

For restoring health and alleviating suffering, you should use the nursing process format to carry out proper assessment and accurate diagnosis of clients and then plan and implement quality care that will meet the health needs of the client and ensure his satisfaction. In doing all these you should:

a. Handle the clients with respect and dignity and provide the care equitably to all who need it.
b. Promote an environment in which the rights, values, customs and spiritual beliefs of the individual, family and community are respected.
c. Not impose your own values, customs and belief on the client. If you find the client's values and beliefs are such that are detrimental to the health of the client and will affect the care plan adversely, you should provide information that will help the client see the problems in such beliefs and values and the need to clarify and redefine them.
d. Inform the client of available options from which he/she can choose those that will impact positively on his/her health. This way, the client's right to participate in treatment decisions and to choose treatment plan would not be infringed on.
e. Ensure that the client receives sufficient relevant information on which to base consent for care and related treatment and that you hold in confidence

personal information given by the client and that you use judgment in sharing the information. This implies that in determining and implementing care, you should work with the client and find out how much the client knows about his illness and the management of his problem.

f. Provide information that will help the client to clarify issues, correct misconceptions he/she may hold and increase knowledge about his/her condition and the necessary care. This will help the client to make informed choices and to work toward promotion of his own health and that of others.

During this interaction with the client, the client may give you intimate and private information, you should maintain the confidentiality with which the information was given and share it only if the client gives his consent or when it becomes absolutely necessary to do so. By doing these, you will be complying with such rights of the client as information disclosure and confidentiality of health information.

Figure 5.2: *A Nurse interacting with a Patient*

Since, as a nurse, you share with society the responsibility for initiating and supporting actions to meet the health and social needs of the public, in particular those of vulnerable population, you should work with individuals, families, and communities to identify their health and social needs, plan to meet these needs, implement and evaluate such plans that they may have agreed upon.

Being the professional that carries responsibility and accountability for nursing practice, you should direct and co-ordinate these activities. In all the activities, you should encourage the client to take responsibility for certain aspects of his care. In delegating assignments to the client, you should consider his/her capability at particular times.

For example, when the client is acutely ill, he/she may not have the energy nor be in the right frame of mind to participate fully in his/her care. You should take charge of those aspects of care that the client cannot do for himself, but would have done if he had the necessary strength. This helps to conserve the client's energy for such activities, as respiration, digestion, etc., that no one can carry out for him/her.

As the client's condition improves, you should gradually involve him in his care. The benefit of participation is that it improves knowledge and understanding of health care activities that help clients to become self-reliant and responsible for their health and that of others. You should also consider your own capability in accepting responsibility so as to avoid harm to the client that will result in your being liable.

You should maintain a cooperative relationship with co-workers in nursing and other fields and you will achieve this by:

a. Understanding and respecting co-workers, treating them with dignity and courtesy and by abiding by rules and regulations.
b. Acting responsibly through providing timely, high quality service, working collaboratively and carrying your share of the load of care and meeting performance expectations.
c. You should also take appropriate actions to safeguard individuals when their care is endangered by a co-worker or any other person.
d. You should draw the attention of such co-worker to the areas he/she is failing to perform and if he/she does not improve you should take necessary steps to stop him/her.

Summary

In this study session, you have learnt that:

1. Right does a claim to a particular privilege and legal rights co-exist with obligation.
2. Among the objectives of the patients' bill of rights is to strengthen consumers' confidence by assuring the health care system is fair and responsive to consumers' needs.
3. There are principal areas of rights and responsibilities in the patients' bill of right some of which are: information disclosure, participation in treatment decisions, and confidentiality of health information, respect and non-discrimination.
4. As a nurse, you are privileged to make decision about areas of care and you are expected to be able to justify the basis on which your decisions are made.

Self-Assessment Questions (SAQs)

SAQ 5.1 (testing learning outcome 5.1)

Outline the rights of patients in health care

SAQ 5.2 (testing learning outcome 5.2)

Discuss the nurses' responsibility in health care delivery

Notes on SAQs

SAQ 5.1

- All patients have the right to informed consent in treatment decisions, timely access to specialty care, and confidentiality protections.
- All patients have the right to concise and easily understood information about their coverage.
- All patients have the right to know how coverage payment decisions are made and how they can be fairly and openly appealed.
- All patients have the right to complete and easily understood information about the costs of their coverage and care.
- All patients have the right to a reasonable choice of providers and useful information about provider options.
- All patients have the right to know what provider incentives or restrictions might influence practice patterns.

SAQ 5.2

Responsibility is an obligation on the part of a person to perform some act for which he/she becomes accountable. The nurses' responsibilities are embedded in the code of ethics for nurses.

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Study Session 6: Obtained Information Consent

Introduction

In the past, nurses and doctors told the client what care he was going to receive and the client agreed to it. Recently there has been a shift in the balance of power between the caregiver and the care receiver.

Clients are seeking more self-determination and control over their bodies when ill. In this study session, we will examine the concept of consent, the responsibilities of the nurse in obtaining consent, stages in obtaining informed consent, problems that may be encountered in obtaining consent and how the problems can be effectively dealt with.

Learning outcomes

By the end of this study session, you should be able to:

6.1 Describe the history and assessment of informed consent.

6.2 Outline the responsibilities of the nurse in obtaining consent.

6.3 Describe the process of obtaining consent.

6.4 Outline the stages of on-going care and problems encountered in obtaining consent.

6.1 History of Informed Consent

Informed consent is a legal procedure to ensure that a patient, client, and research participants are aware of all the potential risks and costs involved in a treatment or procedure. The elements of informed consent include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment.

Figure 6.1: *Informed Consent*

"Informed consent" is a technical term first used in a medical malpractice (United States) court case in 1957. In tracing its history, some scholars have suggested tracing the history of checking for any of these practices:

1. A patient agrees to a health intervention based on an understanding of it. For example a person may verbally agree to something from fear, perceived social pressure, or psychological difficulty in asserting his true feelings. The person requesting the action may honestly be unaware of this and believe the consent is genuine, and rely upon it. *Consent is expressed, but not internally given.*

2. The patient has multiple choices and is not compelled to choose a particular one. For example a person may state he understands the implications of some action, as part of his consent, but in fact has failed to appreciate the possible consequences fully and later deny the validity of his consent for this reason. *Understanding needed for informed consent is stated to be present but is in fact (through ignorance) not present.*

3. The consent includes giving permission. For example a person may move from friendship to sexual contact on the basis of body language and apparent receptivity, but very few people on a date that results in sexual contact have explicitly asked the other if his or her consent is informed, if he does in fact fully understand what is implied, and all potential conditions or results. *Informed consent is implied (or assumed unless disproved) but not stated explicitly.*

These practices are all part of what constitutes informed consent and their history is the history of informed consent. They combined to form the modern concept of informed consent rose in response to particular problems which happened in modern research. Whereas various cultures in various places practiced informed consent; the modern concept of informed consent was developed by people who drew influence from Western tradition.

6.1.1 Assessment of Consent

Informed consent can be complex to evaluate, because neither expressions of consent, nor expressions of understanding of implications, necessarily mean that full adult consent was in fact given, nor that full comprehension of relevant issues is internally digested. Consent may be implied within the usual subtleties of human communication, rather than explicitly negotiated verbally or in writing.

In some cases consent cannot legally be possible, even if the person protests he does indeed understand and wish. There are also structured instruments for evaluating capacity to give informed consent, although no ideal instrument presently exists. There is thus always a degree to which informed consent must be assumed or inferred based upon observation, or knowledge, or legal reliance. This especially is the case in sexual or relational issues.

In medical or formal circumstances explicit agreement by means of signature which may normally be relied upon legally, regardless of actual consent, is the norm. This is the case with certain procedures, such as a "do not resuscitate" directive signed by a patient prior to their illness.

In Text-Question

What is informed consent?

In Text-Answer

Informed consent is a legal procedure to ensure that a patient, client, and research participants are aware of all the potential risks and costs involved in a treatment or procedure.

6.2 Nurses Responsibilities in Obtaining Consent

Obtaining informed consent for specific medical and surgical treatment is the responsibility of a physician. This responsibility is delegated to nurses in some agencies and no law prohibits the nurse from being part of the information – giving process. The practice however is highly undesirable. This is so because it is not right for you to obtain consent for a procedure that you are not in control of.

The person who is going to carry out the procedure and who knows what is involved in the procedure is in the position to obtain the consent as he is expected to explain to the client what is intended before asking for consent to carry it out.

