

NSC502 PUBLIC-COMMUNITY HEALTH NURSING IV



NATIONAL OPEN UNIVERSITY OF NIGERIA

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COURSE GUIDE

NSC502 PUBLIC-COMMUNITY HEALTH NURSING IV

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MODULE 1 Health Need and Assessment

UNIT 1: IDENTIFYING HEALTH NEEDS

INTRODUCTION

The pattern of health services frequently reflect only the health needs of the population that it is serving while those with greatest needs receive least attention because they were minority and not identified. This is what increased interest in continuous need assessment of the communities. Again, there is a pressure on the allocation of scarce healthcare resources to those in need of it also increased the need of health assessment provide a method of monitoring and promoting equity in the provision and use of health services and addressing inequality in health.

2.0 Objectives: At the end of this unit you should be able to

- (1) State the importance of health need assessment.
- (2) Outline the uses of health need assessment and types of health needs
- (3) Discuss different health assessment approaches

- (4) Describe steps of assessment of health need project.
- (5) Describe the use of SWOT and PESTEL analysis.
- (6) Outline the characteristics of healthy community.
- (7) Discuss the application of Gordon Health Pattern in public-community health nursing assessment.

3.0 Main Content

3.1 Importance of health assessment

Health need assessment is defined as a systematic method of reviewing the health needs and issues facing a given population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (HAD 2005).

Health need assessment provide the following opportunity for:

1. Describing the pattern of disease in the local population and the differences from local, state and national disease patterns.
2. Learning more about the needs and priorities of their patients and the local population.
3. Highlighting the areas of unmet need and providing a clear set of objectives to work towards meeting these needs.

4. Deciding rationally how to use resources to improve their local population's health in most effective and efficient way.
5. Influencing policy formulation in health,
6. Help in identifying inter-agency collaboration
7. Help in conduct of research in research and
8. development priorities

Information gained from on health need assessment is the basis for designing and implementing programme of health and healthcare that is acceptable and accessible to the Local Community as is based on evidence of cost-effectiveness. It is also the primary means of allocating scarce health and public health resources to individual and communities with the greatest need.

3.1.2 The use of health need assessment:

1. **Planning:** This is the central objective of need assessment, to help decide what services are required, for how many people, the effectiveness of the service, the benefits that will be expected and at what cost.

- 2. Intelligence:** Gathering information to get an overview and an increased understanding of the existing healthcare services, the population it serves and the population's health needs.
- 3. Target Efficiency:** Having assessed needs, measuring whether or not resources have been appropriately directed.
- 4. Involvement of Stakeholders:** This is carrying on health need assessment, can stimulate the involvement and ownership of the various players in the process.
- 5. Equity:** Improving the spatial allocation of resources between and within different groups. Equity may be horizontal or vertical. The horizontal equity is concerned with the equal treatment of equal needs irrespective of socio-economic background. This means that to be horizontally equitable, the healthcare allocation system must treat two individuals with the same complaint in an identical way. While vertical equity is concerned with the extent to which individuals who are unequal should be treated differently. This means unequal treatment for unequal need in order to achieve equal health status.

3.1.3 NEEDS: Needs is a critical concept in the pursuit of efficient healthcare and is equally critical to the development of services that are equitable. In healthcare need has a variety of meanings that may change over time, so it is not surprising that different groups of health professionals refer to needs assessment in different ways. There are four types of health needs:

1. **Normative Needs:** This is distinguished by professionals such as vaccination.
2. **Felt need:** Wants, wishes and desires of the community or individuals
3. **Expressed needs:** Vocalized needs or how people use services.
4. **Comparative need:** These are needs arising in one location may be similar for people with similar socio-demographic characteristics living in another location.

In public health context health need exists only if there is capacity to benefit from the particular health care service. So, need is

different from demand, which arise when someone with a need for care expressed it. Need is a measurable change in health status attributed to the intervention. Health demand is what people ask for. It is not necessarily what they need. They may not benefit from their demand. Health supply is the healthcare interventions and services that are available to the population, including the resources that made it available. Health supply depends on the interests of health professionals, the priorities of politicians and the amount of many available.

3.2 HEALTH NEED ASSESSMENT APPROACH

There are four approaches that could be used for need assessment, they are:

1. **Epidemiology:** The advantage of this approach is that it gives overall figures of numbers likely to have specific problems.
 - It is relatively quick and easy.
 - It identifies the broad range of clinical conditions.
 - It is systematic and objective.

The disadvantages are:

- It assume uniform prevalence, although can be weighted for known risk factors.
- It is only possible for some conditions where there is straightforward means of identification.
- There is frequent lack of existing local epidemiological data and lack of evidence for certain interventions.
- It is costly and time consuming.

2. **Comparative:** The advantages are:

- It sets local service provision against national norms.
- It is good for identifying inequalities.
- It uses existing data and multiple sources of information.

The disadvantages are:

- The relationship is unclear between provision, utilization of services and actual needs.
- It assumes that the intervention rate in the area where it is higher is the correct one.
- It fails to take account of difference rates or of previous treatment.

3. **Corporative:** The advantages include:

- It involves local healthcare providers and local people.
- It is responsive to local concerns and fosters local ownership of the issues.

The disadvantages are:

- If carried out in isolation, many determine demands rather than needs and stakeholder concerns may be influenced by the political agenda.
- Risk legitimizing existing patterns area of care that many have little rational basis.

4. **Rapid Appraisal:** the advantages are:

- It is good for community profiling.

Highly participative

Health need assessment is defined as a systematic method of reviewing the health needs and issues facing a given population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (HAD 2005).

Information gained from on health need assessment is the basis for designing and implementing programme of health and healthcare that is acceptable and accessible to the Local Community as is based on evidence of cost-effectiveness. It is also the primary means of allocating scarce health and public health resources to individual and communities with the greatest need.

3.3 STEPS OF HEALTH NEED ASSESSMENT OF PROJECT

1. STEP 1: Getting started

The aims of this step are;

- Identify the population.
- Identify what is to be achieved.
- Identify the needs.
- Identify resources that are required
- Identify the risk.

The outcomes of this step include:

- State clear definition of the population that are to be assessed and rationale for the assessment and its boundaries.

- Agreement to proceed with allocation of resources required for the project.
- Identify the project lead and steering group.
- Policing the project in place with timescales for each task.

2. **STEP 2: Identifying health priorities.** The aims of this step include:

- Population profiling
- Gathering data
- Perceptions of needs
- Identifying and assessing health conditions
- Identifying determinant factors.

The outcomes for this step are:

- List of health priorities identified for the profiled population with a profile of these issues.
- Using the impact and changeability as explicit criteria.
- Determine limited number of overall health priorities.
- Check these with the steering group and other stakeholders.

3. Step 3: Assessing a health priority for action:

The aims of this step are:

- Assessment of a specific health priority for action.
- Determining effective and acceptable interventions and actions.

The expected outcomes are:

1. Select factors that have most significant impact on health functioning for the selected priority.
2. Focus the action on reducing health inequalities for the health priority.
3. Acceptable and cost-effective actions to improve the selected health priority are identified.

STEP 4: Planning for change: The aim of this step are to

- Clarity aims of intervention.
- Action planning
- Monitoring and evaluation strategy
- Risk management strategy

The expected outcomes of this step are:

- Agree on aims, objectives, indications and target.
- Set out the actions and tasks needed to undertake to achieve the aims and objectives.
- Agree on how to evaluate the programme.
- Identify the risk and how to manage them.

STEP 5: Moving on/Review

The aims of this step are:

- State what is learnt from the project.
- Measuring impact.
- Choosing the next priority.

The outcomes of this step include:

- What went well and why?
- What did not went well and why?
- Is there any further action required?

3.4 COMMUNITY HEALTH NEED ASSESSMENT

The community health need assessment is a process that described the state of health of local people that enables the identification of the

major risk factors and causes of ill health and actions needed to address these.

Health profiling is a method by which needs are assessed and used mainly quantitative data. The health profile information includes:

1. Characteristics of the population

- Geography
- Number
- Age distribution
- Gender distribution
- Ethnicity and religion
- Population trends
- Educational factor

2. Health status of population

- Mortality
- Morbidity
- Low birth weight
- Disease prevalence
- Health behaviours

- Use of local health services

3. Local Factors affecting work and employment

- Poverty and income
- Environment
- Transport
- Access to leisure services

4. Health concerns and priorities of the Local Community

- Interviews
- Focus groups
- Community/residence survey

5. Local and national priorities and targets

The purpose community health analysis is to identify the key issues that the organization is to address.