Since you are not the one that will perform the surgery nor are you the one to administer the anaesthesia, you might not be in a good position to explain to the client what is involved and therefore should not be the one to obtain the consent. Often your responsibility is to witness the giving of the informed consent for medical procedures. This involves the following:

- Witnessing the exchange between the client and the physician.
- Establishing that the client really did understand, that is, was really informed.
- That the client freely or voluntarily gives his/her consent

- Witness the client's signature or thumb printing

If you witness only the client's signature and not the exchange between the client and the physician, you should write "witnessed signature only'' on the form. If you find that the client really does not understand the physician's explanation, then the physician must be notified. Obtaining informed consent for nursing procedures is the responsibility of the nurse.

This applies in particular to nurse anaesthetists, nurse midwives, and nurse practitioners performing procedures in their advanced practices. However, it applies to other nurses, including you, who perform direct care such as insertion of nasogastric tubes or administration of medication.

In the United Kingdom and countries such as Malaysia and Singapore, informed consent in medical procedures requires proof as to the standard of care to be expected as a recognized standard of acceptable professional practice (the Bolam Test), that is, what risks would a medical professional usually disclose in the circumstances (see Loss of right in English law). Arguably, this is "sufficient consent" rather than "informed consent."

In the United States, Australia, and Canada, a more patient-centered approach is taken and this approach is usually what is meant by the phrase "informed consent." Informed consent in these jurisdictions requires that significant risks be disclosed, as well as risks which would be of particular importance to that patient. This approach combines an objective (the reasonable patient) and subjective (this particular patient) approach.

In Text-Question

Obtaining informed consent for specific medical and surgical treatment is the responsibility of a……..

a. Nurse
b. Physician
c. Patient
d. All of the above

In Text-Answer

Physician

The doctrine of informed consent should be contrasted with the general doctrine of medical consent, which applies to assault or battery. The consent standard here is only that the person understands, in general terms, the nature of and purpose of the intended intervention.

As the higher standard of informed consent applies to negligence, not battery, the other elements of negligence must be made out. Significantly, causation must be shown: That had the individual been made aware of the risk he would not have proceeded with the operation (or perhaps with that surgeon).

Optimal establishment of an informed consent requires adaptation to cultural or other individual factors of the patient. For example, people from Mediterranean and Arab appear to rely more on the context of the delivery of the information, with the information being carried more by who is saying it and where, when, and how it's being said, rather than *what* is said, which is of relatively more importance in typical "Western" countries.

The informed consent doctrine is generally implemented through good healthcare practice: pre-operation discussions with patients and the use of medical consent forms in hospitals. However, reliance on a signed form should not undermine the basis of the doctrine in giving the patient an opportunity to weigh and respond to the risk.

In one British case, a doctor performing routine surgery on a woman noticed that she had cancerous tissue in her womb. He took the initiative to remove the woman's womb; however, as she had not given informed consent for this operation, the doctor was judged by the General Medical Council to have acted negligently.

The council stated that the woman should have been informed of her condition, and allowed to make her own decision.

6.3 Obtaining Informed Consents

To capture and manage informed consents, hospital management systems typically use paper-based consent forms which are scanned and stored in a document handling system after obtaining the necessary signatures.

Hospital systems and research organizations are adopting an electronic way of capturing informed consents to enable indexing, to improve comprehension, search and retrieval of consent data, thus enhancing the ability to honor to patient intent and identify willing research participants.

More recently, Health Sciences South Carolina, a statewide research collaborative focused on transforming healthcare quality, health information systems and patient outcomes developed an open-source system called Research Permissions Management System (RPMS). RPMS has been released as an open-source application.

6.3.1 Written Consent Process

Obtaining written informed consent from a potential subject is more than just a signature on a form.

a. The consent document is to be used as a guide for the verbal explanation of the study.
b. The consent document should be the basis for a meaningful exchange between the Investigator and the subject.
c. The subject's signature provides documentation of agreement to participate in a study, but is only one part of the consent process.
d. The consent document must not serve as a substitute for discussion.

In research

In medical research, the Nuremberg Code set a base international standard in 1947, which continued to develop, for example in response to the ethical violation in the Holocaust. Nowadays, medical research is overseen by an ethics committee that also oversees the informed consent process.

As the medical guidelines established in the Nuremberg Code were imported into the ethical guidelines for the social sciences, informed consent became a common part of the research procedure. However, while informed consent is the default in medical settings, it is not always required in the social science. Here, research often involves low or no risk for participants, unlike in many medical experiments.

Second, the mere knowledge that they participate in a study can cause people to alter their behavior, as in the Hawthorne Effect: "In the typical lab experiment, subjects enter an environment in which they are keenly aware that their behavior is being monitored, recorded, and subsequently scrutinized.

In such cases, seeking informed consent directly interferes with the ability to conduct the research, because the very act of revealing that a study is being conducted is likely to alter the behavior studied. List exemplifies the potential dilemma that can result:

"If one were interested in exploring whether, and to what extent, race or gender influences the prices that buyers pay for used cars, it would be difficult to measure accurately the degree of discrimination among used car dealers who know that they are taking part in an experiment".

In cases where such interference is likely, and after careful consideration, a researcher may forgo the informed consent process. This is commonly done after weighting the risk to study participants versus the benefit to society and whether participants are present in the study out of their own wish and treated fairly. Researchers often consult with an Ethics Committee or institutional review board to render a decision.

In Text-Question

How does hospital capture and manage informed consents?

In Text-Answer

Hospital management systems usually use paper-based consent forms which are scanned and stored in a document handling system after obtaining the necessary signatures.

6.3.2 Exception in Obtaining Consent

Three groups of clients cannot provide consent. They include:

a. Minors: These are people who are below the age of 18years. For this group a parent or guardian must give consent before they can obtain treatment. The same is true of an adult who has the mental capacity of a child and who has an appointed guardian. However minors who are married, pregnant, parents, members of the military are in some places, often legally permitted to provide their own consent.
b. Unconscious persons or persons who are injured in such a way that is unable to give consent. In these situations, consent is usually obtained from the closest adult relation. In a life threatening emergence, if consent cannot be obtained from the client or relation, the law generally agrees that consent is implied.
c. Mentally ill persons who have been judged by professionals to be incompetent. The mental health act or similar statutes generally provide

definitions of mental illness and specifies the rights of the mentally ill under the law as well as the rights of the staff caring for such clients.

The three major elements of informed consent are:

- The consent must be given voluntarily or freely
- The consent must be given by an individual with the capacity and competence to understand.
- The client must be given enough information to be the ultimate decision-maker.

6. 4 On-going Consent to Care

Most often consent is directed mainly at specific episodes of care, for example, procedures and surgery. It is not therefore specific enough or appropriate for those receiving long-term care, for which the issue is on-going consent to care and treatment, not specific episode. For such clients, active participation in the planning and reviewing of their care is required to ensure on-going consent to care.

6.4.1 Stages of On-going Consent to Care

The process of on-going consent to care is examined in five stages from the perspectives of the service user:

Stage 1: Giving Information

Every client must have a care plan in which his or her assessed care needs and the care to be given are recorded. For mentally competent people, the first stage should be for you to inform them that they have a plan. Offer those who can read the opportunity to read the plan and for those who cannot read, explain the content of the plan.

This is necessary so that they can actively participate in the review of the plan when the need arises. If they don't know about the plan, it will be difficult for them to participate actively in its review. However, access to client's health records can be refused where the access would likely cause serious harm.

General Guide to the amount and type of information required for client to make informed consent.

The client should know the following:

- The purpose of the treatment
- The intended benefits of the treatment.
- Possible risks or negative outcomes of the treatment.

- Advantages and Disadvantages of possible alternatives to the treatment including no treatment.

Stage 2: Consultation with the client

Consultation with the client implies that you take into account issues such as clients' beliefs, values, preferences and perceived quality of life when making a decision on their behalf. You will have information on these only if you consult with or involve the client.

If there is no evidence of consultation with the client then you are delivering care and treatment with their "compliance" rather than their expressed consent. You are therefore cautioned not to confuse compliance with consent.

For consent to be valid, the client should be given adequate information and have the mental capacity to be able to understand and process the information. If the first two parts of this process, that is, information giving and involvement of the client, have not been complied with, then a valid consent cannot be given.

In Text-Question

State what is involved in stage one of on-going care.

In Text-Answer

Giving Information: Every client must have a care plan in which his or her assessed care needs and the care to be given are recorded.

Stage 3: Active Participation of the Client

You should encourage the clients to be actively involved in planning and reviewing their care as recorded in their care plan. Active participation of the client can have potential benefits which include:

- The client's care plan is likely to be more individualized if the client had helped to compile it.
- Clients are assisted to become more independent and thus minimize hospitalization.
- The care plan is likely to be a more valid and workable tool from the client perspective and thus increase the client's co-operation with the strategies prescribed.

Stage 4: Consent to care

Here the client agrees to the care. For any person to be able to give a meaningful consent to his or her care, the previous three stages must be followed. Without

adequate information, the ability to process the information and the opportunity to ask questions, the client cannot give a valid consent.

Stage 5: Making an advance statement and/or directive.
The logical and progressive stage after giving consent to the care that was suggested would be for the client to specify the care strategies he wants or does not want in any given situation. Clients who have made an advance statement and/or directive should be able to feel confident that their wishes will be complied with even if they are not able to give their instructions personally.
This can be seen as the ultimate in client participation, empowerment and taking control. An advance statement is a statement of views or wishes to be taken into account in decision making and is not intended to be binding on the health care team. An advance directive or living will is intended to be binding on the health team. For example, an advance directive is not to institute artificial feeding for people at the end stage of dementia.
Although some people might see the use of a feeding tube as just a different method of delivering food and fluids, and therefore to be maintained at all cost rather than allow the client to starve to death, others might view it as an invasive procedure or as a technological support.
Some people may consider this method of feeding as too invasive, but unless an advance directive specifically refusing this technology has been made, it may be used if seen by you to be appropriate in the client's best interest.

6.4 .2 Problems in Obtaining Consent
Sometimes you may encounter a client or members of a client's family whom for various reasons resist or oppose treatment. Such reasons may be religious, socio-cultural, economic or politically based. Examples of such problems include:

- The patient who needs but refuses treatment.
- The parent who refuses permission to treat a child with life threatening illness.
- The mentally ill person
- The intoxicated or belligerent clients
- Client who gives and then withdraws consent for treatment etc.

These situations create conflicts of values, rights and responsibilities. For instance, the right to life and the duty to preserve life versus the right to die and the duty to

alleviate pain and suffering. The risk of legal and ethical liability for failing to act appropriately in such cases cannot be overstated.

6.4.3 Strategies to resolve problems in obtaining consent

In order to deal effectively with the problems from the client or the family in obtaining consent, the nurse must integrate fundamental principles of behaviour assessment and modification into the treatment process. The steps are as follows:

- Assess the client to identify and deal effectively with any psychosocial or physical difficulties that could be militating against obtaining consent.
- Institute every effort reasonable and lawful to convince the client to urge him to accept the required treatment.
- If a conscious and rational adult client or parent refuses to give consent, he cannot be treated without risk of civil and criminal liability. In such a situation, the refusal should be carefully documented and witnessed. An example of this is "discharge against medical advice".
- Obtain legal consultation if the client's condition is sufficiently grave.

Summary

In this study session, you have learnt that:

1. Obtaining informed consent is a fundamental part of your care giving process and failure to obtain consent to care can expose you to the risk of legal and ethical liability.
2. It is important that you know and understand your responsibilities in obtaining consent to care.
3. Informed consent is an agreement by a client to accept a course of treatment or a procedure after complete information has been provided by a health care provider.
4. The process of on-going consent to care is in five stages as follows; giving information, consulting with client, encouraging active participation of client, and giving consent to care and advanced statements and/or directives from the client.

Self-Assessment Questions (SAQs)

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 6.1 (tests learning outcome 6.1)

State the origin of informed consent.

SAQ 6.2 (tests learning outcome 6.2)

Enumerate the steps of obtaining informed consent for medical procedures.

SAQ 6.3 (tests learning outcome 6.3)

Explain three groups of clients that cannot provide consent

SAQ 6.4 (tests learning outcome 6.4)

Describe Stage 3 of the on-going care

Notes on the Self-Assessment Questions (SAQs)

SAQ 6.1

Origins of Informed Consent are as follows:

a. A patient agrees to a health intervention based on an understanding of it
b. The patient has multiple choices and is not compelled to choose a particular one
c. The consent includes giving permission

SAQ 6.2

Steps of obtaining informed consent for medical procedures are:

a. Witnessing the exchange between the client and the physician.
b. Establishing that the client really did understand, that is, was really informed.
c. That the client freely or voluntarily gives his/her consent
d. Witness the client's signature or thumb printing

SAQ 6.3

They include:

a. Minors: These are people who are below the age of 18years. For this group a parent or guardian must give consent before they can obtain treatment.

However minors who are married, pregnant, parents, members of the military are in some places, often legally permitted to provide their own consent.

b. Unconscious persons or persons who are injured in such a way that is unable to give consent. In these situations, consent is usually obtained from the closest adult relation. In a life threatening emergence, if consent cannot be obtained from the client or relation, the law generally agrees that consent is implied.
c. Mentally ill persons who have been judged by professionals to be incompetent. The mental health act or similar statutes generally provide definitions of mental illness and specifies the rights of the mentally ill under the law as well as the rights of the staff caring for such clients.

SAQ 6.4

Active Participation of the Client: You should encourage the clients to be actively involved in planning and reviewing their care as recorded in their care plan. Active participation of the client can have potential benefits which include:

- The client's care plan is likely to be more individualized if the client had helped to compile it.
- Clients are assisted to become more independent and thus minimize hospitalization.

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Study Session 7: Theories and Models of Maternal and Child Health Care I

Introduction

The health and safety of the mother and baby are of paramount importance in both the midwifery and medical models. But, they are not the midwife's only goals. Midwives value childbirth as an emotionally, socially, culturally, and often spiritually meaningful life experience - something to be experienced positively, with potential for making women feel stronger, and be stronger, and for strengthening bonds between the mother, father, other siblings and the new-born.

In addition, the baby is not the only important outcome of the pregnancy. Pregnancy, especially every first pregnancy, is a critical developmental process for a woman. Pregnancy results in a mother as well as a baby. It is important that the woman's transition into motherhood is a positive experience, that she and all members of her family make emotionally healthy adjustments to each pregnancy and birth, and that she has the means to acquire the necessary information, skills, support, and self-confidence needed to successfully assume the roles and responsibilities of motherhood. Breastfeeding and mother craft are part of the focus of midwifery

In this session, you will learn Roy's Adaptation theory, Abraham Maslow theory and Helbert Dunn's theory.

Learning Outcome for Study Session 7

When you have studied this session, you should be able to;

7.1 Explain the various theories and emphasis on health Care

7.2 Discuss the Roy's Adaptation Theory

7.3 Abraham Maslow Theory

7.4 7.4 Helbert Dunn's Theory

7.1 Theorist and Concepts of Theory.

Theorist	Major Concepts of Theory	Emphasis of Care
Patricia Benner	Nursing is a caring relationship. Nurses grow from novice to expert as they practice in clinical settings	Assess Terry as a whole. An expert nurse is able to do this intuitively from knowledge gained from practice.
Dorothy Johnson	A person comprises subsystems that must remain in balance for optimal functioning. Any actual or potential threat to this system balance is a nursing concern	Assess the effect of lack of arm function on Terry as a whole; modify care to maintain function to all systems, not just musculoskeletal
Imogene King	Nursing is a process of action, reaction, interaction, and transaction; needs are identified based on client's social system, perceptions, and health; the role of the nurse is to help the client achieve goal attainment.	Discuss with Terry the way she views herself and illness. She views herself as a well-child, active in Girl Scouts and school; structure care to help her meet these perceptions.
Madeleine Leininger	The essence of nursing is care. To provide transcultural care, the nurse focuses on the study and analysis of different cultures with respect to caring behavior.	Assess Terry's family for beliefs about healing. Incorporate these into care.
Florence Nightingale	The role of the nurse is viewed as changing or structuring elements of the environment such as ventilation, temperature, odors, noise, and light to put the client into the best opportunity for recovery.	Turn Terry's bed into the sunlight; provide adequate covers for warmth; leave her comfortable with electronic games to occupy her time
Betty Neuman	A person is an open system that interacts with the environment; nursing is aimed at reducing stressors through primary, secondary, and tertiary prevention	Assess for stressors such as loss of self-esteem and derive ways to prevent further loss such as praising her for combing her own hair.
Dorothea	The focus of nursing is on the	Arrange over bed table so