3.4.2 The framework for community assessment:

1. **SWOT ANALYSIS:** This is an analysis of strengths, weakness, opportunities and threats. It provides a simple framework to evaluate the current public health services.

STRENGTHS are aspect of public health which are delivered well and are meeting the needs of the local population, **WEAKNESSES** are aspects which are not achieving targets or making a difference to public health. Strengths and weaknesses often relate directly to the internal environment of the organization in terms of how well current resources are being used in the delivery of public health.

OPPORTUNITIES are those aspects that can only be capitalized upon if there are sufficient and appropriate resources to meet the challenges posed. **THREATS** are relate to the aspect that the capabilities to deal with the problem do not exist. Opportunities and threats are related to the external environment of the organization.

SWOT analysis is normally presented as a matrix and should be limited to those factors that have most impact so that attention can be concentrated upon them. Factors identified through the SWOT analysis many fit into more than one category, so something that is seen as strength may also be identified as a threat. The SWOT analysis aims to identify internal strengths to take advantages of

external opportunities and to avoid threats whilst addressing weaknesses.

2. **PESTEL ANALYSIS** This is related to the following factors:

Political, Economic, Socio-cultural, Technological, Environmental and Legal factors that provide a framework to analyze and categorize environmental influences impacting upon public health.

A PESTEL analysis enables the identification of public health opportunities provided by environmental conditions as well as current or emerging threat.

The SWOT and PESTEL analysis provide a view of how well the current public health strategy is being achieved and what the future challenges may be. In order to develop a meaningful public health strategy, a need assessment will also be undertaken.

COMBINING SWOT AND PESTEL ANALYSIS TO TEENAGE PREGNANCY

STRENGTHS		WEAKNESS	OPPORTUNITY	THREATS
Political	Existing policy	Socio-cultural	Partnership and	Lack of

	from work	influence	collaboration working practices	community engagement
Economic	Reduce cost of health	Might come from new finance	Cross boundary commissioning	Reduce functioning
Socio- cultural	Building for the future, young people, friendly, positive life style	May perpetuate social boundaries, entire negative belief	Positive influence and healthy life style choice	Misunderstanding of the purpose
Technology	To utilize modern advances in the field	Technology increase cost	More efficient and effective services	Lack of knowledge and skills
Environment	Facilitators	High cost due	To be part of	Negative press

	that are accessible and equitable	to location limited interagency working	community infrastructure based on local needs	
Legal	Meets trust performance targets	Preventing objections	Promote positive understanding of the law	Risk assessment could restrict the development

3.5.1 HEALTHY COMMUNITY

Health protection is a branch of public health that seeks to protect the public from and limit exposure to hazards that may be harmful to health. It is concerned with the prevention, investigation and control of infections as well as environment hazards. Health protection is also concerned with readiness for emergency situations that may impact on human health, including act of terrorism and the deliberate release of hazardous agents.

Public health nurses are involved in health protection through a variety of primary, secondary and tertiary interventions aimed at reducing the incidence of diseases and its consequences and of promoting wellbeing in affected individual or group.

The Community/Public Health Nurse is concerned with the health of the individual, the family, populations and the community. A healthy community is one which residents are happy with their choice of location and which exhibits characteristics that would draw others to the location.

3.5.2 CHARACTERISTICS OF HEALTHY COMMUNITY

The component or characteristics of a healthy community include:

- Low crime rate.
- Good school
- Strong family life
- Robust economy (good job)
- High environmental quality
- Accessible quality health services
- Adequate housing

- Civic involvement
- Nice weather
- Good transportation
- Leisure activities
- Exposure to the arts
- Reasonable taxes

Screening is the process of using clinical test and/or examination to identify patients who required diagnosis and additional health-related interventions. The goal of screening is to differentiate correctly between persons who have a previously unrecognized illness, developmental delay or other health alteration and those who do not. Screening recommendation most often used for health screening events and routine health care appointment are based on clinical research and evidence-based preventive care.

3.6 APPLICATION OF GORDON'S HEALTH FUNCTIONAL PATTERN IN PUBLIC-COMMUNITY HEALTH ASSESSMENT

OBJECTIVES

At the end of this section of the unit you should be able to:

- (1) Use Gordon's Health Functional Pattern to assess both family and community that are at-health-risk.
- (2) List areas to focus in family and community health-risk-assessment.
- (3) State the characteristics of family and community at-risk in different health patterns
- (4) Outline the at-risk-families and communities
- (5) State some nursing diagnosis for family and community at-risk

Gordon's health Functional pattern include :

3.6.1 Health perception- health management patterns:

According to Gordon (2008) health perception – health management patterns should be assessed because it verifies family and community perception of their medical problems and help to clarify misconception and adherence to the therapeutic regimen. It also helps to identify health behaviours and other values that promote or impede proper health behaviours.

Family assessment; It involves current health and well-being, health risk and disease management, age-appropriate immunization and health care utilization.

Characteristics of at-risk family in this pattern include

- History of absent from school by children in the family
- Absent from work by adults in the family
- Low income and
- Over crowding
- Low age appropriate immunization coverage

Nursing diagnoses: - Ineffective family therapeutic regimen management, Readiness for enhanced immunization status. Here the nurse take action to integrate into the family processes a programme for treatment of illness.

Community assessment: -The nursing assessment focuses on

- Health education programme and activities
- Hospital, clinic and related organization
- Future health planning
- School health programme

The characteristics of community at risk in this pattern are

- History of epidemic
- Heavy industries
- Disaster
- High accident rate
- Bad road condition
- Poor health facilities
- Inappropriate food handling
- No on-going health promotion activity
- Low ratio of health professional
- High alcohol drinking pattern
- High drug use
- High incidence of sexually transmitted disease.

Nursing diagnosis

- Ineffective community therapeutic regimen management.

Plan to integrate into community programmes what will help to improve treatment of illness and eliminate unsatisfactory methods.

Tips; Consider the culture of the people and use community representatives for interview.

3.6.2 Nutrition-metabolic patterns

Family Assessment:-The assessment should focus on

- Family pattern of food and fluid intake
- The presence of household member during mealtime
- Dietary restrictions and related problems

- Use of food aids
- Available food types
- Food storage,
- Meal preparation
- Family menu
- Water supply and storage system

Family at risk in nutrition-metabolic pattern

The characteristics of family at risk are

- Low income
- Deficient knowledge of daily nutrient requirement
- Frequent use of fast-food meals by the members
- Presence of malnourished member

No Nursing diagnosis for family

Community assessment:- Focus on

- Water supply
- Food hygiene
- Nutritional needs of the population
- Available food commodities

Characteristic of community at risk; include

- Inadequate financial resources
- Lack of regulation of food handling
- Lack of food inspection and supervision
- High rate of infant malnutrition
- Displaced people

No nursing diagnosis for community

3.6.3 Elimination Pattern

Elimination pattern of a family involves handling of wastes and disposal of hazardous and non-hazardous material which has to be disposed in a way that do not risk or contaminate the environment.

It is focused on

- Family disposal of garbage
- Disposal of human and animal waste and related hygiene practices

Characteristics of family at risk

- Lack of toilet hygienic practices
- Improper animal waste disposal
- Inadequate water for dish washing and other domestic activities
- Open garbage that attract flies

Nursing diagnosis; Risk for infection and risk for contamination

Community assessment; focus on

- Community industrial waste
- Auto emission
- Contamination of underground water
- Workers exposed to chemicals

Characteristics of community at risk

- Underdeveloped sanitation codes
- Absence of laws protecting food, water supply and environment
- History of industrial air, water and environmental pollution

Nursing diagnosis

- Risk for contamination,
- Impaired elimination pattern,
- Ineffective Refuse Disposal System

3.6.4 Activity – Exercise Pattern

Activity – exercise describes family pattern of activities, exercise, leisure and recreation. It include how the family budgets time and resources in order to

organize its activities of daily living such as working, dependent care, self-care, cooking, shopping, cleaning and home maintenance.

Family at risk

The characteristics of family at risk in this pattern are

- Time constrain e.g. job
- Knowledge deficit on time management
- Fatigue
- Members with disability
- Insufficient budgeting of family finances
- Low income

Area to focus on nursing assessment

- Shopping pattern
- Schedule keeping for members – children activity
- Meal preparation
- House keeping
- Budgeting for food, clothing and holiday

Nursing diagnosis

No family diagnoses but the following are relevant for family in child-bearing age.