Orem	individual; clients are assessed in terms of ability to complete self-care. Care given may be wholly compensatory (client has no role); partly compensatory (client participates in care); or supportive-educational (client performs own care).	Terry can feed herself; urge her to participate in care by doing as much for herself as she can
Ida Jean Orlando	The focus of the nurse is interaction with the client; effectiveness of care depends on the client's behavior and the nurse's reaction to that behavior. The client should define his or her own needs	Ask Terry what she feels is her main need. Terry says that returning to school is what she wants most. Stress activities that allow her to maintain contact with school, such as doing homework or telephoning friends
Rosemarie Rizzo Parse	Nursing is a human science. Health is a lived experience. Man-living-health as a single unit guides practice.	Ask Terry what being sick means to her. Allow her to participate in care decisions based on her response.
Hildegard Peplau	The promotion of health is viewed as the forward movement of the personality; this is accomplished through an interpersonal process that includes orientation, identification, exploitation, and resolution	Plan care together with Terry. Encourage her to speak of school and accomplishments in Girl Scouts to retain self-esteem.
Martha Rogers	The purpose of nursing is to move the client toward optimal health; the nurse should view the client as whole and constantly changing and help people to interact in the best way possible with the environment	Help Terry to make use of her left side as much as possible so that she returns to school and to her previous level of functioning as soon as possible.
Sister Callista Roy	The role of the nurse is to aid clients to adapt to the change caused by illness;	Assess Terry's ability to use her left hand

	levels of adaptation depend on the degree of environmental change and state of coping ability; full adaptation includes physiologic interdependence.	to replace her right-hand functions, which are now lost; direct nursing care toward replacing deficit with other factors, self-concept, role function, and skills.

Theories in Nursing

Nursing theories describes the relationship of the client and the nurse with health and environment. Scientific theories are applied in each step of the nursing process; therefore nurses must understand some specific things of each theoretical approach for effective use in the nursing process.

There are many theoretical approaches. Some of these are:

- General system approach
- Subsystem approach
- Adoptive system approach
- Personal system approach
- Interpersonal system approach, and
- Social approach

For each theoretical approach, the nurse must understand the underlying assumptions, definition of each concept, and interrelationships of the concepts. Misunderstanding these aspects may lead the nurse to apply inappropriate theory to a client's situation.

- In choosing the most appropriate approach, the nurse considers the client's health, status and comprehensive situation so as to determine which approach is appropriate. In order to choose a specific framework or model, the following should be decided. We will describe some theories and models.

7.2 Roy's Adaptation Theory

Roy's Adaptation model is a theory propounded by sister Callista Roy in Richi and Roy (1980 PP.179-206). This model reflects the general customs theory approach. It explains how an individual interact with and adapts to the environment. As an adaptive system, the person functions as a totality.

This means that the interaction requires use of adaptive mechanisms to conserve energy and maintain equilibrium. In Roy's Model, nursing assists the client to adapt physiological alternation in four ways.

These are:

- Basic Physiological needs
- Self Concept
- Role mastery of function
- Interdependence relations

Failure of coping mechanisms leads to problems.

In-Text Question

……. is the model that explain how an individual co-operate with and familiarises to the environment.

In-Text Answer

Roys Adaptation Theory

7.2.1 Basic Physiological Needs:

The basic physiological needs are composed of 7 areas namely:

1. **Exercise and Rest**: Too little or too much of this can lead to immobility, hyperactivity, fatigue or insomnia.
2. **Nutrition**: Problems in this area include malnutrition nausea, vomiting.
3. **Elimination Needs**: any problem in this area may cause retention hyper excretion, constipation, diarrheal and incontinence.
4. **Fluid and Electrolytes:** Excess or deficit may cause Dehydration, oedema, and electrolyte imbalance.
5. **Oxygen**: Lack of this will lead to ischemia or fatigue
6. **Circulation Needs**: Failure lead shock or overloading the heart causing heart failure.
7. **Regulation of Temperature, Senses and the Endocrine System:** Problems in these areas may cause fever, hypothermic sensory deprivation, overload and endocrine imbalance.

7.2.2 Self Concept

This has three parts: Physical, Personal and Inter-personal

Physical; the physical self-concept is made up of images and sensation.

Personal; The personal self-concept comprises of ethical issues, consistency of self-behavior with values and one's ideal and expected behavior.

Interpersonal; the interpersonal self-concept is the individuals view of one's interaction with others.

7.2.3 Roles Mastery/Function

This is the instrumental and expressive aspect of the individual's position in the society. In this area, the problems that may arise are role conflict and role failure.

In-Text Question

…… and ……. that made up the physical self-concept

In-Text Answer

Images and sensation

7.2.4 Interdependence Relation

This is the ability of the individual to achieve comfortable balance between dependent and independence. The inability to distinguish between these may result to in alienation, rejection, aggression, hostility, loneliness, dominance and exhibition.

Roy's model also includes the regulator and congnator sub items. The regulator subsystem reacts to internal and external physical stimuli. The congnator subsystem reacts to internal and external psychosocial stimuli.

The stimuli are received via

- *Perception,*
- *Learning,*
- *Judgment*
- *Emotion.*

When the regulator and cognate subsystems are faulty the individual develops maladaptive behaviors.

SOURCES OF STIMULI

There are three sources:

- Focal
- Contextual
- Residual

Focal: Related to environmental changes

Contextual: Stimuli from other internal and external sources that may influence the situation.
Residual: Refers to the personal characteristics of the individual which are relevant to the situation.

APPLICATION TO NURSING
The purpose of nursing is to change the stimuli to promote the client's adaptation. That is to guide the client to adapt to physiological alterations.
The nurse examines the client's four ways of identifying problems.
Then the nurse identifies the stimuli that cause the mal adaptation and he/she alters the stimuli.
The alteration of the stimuli, Roy believes will help the client's regulator and cognator subsystems to resume effective adaptive behaviors.

Roy's model is broad enough to be used for individuals or families in the nursing process.
It is very useful for assessing and analyzing client's patterns.
It is a good guide when nursing implementation strategies are geared at changing source of stimuli.
ITQ: Give an example of a model in maternal and child health care

7.3 Abraham Maslow's Theory
Abraham Maslow developed the theory of human needs in 1940. He defined a need as a satisfaction whose absence causes illness.
According to him a basic need has the following characteristics:
- Its absence breeds illness.
- Its presence prevents illness.
- Its restoration cures illness.
- Under certain situation of free choice, it's preferred by a deprived person over satisfactions.
- It is found to be inactive or functionally absent in the heal\thy person.

To Maslow, needs motivate the behavior or the individual. His model of human needs includes both physiology and psychological needs, which he ranks according to how critical to survival they are.

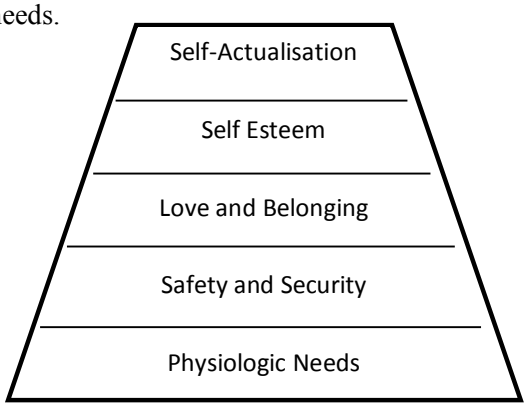
According to Maslow, the needs at one level must be met before the needs on the next level can be met. Thus, the physiologic needs must be met before the safety needs are met. Throughout life, people strive to meet their needs at each level; however, the dominant needs within one level' may vary at different times of it.
Maslow sees humans as being who continue to grow and develop from conception until death. Once a need is completely met, Maslow believes that he/she is breathing until the need for air crops up as in suffocation.

In-Text Question
Abraham Maslow believes that fulfilment whose absence causes ……

In-Text Answer
Illness.
Needs may be completely met, or not met at all. An individual usually persists in behaviour to meet a need until it is met; for example, a thirsty man who cannot find a drinking fountain will search until he finds another source of water.
Abraham Maslow in 1970 identified five categories of needs in order of priority i.e. hierarchy of human needs; this hierarchy of human needs begins with basic fundamental needs of the individual that must be satisfied before proceeding to the next higher level. The desire to gratify human needs at each level motivates the individual and strengthens goal – directed behaviours.
Generally, the basic physiological needs and safety, needs must be relatively satisfied in the individual before striving for higher level needs.
The five Categories are as follows in order of priority

1. **Physiology needs**
2. **Safety and security needs**
3. **Love and belonging needs**
4. **Self – esteem needs**
5. **Need for self – actualization.**

Those are better analyzed in a pyramid forms as follows with the basic physiologic forming the base of the pyramid and at the apex of the pyramid are the self-actualization needs.