- Developmental delay in self-care skill

Community assessment:-

Activity – exercise pattern describe the type, quantity and quality of leisure and recreation programme available to various age groups in the community. These include.

- Senior centre
- Teenage recreation centers
- Housing and transportation
- Amusement park
- Zoo
- Botanical gardens

At risk community:-The characteristics of at risk community include

- High crime rate that restrict movement
- High rate of juvenile delinquency
- Low rehabilitation services
- Inadequate transport system
- Inadequate community centers
- Inadequate playground
- Housing-low income – high income
- Cultural programmes (community festivals)
- Environment friendly for handicaps

No community diagnoses in this pattern

3.6.5 Sleep – rest pattern

Family assessment:- The problem of sleep-rest pattern may arise from environmental factors such as

- Sleeping arrangements
- Sleep interruptions
- Outside noise
- Patterns of life of family members
- Night-time routine

The characteristics of family at risk include

- Disorganized lifestyle
- Living in overcrowded housing
- Members who do shift work
- Nocturnal neighbourhood activities

Focus on assessment

- Preparing for work and school
- Sufficient space
- Quiet, dark sleeping space available
- Young baby in family
- Enough time to sleep

Nursing diagnoses; Disturbed sleep,

Community assessment

The assessment is focus on environmental factors and should be obtained from the residents and it can also be observed in the environment to see if it is conducive for sleep and rest.

At risk community:- The characteristics of at risk community in the pattern of rest-sleep include

- Housing built along a major highway or busy city street
- Housing built near an airport
- Housing built on late-closing commercial areas.

Housing diagnoses – none yet

3.6.6 Cognitive – perception pattern

Family assessment

The assessment of family on cognitive-perception pattern is focus on

- Family patterns of problem – solving and decision making
- Information and information gathering strategies.

Family identity include

- Nuclear family – parent and children
- Extended family – relations

Family self-esteem include

- Quality of relationship
- Cohesion of member
- Concern for each other

Family self-competency is ability to handle

- Daily activities
- Financial matters
- Plan for the future

- Family stress

At risk family:- The characteristics of at risk family include

- Financial difficulty
- Drug abuse
- Alcohol abuse
- Homelessness
- Members of a minority cultural group

Nursing diagnoses; Ineffective Impulse control,

Community Assessment: The self-perception self-concept pattern describes community members perception of community self-image, identify and stability. This includes amount of culture, age, racial, and socioeconomic diversity of the community and attitude toward minority groups within the community.

Community at risk: The characteristic of at risk community in this pattern include

- High crime rate
- Littering of street
- Changing demography
- Racial or ethnic tension
- Unemployment
- Teen suicide
- School bullying
- School dropouts

No community diagnosis

3.6.7 Role-Relationship pattern

Family Assessment

In the family, relationships vary in intimacy and roles. Roles vary according to the position in the family like.

- Father
- Mother
- Marital status

- Socio-political position
Traditionally family provides an environment for individual growth and development with focus on
- Physical
- Psychological
- Moral and
- Spiritual well being

Family of risk: the characteristics of at risk family include

- **Family members with a diagnoses of terminal illness**
- Death of a family member
- Immigrant family with lack of pre-departure support
- Recent retirement
- Divorce or separation
- History of domestic violence or abuse
- Prolonged caregiving to a member

Nursing Diagnosis

- Interrupted family process (specify)
- Dysfunctional family process (Alcohol, psychosocial etc)
- Readiness for enhanced family process,
- Disorganized family behaviour

Community Assessment: The assessment on this pattern focus on

- Opportunities for community to provide social amenities
- Composition of community includes age group ethnic group and racial group.
- Relationships among ethnic, racial and age group
- Resources including natural resources, and healthcare
- Law and regulation that govern role-relationships that maintain the structure of the community.

At risk community: The characteristics of community at risk includes

- History of ethnic or racial problems or violence

- Isolation of ethnic or racial group
- Tensed relationship amount groups
- People feeling powerless over political issue that affect their lives
- Lack of community senior centre
- Lack of spiritual programmes
- Inadequate mental health services
- High rate of school dropouts
- High divorce rate

3.6.8 Sexuality-Reproductive pattern

Family Assessment: the family sexuality-reproductive pattern focuses on

- Martial relationship
- Sexual relationship
- Family planning
- Ability to educate and counsel children on sexual matters

Family at risk: The characteristics of at risk family include

- History of domestic violence
- Verbal abuse
- Present loss of significant other
- Death of a child
- Knowledge deficit regarding sex education
- Lack of privacy in the home
- Stress from job,
- Family finances
- Chronic illness of a member
- No specific nursing diagnosis

Community Assessment: Social, cultural, religious diversity and national, state and local laws affect the community in many ways such as

- Selling printed materials
- Pornographic video
- Acceptability of radio and TV content
- Abortion laws

- Marriage licensing and age allowed
- Sex education
- Reproductive issues

Community of risk: the characteristic of at risk community in this pattern include

- Increasing member of teen pregnancies
- Few community controls on adult entertainment including movies,
- Insufficient crime preventive measures
- Lack of organized crimes control centres
- Insufficient prevention and treatment clinic for STDs
- High rate of divorce

No specific Nursing diagnosis

3.6.9 Coping-stress tolerance pattern

Family assessment

Family mobilizes human and materials resources enable members to withstand stressors when the occur, family may involve through

- Role relationship changes within the family
 - Formally dependent members assume caregiving role
 - Calling upon social network and community resource for assistance
- The nurse should focus on
- Current stresses on family function
 - Coping strategies available
 - Effectiveness of the coping strategies

Family of risk: The at risk family is characterizing by

- Lack of time for interaction or communication
- Financial problems
- Multiple stresses within a short period
- Overwhelming responsibilities
- Unresolved needs like food, clothing and housing
- Illness or disability of a member

Nursing Diagnosis

- Compromised family coping
- Disabled family coping
- Readiness for enhanced family coping

Community Assessment

Community coping involves mobilizing people and materials to deal with the problem. The community

- Minimize the possible event
- Planning for event
- Mobilize resources

The stressor may be disasters like

- Tornadoes
- Hurricane
- Coal mine disasters
- Large industrial accident
- Terrorist attacks
- Volatile demonstration

Community at risk

Characteristics of at risk communities include

- Political conflict interfering with law and order
- Inadequate financial resources
- Inadequate training of health-care providers for emergency
- Community feeling helpless to a problem
- Inadequate emergency medical system, including police and fire services
- High crime rate
- Lack of respect for constituted authority
- Inadequate communication infrastructure for handling major community stressors

Nursing Diagnosis

- Ineffective community coping
- Readiness for enhance community coping

3.6.10 Value – belief pattern

Family Assessment

Family assessment should focus on values and beliefs of the family.

The family has the responsibility for passing on to children

- Cultural and moral values
- Spiritual values and beliefs
- Family tradition
- Meaning and value of relationships
- Interconnection of family members
- Meaning of family life

Spiritual values can give hope and comfort during family transitional, physiological or psychological crises situation.

Family at risk: at risk family is characterized by

- Single-parent family without
- Extended family support
- Recent death of a family members
- Drug alcoholic abuse issues
- Poor family and neighbourhood role
- Recent retirement of family members
- Social rejection or alienation
- Terminally ill family members
- Family member with depression

Nursing diagnosis; hopelessness, spiritual distress, Readiness for enhanced spiritual well-being

Community Assessment

The focus is on

- Provision of spiritual support through building worship centers
- Provide opportunities for people to get to know each other and serve as support system for each other when necessary
- Supporting businesses that serve needs and values of the community
- Facilities development projects

Community at risk

The characteristics of at-risk community are

- conflict among adults
- lack of concern for community aesthetics such as flowers and clean streets
- lack of support for libraries, museums and cultural resources
- discriminatory practices
- lack of support to community organizations

No community diagnosis

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UNIT 2 COMMUNITY HEALTH PLANNING

Introduction

Health planning is a continuous social process by which data about clients are collected and analyzed for the purpose of developing a plan to generate new ideas, meet identified client needs, solve health problems and guide changes in healthcare delivery.

2.0 OBJECTIVES

At the end of this unit you are expected to:

- (1) Discuss nursing process as applied to public health nursing
- (2) Identify steps involved in planning community project
- (3) Make community Diagnosis
- (4) Identify Community Planning Group
- (5) Conduct community programme evaluation
- (6) Discuss steps in evaluation of programme plan.

3.0 Main Content

3.1 Community Health Programme planning

A population –focused health planning is the application of a problem-solving process to a particular population. In population-focused health planning, communities are assessed, needs and problems are prioritized, desired outcomes are determined and strategies to achieve the outcomes are delineated.

Population-focused health planning can range from planning health care for a small group of people to planning care for a large aggregate or an entire, city, state or nation. Increased costs have placed heavy demands on the healthcare system which makes health planning essentially economically focused. Nursing process describe the components of and steps used in programme planning, the types of interventions appropriate for the community level, and the responsibilities of a public –community health nurse in planning and implementing care with population. The nursing process is dynamic as the needs of community are dynamics.

ASSESSMENT AND ANALYSIS	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
It includes community members in process	It identifies health issues and problems	Involve community leaders	<ul style="list-style-type: none"> - Select intervention. - Health education - Screening - Direct health service 	<ul style="list-style-type: none"> - Outcome - Community

3.2 STEPS OF PROGRAM PLANNING IN COMMUNITY HEALTH

The planning process consists of a series of specific steps. Occasionally, several steps may be taking simultaneously or they may occur in slightly different order. The steps are as follows:

1. Assessment
2. Diagnosis
3. Validation
4. Prioritization of need
5. Identification of the target population

6. Identification of the planning group
7. Establishment of the programme goal
8. Identification of possible solutions
9. Matching solutions with at risk aggregates
10. Identification of resources
11. Selection of the best intervention strategies
12. Delineation of the intervention work plan.
13. Delineation of the intervention work plan
14. Planning for programmes evaluation.

Steps 8 to 14 are called operations planning. It should be noted that these 14 steps are included in the nursing process.

3.3 COMMUNITY DIAGNOSIS

After analyzing the data, the next step is to make a definitive statement (diagnosis) identifying what the problem is or the needs are. Nursing diagnosis for communities may be formulated based on the following issues:

1. Inaccessible and unavailable service.
2. Mortality and morbidity rates

3. Communicable disease rate
4. Specific population at risk for physical or emotional problems
5. Health promotion need for specific populations
6. Community distinction
7. Environmental hazards

3.4 IDENTIFICATION OF THE PLANNING GROUP

The nature and extent of the community's needs determine who should be involved in developing the plan. Consideration should be given to:

1. Persons for whom the plan is designed, that is, the target population.
2. Those who are concerned with health problem.
3. Those who appear best able to contribute resources to the plan.
4. Those who are most likely to follow through in carrying out the plan of actions.
5. Leaders of the groups eg women leaders
6. Political leaders
7. Religious leaders

3.5 COMMUNITY PROGRAMME EVALUATION

Evaluation is the process by which a nurse judges the value of nursing care that has been provided. Public community health nurse seeks to determine the degree to which planning were achieved and to describe any unplanned results.

The purpose of evaluation is to facilitate additional decision making.

Evaluation is based on several assumptions;

- That nursing actions have results, both intended and unintended.
- That nurses are accountable for their actions and care provided and
- That different set of actions results in resources being used differently.
- Evaluation involves two parts
- Measurement and
- Interpretation

In nursing process, the idea of measuring is to be sure if planned goals were achieved. This is the same as if results are outcome attainment, performances evaluation, results of effort and Evaluation

of effectiveness. The result may also be described appropriate i.e. suitable for a particular occasion or use.

- Adequate – able to fill a requirement.
- Effective – producing an expected results

Evaluation of effectiveness of care that takes place after the interventions have been performed is known as summative evaluation while formative evaluation is evaluation that occurs throughout the nursing process but before the outcome of care.

3.6 STEPS IN EVALUATION

Plan the Evaluation:

1. Review goals and objectives
2. Meet with stakeholders to identify which evaluation questions should be answered.
3. Develop a budget for evaluation.
4. Determine who will conduct the evaluation.
5. Develop the evaluation design (what will be done)
6. Decide which evaluation instruments will be used to collect information.

7. Analyze how the evaluation questions relate to the goals and objectives.
8. Analyze whether the questions of stakeholders are addressed.
9. Determine when the evaluations will be conducted (develop a timeline)

COLLECT EVALUATION DATA

10. Develop specific processes for collecting data through questionnaires, review of records or documents, personal interviews, telephone interviews and observation.
11. Determine who will collect the data.
12. Pilot the data collection instrument.
13. Refine the instruments based on data from the pilot.
14. Identify the sample of persons from whom evaluation data will be collected.
15. Collect the data.

ANALYZE THE DATA

16. Determine how the data will be analyzed.
17. Determine who will analyze the data.

18. Analyze the data, generate several interpretations and make recommendation.

REPORT THE EVALUATION

19. Determine who will receive results.

20. Determine who will report the findings

21. Determine format for the report, including and executive summary.

22. Discuss how the findings will affect the programme.

23. Determine which findings will be included in the report.

24. Distribute the report.

IMPLEMENT THE RESULTS

25. Plan how the result will be implemented.

26. Identify who will implement the result.

27. Determine when the result will be implemented (develop a timeline).

3.7 HEALTH RISK APPRAISAL

The health risk appraisal is a method for estimating an individual's health threat due to demographic behavioral and personal

characteristics. The personal risk profiles are developed based on information from laboratory and other assessments.

One goal of the health risk assessment is to collect and organize personal data to provide an accurate, individualized assessment of risk factors that may lead to health promotion. A second goal of health risk assessment is to stimulate the necessary behavioral changes that may reduce health risk.

3.8 SCREENING

Screening is the process of using clinical test and/or examination to identify patients who required diagnosis and additional health-related interventions. The goal of screening is to differentiate correctly between persons who have a previously unrecognized illness, developmental delay or other health alteration and those who do not. Screening recommendation most often used for health screening events and routine health care appointment are based on clinical research and evidence-based preventive care.

UNIT 3: EPIDIMIOLOGICAL PERSPECTIVE

Introduction

Epidemiology is the investigate study of disease trends in populations for the purposes of diseases prevention and health maintenance. Epidemiology and relies on statistical evidences to determine the rate of spreads of diseases and the population of people affected by the diseases. It is used to evaluate.

- (1) Effective of disease prevention and health promotion activities.
- (2) It is used to determine the extent to which goals of health promotion is active.
- (3) It is used to determine diseases prevention initiatives have been met.

Objectives:-

At the end of the unity you should be able to:

- (i) Discuss the role of epidemiology in Community Health Nursing
- (ii) Describe the use of epidemiology in community health nursing.
- (iii) Identify the epidemiological triangle
- (iv) Discuss the types used in the epidemiological process.
- (v) Use proportion and ration to determine disease incidence, prevalence, morbidity rate and outlook rates.

3.0 Main Content;

3.1 Definition of Epidemiology

Epidemiology is useful for public-community based nursing in providing a broad understanding of the spread and transmission of disease. This understanding often forms the basis of community health presentation using the scientific problem – solving method, the nurse is able to pinpoint health needs in the community and develop appropriate approaches. Community/public health nurses are in the unique position of being able to identify cases, recognize patterns of diseases, eliminate barriers to disease control and provide education and counseling targeted of a disease condition or specific risk factors.

Epidemiology refers to the study of the distribution of diseases in human population against the background of their total environment. It includes the study of pattern of disease as well as a search for the determinants of disease.

3.2.1 Epidemiological Process

Epidemiological process involves the following steps

1. Determine the nature, extent and possible significant of the problem. During the step, the nurse collects information from as many sources as possible. This information is then used to determine the scope of the problem.
2. Utilization of the gathered data formulate a possible theory. At this top, the possible explanation are projected and explored for consideration.
3. Gather information from a variety of sources in order to narrow down the possibility. At this step assessment of all possible site to gather information related to the disease process. The plausibility of the proposed hypothesis is evaluated.
4. Make the plan: In this step of the process, the nurse focuses on breaking the cycle of disease. All factors influencing the spread of the disease must be considered and identified. Priorities are established to break the chain of transmission and to control the spread of the diseases.
5. Put the plan into action: The nurse use all available means, the plan for controlling the disease is put into actions.
6. Evaluation of plan: The nurse gathers all pertinent information to determine the success of plan. Using this plan, evaluate the success in prevention of the spread of the diseases.
7. Report and follow up: The nurse synthesizes evaluation data into a format that is understandable. Evaluate success and failures and base follow-up on the evaluation information.