7.3.1 Physiologic Needs

These are identified fundamental physical needs of the individual. They include air, food, sleep, sex, fluids, exercise, rest, temperature maintenance and elimination. A person who is starving or deprived of fluid for an extended time will center his or her activities on meeting that need.

For survival and satisfactory function, every individual must have these basic physiologic needs met. Some people require more sleep or food than others, but individuals must satisfy these needs at their own specific levels.

7.3.2 Safety and Security Needs

When basic physical needs are relatively satisfied, the need to feel safe, in one's environment emerges. This need for safety has both physical and psychological aspect. The person needs to be secured to feel safe, both in the physical environment and in relationships.

Under these needs are stability, order, and freedom from fear, protection and sometimes, dependency. These needs reflect self-protection through the establishment of structure, law, order and limitations

Needs for safety and protection from harm may become more prominent when the individual is threatened by body may become harm as in physical illness or potential injury.

Safety needs involve both imminent danger or concerns and potential loss, such as loss of a spouse or occupational position.

7.3.3 Love and Belonging

This emerges as the safety and security needs are reasonably satisfied. With this category are needs for affectionate relationships, identification within various groups (family, church and work) and companionship.

These needs may be expressed through contact with significant others, tenderness, affection, and intimacy in sharing time spent together. Love and belongings need may include contact with and affection for family members, friends and associates of all age group and both sexes.

When love and belongings needs remain unsatisfied, the individual may feel alone, alienated, estranged, and distant from friends and relatives. According to Maslow, the need for love encompasses both giving and receiving. Belonging needs also include attaining a place in a group e.g. belonging to a family.

7.3.4 Self – Esteem Needs

When the above needs have been gratified, the individual's needs for esteem and recognition arise. The individual needs with self – esteem and esteem from others. Self – Esteem deals with feelings of independence, competence, and self-respect while esteem from others has to do with recognition, respect, and appreciation:

The desire for esteem and recognition motivates an individual towards **Goal – directed Behaviours** thus leading to achievement of these needs in one's own unique way. As this is satisfied, the individual experiences a sense of adequacy, self – worth, self – fulfilment and contentment.

7.3.5 Self-Actualization

When the lower needs in the hierarchy have been relatively satisfied; an individual strives towards self-actualization. The fully self-actualized person has realized his or her full potential. Such person has the ability to connect the past and the future to the present while living fully in the present i.e. he or she is time competent.

The self – actualized person is inner – directed i.e. he is guided by a few basic values and principles. He is also autonomous which means he is free from parental and social pressures. Not all people become fully self – actualization. Some adults continue working towards self – actualization all their lives, while others arrive at a sense of fulfilment or accomplishment in midwife.

In-Text Question

……. may include need of contact with and affection for family members and friends.

In-Text Answer

Love and belongings

Maslow through relating to people in autonomous and time competent ways. A self – actualized person may not always be happy, successful or well adjusted. Maslow views individuals within this category as prideful, vain and possessing doubts and fears.

However, they were able to deal positively with their fears, and failures. Maslow also includes the pursuit of cognitive and aesthetic needs in the category of self – actualization need.

In later research, Maslow identified growth needs in contrast to the deficiency needs. He calls the growth needs "Being values (Meteneods B-Values). These being values resemble needs because, when metaphysical needs are not met the person has a "sickness of the soul" or Metapathalolgy (Maslow 1971, p.43).

He also believes that for some people B-values give meaning to life and there are 14 B-values as follows: truth, goodness, beauty, wholeness, uniqueness, perfection, competition, justice, simplicity, richness, effortlessness, playfulness and self-sufficiency. (Note that these needs are however not ranked (**Globe** 19 PP 47-48).

MASLOW'S CHARACTERISTICS OF A SELF-ACTUALIZED PERSON

1. Is realistic and objective about his or her observations
2. Judges people correctly
3. Has superior perception
4. Has clear notion of right and wrong
5. Is usually accurate in predicting future events
6. Understands art, music, politics and philosophy
7. Possesses humility, listen to others carefully
8. Is dedicated to some work, task, duty or vacation
9. Is highly creative, flexible, courageous and will to make mistakes
10. Is open to new Ideas
11. Is self – Confident and has self-respect
12. Has low degree of self-conflicts, personality is integrated
13. Respects self, does not need fame, possesses a feeling of self control
14. Is highly independent, desires privacy
15. Can appear, remote and detached
16. Is friendly, lowing and governing more by inner directives than by society

17. Can make decisions contrary to popular opinion
18. Is problem centered rather than self-controlled

APPLICATIONS IN NURSING

Maslow's theory is a broad approach that can be used in all components of the nursing process. It is applicable to both individual and family clients. It is most useful in arranging nursing diagnoses in order of priority. It can also serve as a guide in assessing and analyzing data and in planning nursing implementation. It also helps the nurse to understanding people's behavior thus enabling the nurse to respond therapeutically rather than emotionally.

Nurses are able to help clients move toward self-actualization by helping them to find meaning in their illness by:

- ❖ Understanding what is happening to them
- ❖ Maintaining some control over events affecting them
- ❖ Maintaining their identities and self-respect
- ❖ Accepting inevitable outcomes and
- ❖ Feeling good shout them.

MASLOWS HIERARCHY OF NEEDS

PHYSICAL	SAFETY AND SECURITY
Food	Protection from:
Oxygen	Pain
Water	Discomfort
Rest	Punishment
Exercise	Death
Elimination	Losses
Shelter	
Sex	Need for:
	Saneness/Sanity
	Sureness
LOVE AND BELONGING	Familiarity
Affection	Trustworthiness
Approval	Security
Acceptance	Order
Recognition	Consistency

Reassurance	Reliability
	Predictability

SELF ESTEEM	**SELF ACTUALIZATION**
Strength	Self-fulfilment
Achievement	Self-acceptance
Adequacy	Excellence
Mastery	Construct
Competence	Creste
Confidence	
Independence	
Freedom	
Reputation or prestige	
Status	
Dominance	

7.4 Helbert Dunn's Theory

Present serried of needs that is needed by individual to achieve a stage of maximum functioning or high-level wellness. Dunn's basic needs are:

i. Survival
ii. Communication
iii. Fellowship
iv. Growth
v. Imagination
vi. Love
viii) Environment
ix) Communication with the universe
x) Philosophy of living
xi) Dignity
xii) Freedom, and
xiii) Space

In this model, at any point in time, different needs assume a greater relative importance to the individual. Whereas Jourard (1963) believes that people rank their needs according to their relative importance in their lives, he adds the needs for health (physical and mental), Freedom, challenge, Cognitive, Clarity and varied experience to Maslow's list of needs.

Characteristics of Basic Needs

1. All people have the same basic needs, but each person needs are modified by his or her culture. Individual's perception of a need varies according to learning and the standards of the culture e.g. it is not ideal for a woman to

remain unmarried. This may be necessary in a culture or subculture and not be so in another.

2. People meet their own needs relatively to their own priorities. E.g. A mother may feed her baby before feeding herself.
3. Although basic needs generally must be met, some can be deferred e.g. is the need to finish one's education before marriage.
4. Failure to meet needs results in one or more homeostatic imbalances, which can eventually result in illness.
5. A need can make itself felt by either external stimuli e.g. the need for food. A person may experience hungers as a result of thinking about food (internal stimulation) or as a result of food aroma. (External stimulation).
6. A person who perceives a need can respond in several ways to meet it. The choice of response is largely a result of learned experiences and value of the culture.
7. Needs are interrelated. Some needs cannot be met unless related needs are also met. E.g. the need for hydration can be altered if the need for eliminating urine is not met.

In-Text Question

…… assume different needs of human lives for a greater relative importance.

In-Text Answer

Helbert Dunn's theory

NEED SATISFACTION

Needs can be met in healthy and unhealthy ways. Ways of meeting basic needs are considered healthy when they are not harmful to self or others, conform to the individual's socio-cultural values, or is not within the law.

Conversely, unhealthy behaviour has one or more of the following characteristics: It may be harmful to others or to self, does not conform to the individual's socio-cultural values, or is not within the law.

7.4.2 Factors affecting needs Satisfaction

Gauging weather physiologic needs are met is largely on objective judgment. Also gauging whether psycho logic needs have been met is largely a subjective judgment.