3.2.2 Epidemiology method:- The basic tool of epidemiology is rate – That is relating the number of cases to the population at risk. The rate is expressed as the number of events is on arbitrary total.

- (1) Incidence: This describe the new cares. It is calculated by

$$\frac{\text{Total number of new cases detected} \times 1000}{\text{Total population}}$$

- (2) Prevalence: This is the existing disease in a particular population at a particular time.

$$\frac{\text{Total number of cases in population of a specific time} \times 1000}{\text{Total population}}$$

- (3) Mortality rate: The rate of death per 1000 no of death X 1000
Total population

- (4) Mortality rate or attack note

$$\frac{\text{No of people at risk, who developed \& certain disease}}{\text{Total number of people at risk}}$$

3.2.3 Design of Epidemiological Study

The three designs of epidemiological are:

- (1) Descriptive epidemiology:- This is a study in which the distribution of disease is described in terms of the three major variables: people, place and time.
- (2) Analytical epidemiology which is divided into two types
 - (i) Case: Control studies:- In this type a group of affected people is compared with a suitable matched control group of non-affected persons.
 - (ii) Cohort study:- In this study a group of persons who are exposed to the suspected aetiological agents are compared with matched control subjects who have not been similarly exposed.
- (3) Experimental epidemiology:- This involved studies in which one group which is deliberately subjected to an experience is compared with a control group which has not been a similar experience.

3.3 COMMUNICABLE DISEASES

Communicable diseases are characterized by the existence of a living infectious agent which is transmissible. Epidemiology involved the study of the relationships

among an agent, a host and on environments. These three are referred to epidemiology triangle. Their interaction determines the development and cessation of communicable diseases. They form a web of causalities which increases or decreases the risk for disease.

AGENT: This is the animate or moninole object that causes the disease they include:

- (a) Infectious agents that way be viruses, bacteria or fungi.
- (b) Physical agents that way be trauma, genetics, noise and temperature
- (c) Chemical agents that may be drugs, fumes and toxins

HOST:- This is the living being that will be affected by the agent. The host may be.

- (a) Susceptible individuals with altered immunity
Altered resistance
Risk characteristics like genetics, gender age, physiological status, prior disease state social class, cultural group and occupation.
- (b) Non-susceptible host are those with active immunity and passive immunity.

The Environment:- The environment is the setting or surrounding that sustains the host. The environmental reservoirs and modes of transmission include:

- Human reservoir
- Temperature
- Rainfall
- Socioeconomic factors
- Availability of resources
- Access to health care
- Living condition

VECTOR: Vectors are intermediary living things that serve as a reservoir to the infection agents. They include mosquitos, fleas, rodents and birds.

CARRIERS: A carrier is a person who harbours the infective agent without schooling signs of disease but is comparable of transmitting the agent to other persons. A carrier may be classified as

- A healthy carrier:- Who remains well throughout the infection.
- An incubatory or precocious carrier who excretes the pathogens during the incubation period before the onset of symptoms
- A convalescent carrier is one who continues to harbour the infective agent after recovery from the illness.

3.4 ROUTE OF TRANSMISSION

Route of transmission refers to the mechanism by which an infectious agent is transferred from one person to another or from the reservoir to the new host. It may be

1. Contact: This may be either directly, person to person or indirectly through contaminated objects called fomites. This is common in places of overcrowding.
2. Penetration of skin: This may be directly by the chistosomiaais or by bite of a vector eg malaria or through wound by tetanus.
3. Inhalation of air-born infection:- This occur in poor ventilation, overcrowding in sleeping quarters.
4. Ingestion:- This is from contaminated hand, food or water.
5. Transplacental infection:- Infective agents cross the placenta to infect the foetus in the wound.

3.5 METHODS OF CONTROL

There are three ways to control communicable disease they are-elimination of reservoir.

- Interrupt the pathway of transmission
- Protect the susceptible host.

(1) Elimination of the reservoir:-

- Human reservoir: This is controlled
- Isolation
- Quarantine

Quarantine refers to the limitation of movement of persons who have been exposed to infection through the period of time equal to longest duration of the incubation period of the disease.

(2) Animal Reservoir (200noses) measures taken on the level of association of the animal with human. If it is a pet, the animal will be treated and vaccinated where possible. If vectors like rat effort is made to eliminate them from human environment.

Interruption of transmission involves maintenance of personal hygiene and environment hygiene as well as control of victors by use of pesticide agents.

Protection of the susceptible host: This may be achieved by use of antimicrobial agents or by active or passive immunization.

3.6 INVESTIGATION OF DISEASE OUTBREAK

The steps to conduct investigation of infectious disease outbreak include

1. Verify the diagnosis of the disease that is suspected the following factors are considered.

- i. Laboratory test: - The investigator must make sure that the results are reliable from confirmed test from a reliable laboratory.
 - ii. Use clinical criteria that are in tandem to the laboratory results.
2. There should be established existence of outbreak.
 - i. Identify unreported cases that may be part of the outbreak.
 - ii. Determine the population at risk for developing the disease in question.
 - iii. Compare the incidence of new cases of the disease in the population of present with previous period.
3. Characterize the distribution of cases by person, place and time.
 - i. The variable time is used to being the construction of on epidemic curve. A point source of exposure is suggested if all cases occur within one incubation period of the disease. Common source outbreak of disease result from exposure of individuals to the same causal factor.
 - ii. The place can be used to detect a source of infection by identification of spatial clustering of cases. Cases can be plotted by the place individual reside, work or attend.
 - iii. Person can be used to compare the characteristics of the population contracting the disease to the characteristics of the population without the disease.
4. Develop and test the hypothesis.
 - i. Demonstrate the difference in the attack rates of people who were exposed and not exposed to the sources of infection.
 - ii. Apply statistical tests to the data to indicate statistical differences between cases and control.
 - iii. Collect clinical and environment specimens if they are available for processing in an appropriate laboratory.
 - iv. Formulate conclusion based on evidence from the result.
 - v. Report all aspect of the investigation for it to be replicated.

3.7 Prevention of Epidemics:-

PRIMARY PREVENTION: This involves preventing disease onset.

- Elimination the organism in their material reservoir.
- Environmental protection:- This is done by ensuring a safe drinking water supply and safeguarding the food supply.

- Interrupting the chain of transmission: This is done by controlling the insect vector, rodents and modifying behaviour and personal hygiene.
- Reducing susceptibility in the host: This is done by reversing malnutrition and micronutrient deficiency to boost people's immunity in low income countries help to prevent the spread.
- Vaccination:- This is the most successful preventive measure. It helps in global eradication of smallpox.
- Health Education and community participation: This help promote vector control programmes, personal protection like insect repellents and mosquito nets.

SECONDARY PREVENTION:- This involved early arrest of the progression of established disease. This include

- Screening: Where there is an asymptomatic or pre- asymptomatic period in the infection process screening programmes are useful
- It also involved outbreak/epidemic investigation which aimed of identifying the conative agent, route of transmission and risk factors for outbreak.
- It also involved in developing and implementing control and prevention strategies and provide advice to prevent a similar event in the future.

TERTUARY PREVENTION: This involves limiting the consequences of established diseases. This is the rehabilitation of the clients that suffered the infection.

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UNIT 4: VULNERABLE GROUP

Introduction:

Vulnerability is defined as being susceptible to neglect or harm, or being at risk of poor social, psychological and/or physical health, outcomes. The term vulnerable comes from a Latin word that means “WOUND”.

OBJECTIVES

Define the term vulnerable population.

- (ii) Outline the effect of vulnerability
- (iii) Explain factors that relate vulnerability
- (iv) Describe types of health disparities

3.0 MAIN CONTENT

Vulnerable populations are groups who have heightened risk of adverse health outcome. These groups often have higher mortality rate, less access to health care, lower life expectancy and poor quality of life.

Vulnerable group include people with

- Low income
- Low education
- Race and ethnicity
- Chronic illness and disability
- Mental illness and disability
- Alcohol and substance abuse
- Homelessness
- Suicide and homicide risk
- High-risk mothers and infants
- immigrants
- Refugees
- Single parents
- Prisoners

It is difficult to categorize at risk group because the population are usually overlapped.