If a person's psychological need is not satisfied, then for that person, it is not met, regardless of how she appears to others.

Many factors affect people ability to satisfy needs.

Four of these are

- **Illness**
- **Significant relationship**
- **Self-concept**
- **Development stage**.

1. **ILLNESS**

This frequently interferes with peoples abilities to meet their own needs. Nurses help clients to meet their psychological needs at different levels. E.g. a woman recovering from C/S requires intravenous fluids, assistance in moving and reassurance immediately after the operation. Each of these intervention helps to meet different needs. As these needs are met, the client attends to needs at the next level.

2. **Significant Relationships**

This is the second variable effecting needs satisfaction. Ability to meet people's need is greatly influenced by their significant relationships. These relationships are with family and support persons.

Nurses always establish significant relationship with clients by being present at critical times in people's lives, and a relationship of trust often develops quickly. In the relationship, nurses can help clients to be aware of their needs and establish healthy ways of meeting them.

In-Text Question

……. and …….. are among the factors that affect people ability to satisfy wants

In-Text Answer

Illness and Self-Concept

3. **Self-Concept**

This affects not only his or her ability to meet basic needs but also the awareness of whether or not these needs are satisfied. People who feel good about themselves are more likely to recognize needs, and to establish healthy ways of maintaining these needs.

4. Developmental Stage

According to Erickson's model of psychosocial human development, if an individual satisfactorily achieves the developmental task of learning to trust, then the basic needs of feeling safe and secure are readily resolved. The person who has already learned to trust others transfer those feelings to the health personnel caring for him or her.

7.4.3 Assigning Priorities to Needs

Clients and nurses must adjust the priority of needs. People are continually changing and growing thus their need is dynamic. People have many needs at a time; the nurse may be able to help a client meet several needs at once, partially satisfy a need and then go to next need, e.g. a suffocating client's need for air always assumes first priority.

In some cases, one needs does not stand out of priority number one, hence the client and nurses consider several factors. Some of these factors are:

- **PERCEPTIONS**

This is one's view about something. A client may not perceive that he has a specific need to meet. The nurse may allocate low priority, and defer action until the client is ready. E.g. a grand multipara may not see the need to use any method of family planning or to stop child-bearing.

- **HEALTH**

This is doing something according to one's health i.e. how one's health permits e.g. a person recovering from surgery should not be encouraged to participate in strenuous exercise until his health permits, through exercise is an important need to quick recovery.

- **SOCIAL CULTURAL BACKGROUND**

This affects how people rank their needs e.g. a woman may perceive that getting her husband breakfast is more important than resting in bed.

- **SUPPORT PERONS**

This greatly implicated in what order and how needs are met. E.g. a teenage boy may join a gang because his needs for belonging and esteem are not met in the home.

APPLICATION IN NURSING

1. By understanding human needs, nurses can understand people's behavior better.
2. Knowledge of basic needs can prove a framework for, and be applied in, the nursing process at the individual and family levels.

3. Nurses can apply their knowledge of human needs to relieve distress e.g. To alleviate distress, the nurse requires knowledge not only of needs but also of the situation that brings about this unmet needs and the manner in which the client convey the need.
4. The nurse can use the knowledge of human needs to help people develop and grow.

Summary of Study Session 7

In Study Session 7, you have learnt that:

It explains how an individual interact with and adapts to the environment. As an adaptive system, the person functions as a totality.

- Its absence breeds illness.
- Its presence prevents illness.
- Its restoration cures illness.
- Under certain situation of free choice, it's preferred by a deprived person over satisfactions.
- It is found to be inactive or functionally absent in the heal\thy person.

In this model, at any point in time, different needs assume a greater relative importance to the individual.

People meet their own needs relatively to their own priorities. E.g. A mother may feed her baby before feeding herself.

Self-Assessment Questions (SAQs) for Module 7

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 7.1 (tests learning outcome 7.1)

Explain the Roy's Adaptation model

SAQ 7.3 (tests learning outcome 7.3)

Explain the five Categories in order of priority by Abraham Maslow theory

SAQ 7.4 (tests learning outcome 7.4)

Discuss and explain of Helbert Dunn's theory

Study Session 8: Models of Maternal and Child Health Care II

Introduction

In our previous session, you learnt about Roy's Adaptation theory, Abraham Maslow theory and Helbert Dunn's theory. However, nursing theories describes the relationship of the client and the nurse with health and environment. Scientific theories are applied in each step of the nursing process; therefore nurses must understand some specific things of each theoretical approach for effective use in the nursing process.

For each theoretical approach, the nurse must understand the underlying assumptions, definition of each concept, and interrelationships of the concepts.

Learning Outcome for Study Session 8

When you have studied this session, you should be able to;

8.1 Discuss the Jean- Piaget's Theory.
8.2 Social Relation Theory
8.3 Peplau Interpersonal Model
8.4 Dorothy Johnson theory
8.5 Levine Myrae Model
8.6 Eric Erickson theory

8.1 Jean – Piaget's Cognitive Development Theory

Cognition refers to the way in which we give knowledge through the process of thinking, concept formation and problem solving, imagery and remembering.

Jean Piagets is a French/Swiss psychologist. He postulated this theory by means of observations or experiments with his own three children he followed the cognitive development of infants.

Definition: Piaget views cognitive development as a continuous process of unfolding which passes through a series of maturation stages or levels. Cognitive also include perception, language, concept formation, problem solving, thinking, judging and intellectual potential of a child.

Cognitive development is also the growth demonstrated by human being as they progress from a state of not knowing to knowing.

Explanation of Theory: Piaget's theory is completely different from the ones previously discussed but equal important. It makes little reference to emotional and social development but concentrates more on child's development of cognitive, or intellectual capacities.

These include intelligence, reasoning, language, and concepts of nature and of time space and casualty.

Piaget outlines a very active process in which new experiences are continually being assimilated and used to recognize and expand existing capabilities. These, in turn, prepare the ways of the individual to absorb increasingly complex experiences. The individual seeks to repeat the situations that produce new experiences until such times as they have been completely assimilated.

In-Text Question

……. postulated the theory that cognitive development views by observations or experiments.

In-Text Answer

Jean Piaget's

8.1.1 Assumptions of Piaget's Theory

1. Heredity and environment play important roles in cognitive development i.e. it is possible that an infant possesses all the necessary genetic traits and innate (inborn) Factors for coordination, and not yet is not able to manipulate objects because it has been deprived of playing with things necessary for the development of such skills.
2. Piagets assumes that people have natural tendency to know and would actively work to extend their knowledge. It is for this reason that people interact with their environment.
3. According to Piagets, all living organisms share two things in common i.e. organization and adaptation. Every organization tends to interprets experiences into coherent systems i.e. organizations, e.g. we have a tendency to organize basic sensory information in order to form more complex ideas and thoughts. This innate tendency of an organism to interact with its environment in Piaget's view is called adaptation.

In-Text Question

Piagets assumes that people have natural trend to know and would actively work to extend their …….

In-Text Answer

Knowledge.

There are two ways by which a person can adapt to an environment.

These adaptation techniques are assimilation and accommodation.

❖ **Accommodation**: These cause changes in cognitive structure. When an individual interacts with an environment, the new experience must be fitted into the individual's present cognitive structure. This is known as assimilation. Sometimes a new experience is incompatible with the already existing structure and cannot be fitted into it, then it's necessary for the individual to modify his current cognitive structure to accommodate the new experience.

❖ **Assimilation**: Thus for Piaget, every intellectual act necessitates some intellectual structure while intellectual functioning is characteristic by assimilation and accommodation.

1. Piaget assumes that child's cognitive development passes through a series of major cognitive changes which he terms maturation stages.

In-Text Question

There are …… and …… ways a person can be adapted to an environment.

In-Text Answer

Assimilation and Accommodation.

8.1.2 Stages of Cognitives Development

Major stages of Piagets cognitive growth or development of the child from infancy adolescence. They are:

1. **Sensori Motor** (0 – 2 years from ages 0 – 2 years. i.e. preverbal intellectual development. During this stage of development before the onset of speech, the infant learn by means of its senses (natural reflexes) and by manipulation of objects. Between 1 – 4 months, the infant begins to display the kind of behaviours know as circular, reactions or instrument learning. Means are devised for making new adaptations. During this period the infant consolidates the reflex responses by moving its arms, kicking its legs and performs other bodily activities.

Activities are centered upon the infant's own body such as thumb sucking, hand clasping or foot grabbing – period of self investigation. These circular reactions observed are called primary circulation reactions.