3.1 VULNERABILITY AND INEQUALITY IN HEALTH CARE

Unequal distribution of health care to vulnerable groups contributes to persistent and pervasive health conditions of the group. Political resources and social structures can also influence health and multiply the disadvantages and the irregularities associated with poor health of vulnerable group.

Socioeconomic gradient is the inverse relationship between social class and health. Population around the world has been related to poor health outcome.

The socioeconomic gradient has also been noted in behaviours such as smoking. The gradient is also apparent in studies in hospital death. The differences between high and low social and economic groups can be viewed as a disparity in health outcomes.

3.2 HEALTH DISPARITIES

Health disparity is a group of events that are connected by environment, access to utilization of and quality of care, health status and health outcome that require scrutiny. It is disproportionate burden of morbidity, disability, and mortalities found in specific portion of population in contrast to another.

Discrimination can occur during service delivery when there is biased judgment a specific population. Such population may be homeless, during use, people living with HIV, ethnic group.

Disparity by ethnicity is believed to result from complex interactions among genetic variations, environmental factors and specific health behaviour.

Income and education are intrinsically related. People with the work health status are among those with the highest poverty rate and least education. Poverty limits children's access to equal opportunities for growing up healthy. Low income communities are more likely to only have small convenience stores and where quality foods are limited. Low-income children are more likely to live in substandard housing where they are exposed to hazards. Designing communities so that all children have access to fresh food, primary health care, safe housing and on environment free from pollution is a way to prevent disparity in health.

3.3 CARE OF VULNERABLE GROUPS

Public Health Nurse and vulnerable group working with vulnerable group is an important component of the duty of public health Nurse. The nurse must understand the circumstances of a vulnerable group, their health needs and ways to meet their needs.

The roles of the public health nurse in care of the vulnerable groups include

1. Help them take charge of their health:-The goal of the Public Health Nursing is to help the vulnerable group to develop their capabilities to take charge of their own lives. This can be challenging because most of these groups are disenfranchised. Engagement and developing rapport is essential.
2. Empowerment: Empowerment is an active, internal process of growth that help individual actualize the potential inherent in the individual or group. The public Health nurse see the process of empowerment as a two-way that

help the client to gain skills and act on informed choice while it also enable the nurse to continue the act of empowering others. Empowering a vulnerable group include increase in self-efficacy, self-esteem and confidence.

3. Activation of Resilience: The other goal of a Public health nurse when caring for vulnerable group is to activities resilience as the group. Resilience is the ability to recover from the life's stressors without permanent injury. People bounce back to life of different rate. The rate of reliance depends on external support, along with temperament and other individual factors. It is the duties of the public health nurse continue supporting individual till they get to level of independence.

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MODULE 2 MANAGEMENT IN PUBLIC HEALTH NURSING

UNIT 1 ASSIGNING, DELEGATION AND SUPERVISION IN PUBLIC – COMMUNITY HEALTH

INTRODUCTION:-

Assignment is the process of transferring both the responsibility and accountability to client care to another member of the health care team while delegation is transferring the authority and responsibility to another to complete a task while maintaining the accountability. Supervision is the process of directing, overseeing and monitoring the performance of the task by another member of health care team.

2.0 OBJECTIVES

On completion of this unit you should be able to

- (1) Outline factors to be considered when assigning and delegating duties
- (2) Discuss guidelines for delegation of duties

3.0 Main Content

3.1 Factors to be considered on assignment and delegation.

Assignment:- The factors include.

1. Client factors
 - Complexity of care needed
 - Specific care needed
 - Need for special precautions
2. Health care team factor
 - The skill of the staff
 - Experiences of the staff
 - Nurse-to-patient ratio

DELEGATION:- The following factors are considered.

1. Task Factors:-
 - (a) **Predictability of outcome**
 - Will the completion of the task have a predictable outcome?
 - Is it a routine procedure?

- Is it a new treatment?
- (b) Potential for harm**
 - Is there a chance that something negative may happen to the client?
 - Is the client's condition unstable?
- (c) Complexity of care**
 - More computer task should not be delegated.
- (d) Need for problem solving and innovation**
 - Will a judgment need to be made while performing the task?
 - Does it require nursing assessment skill?
- (e) Level of interaction with the client or community**
 - Is there a need to provide psychological support or education during the performance of the task?

3.2 Delegate factor:- Consideration for selection of on appropriate delegate include:

1. Education; training and work experiences
2. Knowledge and skill to perform the task
3. Level of critical thinking required to complete the task.
4. Ability to communicate the task
5. Demonstrated competence
6. Agency policy and procedure
7. Licensing legislation

Care that cannot be delegated according to nursing professional practice standard includes care related to

1. Nursing process
 - Assessment
 - Diagnosis
 - Planning
 - Evaluation
2. Nursing judgment

3.3 GUIDELINE FOR DELEGATION

1. Right task
 - Identify what tasks are appropriate to delegate for each specific client
 - Delegate activities to appropriate level of team members based on professional standards of practice, legal and facility guidelines.
2. Right circumstances
 - Assess the health status and complexity of care required by the client.

- Match the complexity of care demands to the skill level of the health care team member.
 - Consider the workload of the team member
3. Right person
- Assess and verify the competency of the health care team member. The task must be within the team member's scope of practice and the team member must have the necessary competence/training.
 - Continually review the performance of the team member and determine care competency.
 - Assess team performance based on standard and when need be, take step to remediate future to need standards.
4. Right direction/communication:- The communication may be in writing or oral.
- State data that need be collated
 - Method and timeline for reporting, including when to report concerns.
 - Specific task to be performed expected results
5. Right supervision:- The delegating public health nurse should.
- Provide supervision directing or indirectly.
 - Provide clear directions and understandable expectation of the task to be performed
 - Monitor performance
 - Provide feedback
 - Intervene if need be
 - Evaluate the client and determine if outcomes were met.

UNIT2: CONFLICT RESOLUTION

INTRODUCTION:-

Conflict is the result of opposing thoughts, ideas, feelings, perceptions, behaviours values, opinion, or actions between individuals.

2.0 OBJECTIVES

On completion of this unit you will be able to

- (1) Define conflict
- (2) Discuss the advantage and disadvantages of conflict in public health organizations.
- (3) Outline type of conflicts
- (4) Discuss causes of conflicts
- (5) Outline methods of conflict resolutions

3.0 Main Content

3.1 Conflict

It is an inevitable part of professional, social and personal life and can result in constructive or destructive consequences.

- Conflict estimate growth and open honest communication
- It increases group cohesion and commitment to common goals.
- Facilitates understanding of problem solving
- It motivates groups to change
- It stimulates creativity

Disadvantages of conflicts

- Conflict brings divisiveness if not resolved well.
- Where it is not resolved it causes misperception, distrust and frustration among members.
- It leads to group dissatisfaction with the outcome of the organization lack of conflict in an organization create organizational stasis, while too much conflict can be demoralizing, produce anxiety and contribute to burnout. The desired goal in resolving conflict is for both parties to reach a satisfactory resolution. This is called a win-win resolution. A win-win solution is not always possible. There is the possibility of a solution in which one party

wins while the other loses as well as a lose-lose solution in which both parties lose.

3.2 TYPES OF CONFLICTS

1. Intrapersonal conflict

This occurs within the person. This way involve internal struggle related to contradictory values or wants.

2. Interpersonal-conflict

This occurs between two or more people with differently values, goals and/or belief. Interpersonal conflict in the health care setting involves disagreement among nurses, clients, family members and within a health care team. This is assignment issue in nursing, especially in relation to new graduates nurses, who bring new personalities and perspectives to various health care settling interpersonal conflicts contributes to burnout and work-related stress.

3. Inter-group conflict.

This occurs between two or more groups of individuals, departments or organizations. This may be due to new policy or procedure, a change in leadership, or a change in organizational structure.

3.3 ORGANIZATIONAL CONFLICT IN PUBLIC-COMMUNITY HEALTH NURSING:-

Organizational conflict disrupts the working relationship and creates a stressful work environment. It inhibits the community involvement. It must not be allowed to exist. If conflict exist to the level that productivity and quality of care are compromised, the unit leader must do everything possible to identify the course and attempt to resolve it.

The common causes of organization conflict include

- Ineffective communication in the unit
- Unclear expectations in the team members in their various roles.
- Poorly defined or actualizing organization structure.
- Conflicts of interest and variance in standards.
- Incompatibility of individuals
- Management of staffing
- Variation in age, gender and training

Organizational negotiations in conflict resolution: Negotiation is the process in which the parties involved in the conflict try to resolve the conflict by agreeing

upon courses action. They bargain for collective advantage by attempting to design outcome that serve the organization mutual interest.

3.4 ORGANIZATION COMMUNICATION IN CONFLICT RESOLUTION

Open communication among the parties in conflict can help resolve the conflict. The two-way process in communication is needed.

The communication must be assertive to allow each parties to express directly, honestly and appropriately ways that do not infringe upon the right of the other parties. Assertive communication is a communication style that acknowledges and deals with conflict, recognizes others as equals, and provides a direct statement of feeling.

3.5 METHODS OF CONFLICT RESOLUTION

There are about five major ways conflicts can be resolved.

1. **COMPROMISING:-** This method involve each party to give up something. It is considered a win-win solution because something most valuable must be fulfilled. If one party gives up more than the other, it become a win-lose solution. There must be some compromise both sides which may be equal or unequal.
2. **COMPETING:-** This method involves one party pursues a desired solution at the expenses of others. This is usually a win-lose solution. Managers may use this when a quick or unpopular decision must be made. The party who loses something usually feel anger, frustration, and a desire for retribution.
3. **COOPERATING/ACCOMMODATING:-** In this method one party sacrifices something, allowing the other party to get what it wants. This is the opposite of competing. This is a lose-win solution. The original problem may not actually be resolved. The solution may contribute to future conflict.
4. **SMOOTHING:-** This method one party attempts to “Smooth” another party. This decreases the emotional component of the conflict. It is often used to preserve or maintain a peaceful work environment. The focus may on what is agreed upon but this will leave the conflict area mostly unresolved. This is a lose-lose solution.
5. **AVOIDANCE:-** In this method both parties know there is a conflict, but they refuse to face it or attempt to resolve it. This is appropriate for minor conflicts or when one party holds more power than the other party or if the issue may work itself out over time. Since the conflict is still remained on resolved, it may re-surface again a later date and escalate over time. This is also a lose-lose solution.

UNIT3: STAFF DEVELOPMENT AND TIME MANAGEMENT IN PUBLIC-COMMUNITY HEALTH NURSING

INTRODUCTION:

The quality of care given to the communities is directly related to the educational and competency of health care providers. The staff development is intended to enhance the competency of all staff and help to meet standards set for the community programmes. Staff development may be provided by conferences, seminars and in-service training.

2.0 OBJECTIVES: On completion of this unit you will be able to

- (1) Methods of Staff Development.
- (2) Outline the steps in performance improvements.
- (3) Discuss time management in public health

3.0 Main Contents

3.1 Methods of Staff Development

Staff can be developed by

- Indoctrination:- This is the process by which a person is taught the beliefs or ideology of a culture without discouraging independent thought.
- Socialization:- This is a process by which a person learns the values and culture of new setting.

The staff development begins during interview and orientation. Staff orientation helps new public health nurses translate knowledge, principles, skills and nursing theories into practice.

It helps new nurses to gain competence, which is the ability to meet the requirements of a particular role. The unit heads can maintain competencies by

- Use of checklist to provide a record of opportunities and the level of proficiency in relation to skills.
- Use peer observation to assess competence.
- Sending staff to school for higher education.

3.2 STEPS IN STAFF PERFORMANCE IMPROVEMENT

Performance improvement is the process used to identify and resolve performance deficiencies. Performance improvement includes measuring performance against a set of predetermined standards.

The steps in performance improvements include

STEPS I: This is the time standards are developed and approved by programme committee.

STEP 2: Here is where the care is provided according to the set standard this include performance audit. The audits can be classified in terms of time. Timing of audits includes.

- Retrospective audits which is done after the care has been given
 - Concurrent audit occurs while the care is being given
 - Prospective audit is used to predict future outcome of care.
- Audits can also be classified as types. This include
- Structure audits that evaluate the influence of elements that exist separate from or outside of the community and/or patient-staff interaction.
 - Process audit:- this review how care are provided and the relationship between the nurse and quality of care provided.
 - Outcome audit: This is used to determine results of the care provided.

STEP 3: At this step corrective actions in form of education is provided if the standard is not met.

3.3 TIME MANAGEMENT IN PUBLIC HEALTH NURSING

Time management is the art of making the best use of time available to achieve specific tasks. Most of the activities in public community are time specific. Advantages of time management include.

- It facilities greater productivity
 - It decreases work-related stress
 - It helps to ensure the provision of quality care
 - It help appropriate prioritizing community care
 - It decreases burnout by increasing personal and professional satisfaction.
- Poor time management leads to
- Stress
 - Dissatisfaction with care provided
 - Increases the omission of care
 - Result in error of care

Time can be wasted on

- Socialization
- Poor planning that leads to crisis
- Reluctance to delegate work
- Not having the right equipment for a procedure
- Poor proficiency

- Procrastination

Priority setting in time management includes to determine

- What needs to be done immediately
- What needs to be completed by a specific time to ensure client safety.
- What must be done by the end of the shift
- What can be delegated

MODULE 3 VIOLENCE AND DISASTER NURSING

UNIT1: VIOLENCE

INTRODUCTION

According to Mandela (2002), the twentieth century will be remembered as a century marked by violence, less visible but even more widespread is the legacy of day-to-day, individual suffering. It is the pain of children who are abused by people who should protect them, women injured or humiliated by violent partners, elderly persons maltreated by their caregivers, youths who are bullied by other youths and people of all ages who inflict violence on themselves.

2.0 OBJECTIVES: At the end of this unit you will be able to

- (1) Describe the nature of violence.
- (2) Discuss factors associated with violence
- (3) Discuss the control of violence
- (4) State types of violence
- (5) Discuss the cost of violence in public health.

3.0 Main Content

Violence is often seen as an inevitable part of the human condition- a fact of life to respond to rather than to prevent. Encouraged by the success of public health approaches to other environmental and behavioral related health problems, these assumptions are changing. Violence at home and in the community is an issue of concern in public – community health nursing. Violence consists of no accidental acts that result in physical or emotional injury.

3.1 BASIC FACTS ABOUT VIOLENCE

- Men are likely victims of violent crimes by strangers whereas women are more likely to be victimized by intimate partners, relatives, friends or acquaintances.
- Close to 8 in 10 sexual assaults against women are committed by intimates, relatives, friends or acquaintances.
- After spousal homicides, children killed by their parents are the most frequent type of family homicide. Most children who are killed are male and offenders are male.
- About 16% of male murder victims and 9% of female murder victims were killed by strangers, and strangers were responsible for about 42% of all violent crimes.
- Intimate partner violence is the primary crime against women.
- Overall, violence crimes are more likely to occur during the day (6am to 6pm) except rape, which occurs at night (6pm to 6am).

3.1.2 FACTORS ASSOCIATED WITH RISK OF VIOLENCE: The following are factors associated with violence.

1. Sociological factors include
 - Low socioeconomic status
 - Involvement with gangs
 - drug dealings
 - Access to guns
 - Media exposure to violence
 - Community exposure to violence
2. Psychological factors
 - Alcohol or drug abuse
 - Rigid gender role expectations
 - Peer pressure especially adolescents
 - Poor impulse control
 - History of mental health problems
 - Unemployment
 - Younger than 30 years
3. Family factors
 - History of intergenerational abuse
 - Social isolation
 - Verbal threatening of children by parents
 - High levels of family stress

3.2 Roles of Public-Community Health Nurse in control of violence

The health sector has both a special interest and a key role to play in preventing violence. A key requirement for addressing violence in a comprehensive manner is for people to work together in partnership of all kinds and of all levels to develop effective response. The public health nursing approach to dealing with violence threat to well-being involves the following four steps:

1. Defining and monitoring the extent of the problem.
2. Identifying the causes of the problem.
3. Formulating and testing ways of dealing with the problems.
4. Applying widely the measures that are found to work.