Between about 4 – 8 months, secondary circular reactions appear. Events are no longer centered upon the infant's own body. Instead he reaches out to manipulate objects discovered in the environment.

During this period, object permanence is very weak, i.e. the infant thinks that objects cease to exist if they cannot be seen. Object permanence refers to the ability to represent an object to represent an object whether or not it is actually present.

From ages 8 – 12, the infant begins to direct more attention to his physical environment in order to attain specific goals (goal directed behaviour). By this time, the infant realizes that the object still exists although it may have disappeared from sight. The child will, for example, look for a toy which he has seen hidden. In order words, object permanence becomes stronger during this stage.

By 12 and 13 moths, the child is now preoccupied with experimenting new behaviours Problems solving behaviour and metal combinations of signs, symbols of images are evident between 18 – 24 months. The child no longer depends on physical exploration and manipulation of the environment. His ability to think can lead him to sudden insightful solutions without necessarily using the kinds of trial – and – error exploration. Object permanence is fully developed at this stage.

2. **Pre – Operation Period** (Preschool) 2 – 7 years i.e. Development of the ability to use symbols and language. The child's intellectual development is called pre – operational because he has not acquired the logical operation characteristics of later stages of thought.

This period is divided into two stages they are:

- **Pre – conceptual stage**; 2 – 4 years: During this stage; the child begins to represent his environment with symbol. He develops immature concept with Piaget called pre – concepts. For example, a child at pre conceptual stage may have a general idea that birds have wings and that they can fly but will not know the different type of birds.

The child begins to develop language this time, but is still unable to perform certain cognitive operations. He uses languages to symbolize, yet is still unable to group thoughts in a framework of concept and values. Thus, the reasoning that is taking place here depends very much on language, which is the great instrument, because the product of concept is normally represented by a word.

❖ **Intuitive stage: 4 – 7 years**. This period is called intuitive stage because children beliefs are generally based on what they sense to be true rather than on what logic or irrational thought would dictate. In other words, it is the stage in which children appear to make immediate judgment without conscious mental steps in their formulation.

Children's view are primarily centered on themselves, thus their action are described as egocentric. That is, children generally perceive the world only in terms of their own perspective. The thinking of children at this stage is also characterized by irreversibility in that they are not able to go back and rethink a process or concept, e.g. if a child learns 3 + 2 = 5, he will not be able to solve 5 = 3 +? This is because he has not required reversibility.

This is illustrated by physics as law of conservation of liquid i.e. the notion that liquids and solids can be transformed in shape without changing their volume or mass.

During this stage children are not able to comprehend more than one aspect of a problem at a time.

In-Text Question

…… and …… are the per-operation period.

In-Text Answer

Pre – conceptual stage and Intuitive stage.

3. **Concrete Operations**: 7 – 8 years

Ability to conserve marks the end of the pre-conceptual period and the beginning of conserve operations. It is the acquisition of a workable system for understanding and dealing with the work and using experiences it provides.

An operation is defined as the transformation of one state to another state by means of a logical transformation. The beginning of concrete operation is characterized by appearance of reversible thinking.

They also apply "deterring" to comprehend more than one aspect of a problem at a time.

Children are now able to learn the operations of adding. subtracting, multiply and dividing operations that involve the logical thinking basic to classifying objects, and understanding how they are related.

There is also serialization, which is ability to arrange objects according to weight and sizes.

The operation is concrete because the child's action is based on the object that can be seen and he can internalize by memories, images, languages and symbols in language.

4. **Formal Operations** age 8 – 15 Years (Early Adolesence)

Development of the ability to reason in abstraction.(since formal education can play a part here, not all individuals necessarily reach this fourth stage). The concrete operational period gives away at about the age of 8 years to what Piaget regards as the final period of intellectual development or formal operations.

This period coincides with the adolescent period and is characterized by attainment of the intellectual skills of adult. The child's thought processes become more competent, flexible and reversible. He can solve complex problems, formulate hypothesis and make deductions as a scientist. He is not concerned with the future and remote things. The development of formal operations enables the adolescent to transfer understanding from one situation to another situation.

8.2 Social Relation Theory

Social means living in a group. Relation means interaction. Social relation can therefore be defined as the dynamics of interaction between human beings in society.

Social relation theory deals with human interaction.

Types:

- Exchange theory
- Games theory
- Richl theory
- Peplau's interpersonal model

The writer is going to lay emphasis on the Peplau's Interpersonal model as applied to the health care practice.

In-Text Question

…… means living in a assembly or group.

In-Text Answer

Social

8.3 Peplau's Interpersonal Model

Hildegard Peplau described nursing as a therapeutic interpersonal relationship. This relationship facilities the growth and development of both client and nurse. It helps the client progress toward constructive, productive, and creative living.

Nurses help client to:

- Examine their interpersonal relationships,
- Felt needs
- Problems
- Define
- Understand
- Productively resolve them.

During the relationship, the nurse also examines the attitudes towards the client and the relationship. This helps the nurse to understand the interpersonal dynamics and develop the therapeutical use of self. The nurse uses communication technique, unconditional acceptance, and sympathy.

These skills promote a trusting nurse-clients relationship and promote self-reliance and independent decision-making.

In-Text Question

…….describe nursing as a therapeutic interpersonal relationship.

In-Text Answer

Hildegard Peplau.

Peplau describes four phases, in a goal-directed interpersonal

- Relationship;
- Orientation,
- Identification,
- Exploitation and Resolution.

1. **ORIENTATION**: Refers to the initiation of the relationship when the clients recognizes a felt need or difficulty and seeks professional assistance. Upon mutual agreement, nurse defines the nature of the reciprocal relationship and its purposes. The nurse explains that the collaborative role is identified, examined, and find ways to resolve the client's problem.
2. **IDENTIFICATION**: begins the working phrase. The nurse client relationship develops and strengthens as initial attitudes of the client and

nurses are explored. Their perceptions and expectants of each other are clarified. A trusting relationship may develop if they openly share thoughts and feelings. During this phase, they work to work to identify the client's problems or difficulties.

3. **EXPLORATION**: refers to the discussion of solutions after mutual identification and understand of the clients problems. The clients' roles and responsibilities in resolving problem arte clarified. The client gradually assumes responsibility for control of the problem and decision making. There is progressive independence and self-reliance.
4. During this phrase, the client may test the relationship and experience dependent and independent feelings, rich need to be discussed.
5. **RESOLUTION**: refers to the final phrase as the client and the nurse collaborate to resolve the problem; they also must work through psychological dependency need. They should discuss termination before the last meeting because this prepares them for the final separation. Successful resolution occurs when both of them summarise the relationship, its meaning and accomplishments. This promotes the growth and maturity of both individuals.

8.4 Dorothy Johnson Behaviour Theory

Concepts and assumptions about human beings:

1. The individual is a behavioral system
2. The behavioral system consists of patterned, repetitive, and purposeful ways of behaving that characterize each person's life.
3. Subsystems carry out specialized tasks to maintain the integrity of the whole behavioral system and manages its relationship to the environment. The s**ubsystems** are:

1. Attachment or affinitive
2. Dependency
3. Ingestive
4. Aggressive
5. Achievement
6. Eliminative
7. Restorative

Application of Nursing

GOAL OF NURSING: Behaviour system consists of eight subsystems viz:

1. Afflictive,
2. Achievement,
3. Dependence,
4. Aggressive,
5. Eliminative,
6. Ingestion,
7. Restorative
8. Sexual.

Application of Nursing

ROLE OF THE NURSE: A regulator and controller of behavioral system, stability and equibrium.

SOURCE OF CLIENT DIFFICULTY: Functional or structural stress.

INTERVENTION FOUCSES ON

1) Mechanisms of control and regulation
2) Functional imperatives.

MODE OF INTERVENTION: Actions to facilitate, inhibit, defend or restrain the client in the face of functional or structural stress.

CONSEQUENCES: Efficient and effective Client behaviour.

In-Text Question

The role of Nurse as postulated by Dorothy Johnson theory are ……..

In-Text Answer

- Controller of behavioral system,
- Stability
- Equibrium

8.5 Levine Myrae Conservation Model

Concepts and assumption about human beings:

- ❖ The human is a holistic being-a system of systems.
- ❖ The life process of system is unceasing.
- ❖ A system that has direction purpose, and meaning.

- ❖ It goes through a change which is orderly and sequential, occurs through adaptation, which permits the person to protect and maintain his integrity as an individual.

Myra E. Levine model can be summarized as:
GOAL OF NURSING: Promoting of wholeness
CLIENT: Holistic being: an open system of systems that in its wholeness expresses the organization of all its parts. The person retains his or her integrity through adaptive capability.
ROLE OF THE NURSE: Therapeutic, i.e. to influence adaptation favorably or moves client towards renewed social wellbeing, or supportive, i.e. to maintain the status quo.

In-Text Question
The goal of nurse by Levine Myrae Model says ……
In-Text Answer
Promote wholeness

Application of Nursing
SOURCE OF CLIENT DIFFICULTY: Altered relationship with the internal and external environment.
INTERVENTION FOCUS: enhancing patterns of adaptive response.
MODES OF INTERVENTION: Four conservation principles; actions to conserve energy, structural integrity, personal integrity, and social integrity.
CONSEQUENCES OF NURSING ACTIVITY: Adaptive responses that retain wholeness.

8.6 Eric Erickson Development Theory

Erickson development theory is a descriptive theory, which identifies major elements and their relationship. It describes eight stages of development, which are based on biological, psychological and social events.
He believes that **Ego** is the conscious core of personality; the first five stages are parallel to Freud's psychosexual development stages while the last three occur within the adulthood.

Each stage is characterized by negative and positive experiences and emotional crises. Development means struggling between two poles with experiences of two essential for healthy growth.

Life is pictured as a sequence of achievements. Each stage signalled a task that must be achieved. The resolution of the task achievement the healthier the personality of the person. Failure to achieve a task influences the person's ability to achieve the next task. These development tasks are also seen as a series of crises. Successful resolutions of these crises help the person's ego, failure to solve resolve the crises are damaging to the ego.

He also believes in continuous development througho.ut the life cycle, for possible opportunity for new solutions to problems at each stage.

EIGHT DEVELOPMENT TASKS

1. Trust versus Mistrust
2. Autonomy versus shame and doubt
3. Initiate versus Guilt
4. Industry versus Inferiority
5. Identity versus confusion
6. Intimacy versus Isolation
7. Generativity versus Stagnation
8. Integrity versus Despair

TRUST VERSUS MISTRUST (INFANCY STAGE)

INFANCY-18TH MONTHS

1. **INFANCY STAGE**

(Birth – 18 months) Trust Vs Mistrust

The child learns to trust others but a negative resolution shows mistrust, withdrawal and estrangement. The nurse duty is to educate the mother on the importance of allowing the child to trust them hence trusting others for a positive resolution.

2. **EARLY CHILDHOOD**

(18 Months – 3 years) Autonomy as shame & Doubt

The child begins to test the environment, determining the extent to which the environment can be manipulated. Autonomy develops as the toddler explores and controls self and people in the environment. If independent actions are thwarted or

unacceptable to others, the toddler has compulsive self restraint or compliance with shame and doubt.

3. **LATE CHILDHOOD**

(3 years - 5years) INTIATIVE VERSUS GUILT

The child tries to be secretive during interactions with others and the environment. People's approval fosters initiative. Leaning the degree to which assertiveness and purpose influence the environment. The child begins to develop the ability to evaluate one's own behaviour.

Indicators for negative resolutions result in lack of self-confidence, pessimism, fear of wrong doing with over control and over restriction of own activity.

In-Text Question

…… believes in continuous development throughout the life cycle.

In-Text Answer

Eric Erickson theory.

4. **SCHOOL AGE**

(6 years – 12 years) INDUSTRY VERSUS INFERIORITY

The school age directs energy towards learning knowledge and skills applicable in the real worlds. He is beginning to create, develop and manipulate things, develops a sense of competence and perseverance. Negative resolutions lead to loss oh hope, sense of being mediocre and withdrawal from school peers and feeling inferior.

5. **ADOLESENCE**

(12-20 years) IDENTITY VERSUS ROLE CONFUSION

The individual searches for current and future identity. This is an attempt to integrate life experiences into self i.e. sense of self and plans to actualize one's abilities. His views must be socially acceptance norms and values. Inability to meet this leads to confusion. Indecisiveness, inability to find occupational identity and plan for future life and ambition.

6. **YOUNG ADULTHOOD**

(18-25 years) INTIMACY VERSUS ISOLATION

The young adult seeks relationships with others to acquire a sense of sharing, caring and intimacy. There is intimate relationship with another person and commitment to work and relationship. Indicators of negative resolutions lead to impersonal relationship, avoidance of relationship, career or life style commitments.

7. **ADULTHOOD**

(25-65 years) GENERATIVITY VERSUS STAGNATION

The primary task is satisfaction and generating. These includes work, family, home, citizenship and social activities. There is creativity, productivity and concern for others. Indicators of negative resolution involves self-indulgence, self concern and lack of interests and commitments.

8. **MATURITY**

(65 years to Death) INTEGRITY VERSUS DESPAIR

The older adult is satisfied with life and its meaning, beliefs that life is fulfilling, successful, there is acceptance of worth and uniqueness of one's own life.

Application of Theory to Nursing and Midwifery

Erickson believes that Nurses should be aware of indicators of positive and negative resolution of each stage. It is also important to be aware that, according to Erickson, the environment is highly influential to development.

Nurses can enhance people's development by being aware of their developmental stage, by providing opportunities for the individual to resolve his or her development task, and by helping the person develop coping skills relative to stressors experienced at that level.

He believes that it is important for people to change and adapt their behaviour maintain control their lives. In his view, no stage in personality development can be passed, but people can become fixated at one stage or regress to a previous stage.

For example, a middle-aged woman who has never satisfactorily accomplished the task of resolving identity versus role confusion might regress to an earlier stage when stressed by an illness with which she cannot cope. Nurses should also be aware that people continue to change through life. Therefore, the client admitted into an hospital at age 70 years is not the same client the nurse knew 10 years previously.

Nurses can enhance a client's positive resolution of a developmental task by providing the individual with appropriate opportunities and encouragement e.g. a 10 year old child can be encouraged to be creative, to finish schoolwork and to learn how to accomplish these tasks within the limitations as imposed by health. Resolution of developmental tasks is not absolute, a middle aged man, for example

may feel satisfied about one aspect of life, such as his family yet be occupied about another, perhaps his business.

Summary of Study Session 8

In Study Session 8, you have learnt that:

- Cognition refers to the way in which we give knowledge through the process of thinking, concept formation and problem solving, imagery and remembering.
- Social relation can therefore be defined as the dynamics of interaction between human beings in society.
- Hildegard Peplau described nursing as a therapeutic interpersonal relationship. This relationship facilities the growth and development of both client and nurse.
- The individual is a behavioral system
- The behavioral system consists of patterned, repetitive, and purposeful ways of behaving that characterize each person's life.
- Erickson development theory is a descriptive theory, which identifies major elements and their relationship. It describes eight stages of development, which are based on biological, psychological and social events.

Self-Assessment Questions (SAQs) for Module 8

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 8.1 (tests learning outcome 8.1)

Explain the Jean – Piaget's Cognitive Development Theory

SAQ 8.2 (tests learning outcome 8.2)

Mention the Social relation theory that deals with human interaction.

SAQ 8.3 (tests learning outcome 8.3)

Explain the four phrase of goal- directed interpersonal of Peplau theory

SAQ 8.4 (tests learning outcome 8.4)

Explain the Concepts and assumptions about humans beings of Dorothy Johnson Behaviour Theory

Explain the major concept of Dorothy Orems theory.

Notes on the Self-Assessment Questions (SAQs) for module 8

SAQ 8.1: Explain the major concept of Dorothy Orems theory.

Dorothy Johnson

A person comprises subsystems that must remain in balance for optimal functioning. Any actual or potential threat to this system balance is a nursing concern

Assess the effect of lack of arm function on Terry as a whole; modify care to maintain function to all systems, not just musculoskeletal.

SAQ 8.2:

SAFETY AND SECURITY NEEDS: When basic physical needs are relatively satisfied, the need to feel safe, in one's environment emerges.

This need for safety has both physical and psychological aspect. The person needs to be secured to feel safe, both in the physical environment and in relationships. Under these needs are stability, order, and freedom from fear, protection and sometimes, dependency.

These needs reflect self-protection through the establishment of structure, law, order and limitations

Needs for safety and protection from harm may become more prominent when the individual is threatened by body may become harm as in physical illness or potential injury. Safety needs involve both imminent danger or concerns and potential loss, such as loss of the a spouse or occupational position.

References/Further Readings

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