3.3 TYPES OF VIOLENCE

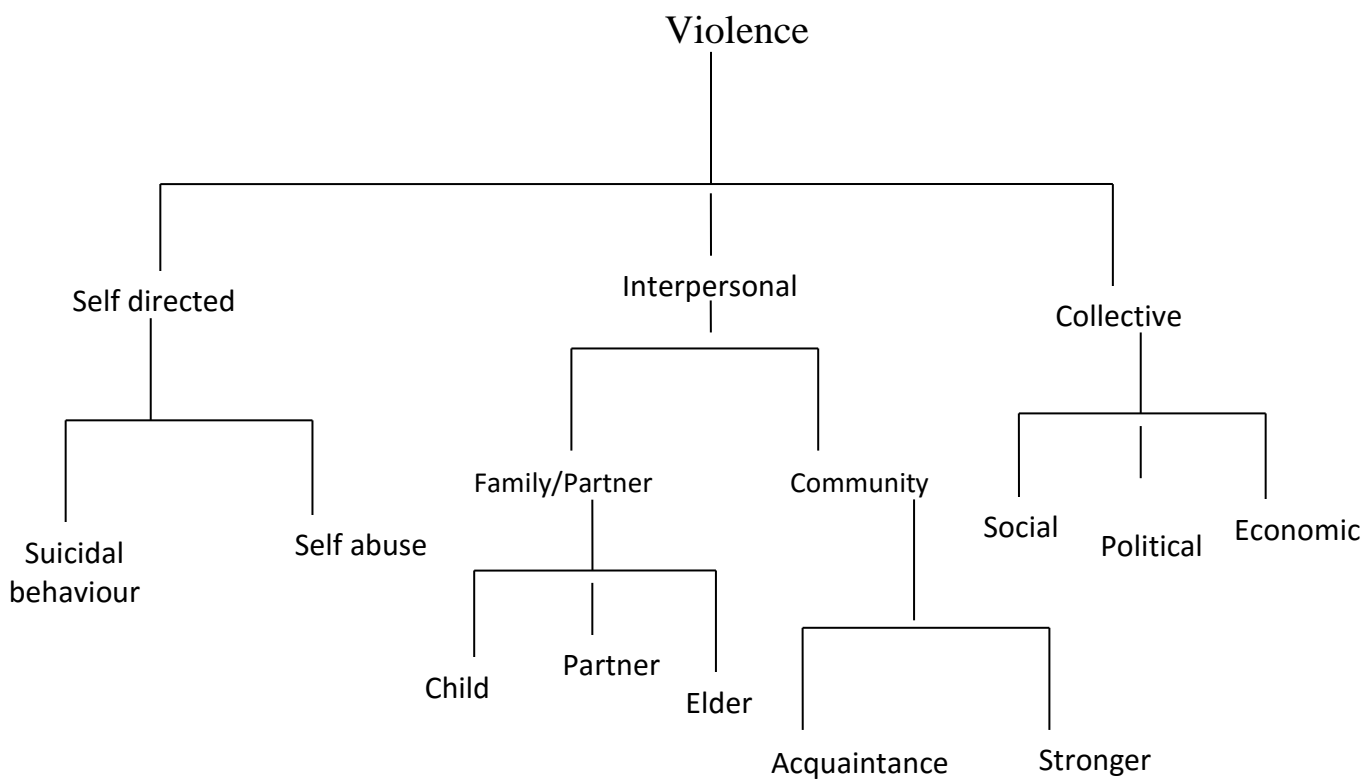
This public-community health nursing approach is science based.

WHO defined violence as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. The definition encompasses interpersonal violence as well as suicidal behavior and armed conflict. It goes beyond physical act to include threat and intimidation, psychological harm, deprivation and mal-development that compromised the well-being of individuals, families and communities.

The three broad categories of violence are:

1. **Self-directed violence** which include suicidal behavior and self-abuse.

2. **Family/Partner violence:** It is violence between family members and intimate partners, usually through not exclusively, taking place in the home.
3. **Community violence:** violence between individuals who are unrelated and who may or may not know each other, generally taking place outside the home.



Data on violence are collected from;

1. Health data on disease, injuries and other health conditions resulting from violence.
2. Self-reporting data on attitude, beliefs, behaviours, cultural practices, victimization and exposure to violence.
3. Community data on population characteristics and level of income, education and employment.
4. Crime data on the characteristics and circumstances of violent event and violent offenders.
5. Economic data related to costs of treatment, social services and prevention activities.
6. Policy and legislative data.

These data can come from a variety of sources including individuals, agency, institutional record, local programmes, community and government record and population based and as well as special studies.

3.4 COST OF VIOLENCE

In calculating the cost of violence to a nation's economy takes into consideration besides the direct cost of medical care and criminal justice include:

1. The provision of shelter or other places of safety and long term care.
2. Lost productivity as a result of premature death, injury, absenteeism, long-term disability and lost potential.
3. Diminished quality of life and decreased ability to care for one's self or others.

4. Damage to public property and infrastructure leading to disruption of services such as health care, transport and food distribution.
5. Disruption of daily life as a result of fears for personal safety.
6. Disincentives to investment and tourism that hamper economic development.

3.5 VIOLENCE PREVENTION

1. Create, implement and monitor a national action plan for violence prevention. A national plan of action is important for preventing violence and for promoting effective response that can be sustained over time. It should take into account of the human and financial resources that are and will be made available for its implementation and should include elements such as the review and return of existing legislation and policy, building data collection and research capacity, strengthening service for victims and developing and evaluating preventive responses.
2. Enhance capacity for collecting data on violence: The national capacity to collect and analyze data and violence is necessary in order to set priorities, guide programme design and monitor progress. System must be designed that are simple and cost-effective to implement, appropriate to the level of skills of the staff using them and confirming to both national and international standards.
3. Define priorities for and support research on the causes, consequences, costs and prevention of violence. There are many reasons to undertake research on violence, but the main priority is to gain a better

understanding of the problem in different cultural context so that appropriate responses can be developed and evaluated.

4. Promote primary prevention responses. Some of the primary prevention interventions for reducing violence include:

- a. Prenatal and perinatal health care for mothers, as well as preschool enrichment and social development programmes for children and adolescents.
- b. Training for good parenting practices and improved family functioning.
- c. Improvement to urban infrastructure, both physical and socioeconomic.
- d. Measures to reduce firearm injuries and improve firearm related safety.
- e. Media campaigns to change attitudes, behavior and social norms.

5. Strengthen responses for victims of violence: National health system as a whole should aim to provide high quality care to victims of all types of violence as well as rehabilitation and support services needed to prevent further complications priorities include:

- a. Improvements to emergency response systems and the ability of the healthcare sector to treat and rehabilitate victims.
- b. Recognition of signs of violent incident or on-going violent situations and referred of victims to appropriate agencies for follow-up and support.

- c. Ensuring that health, judicial, policing and social services avoid a renewed victimization of earlier victims and that those services effectively deter perpetrations from re-offending.
 - d. Social support, prevention programme and other services to protect from him at risk of violence and reduce stress on caregivers.
 - e. Incorporation of modules on violence prevention into the curricula for medical and nursing students.
6. Integrate violence prevention into social and educational policing and thereby promote gender and social equality: Much of violence has links with gender and social inequalities that place large sections of the population of increased risk. Wage full, basic infrastructure deterioration and steady reductions in the quality and quantity of health, education and social services are linked with violence.
 7. Increase collaboration and exchange of information on violence prevention: Better working relations between international agencies, governor, researchers, networks and NGO engaged in violence prevention are needed to achieve better sharing of knowledge, agreement on prevention goals and coordination of action.
 8. Promotion and monitor adherence to international treaties, laws and other mechanisms to protect human right.
 9. Seek practical internationally agreed responses to global drugs trade and the global aims trade.

3.5 BULLYING:- This is a pattern of physical, verbal or other behaviours directed by one or more children toward another child that are intended to inflict physical, verbal and emotional harm. Bullying is common in high schools. Boys use more

physical forms of bullying whereas girls use more relational forms of bullying like exclusion, isolation and initiation of rumors. Bullying has health implications like bedwetting, headaches, anxiety, fatigue and loneliness.

The school nurses are likely to identify students who are bullies or who have been bullied.

3.7 GANG VIOLENCE:- Gangs are flourishing in both rural and urban communities. In Nigeria they are cult members gang members may be male or female and the age range is 8 to 55 years.

The reason people join gangs are

- No job available
- Peer pressure
- For protection
- Companionship
- Excitement

Violence is part of everyday life for gang members.

UNIT2: DISASTER IN PUBLIC HEALTH NURSING

INTRODUCTION

Disaster is a threatening or occurred event that is natural or non-made that caused human suffering and creates human needs that victims cannot alleviate without assistance (American Red Cross 2008). It can also be defined as any material catastrophe (including hurricane, tornado, storm, high water, tidal wave tsunami, earthquake or regardless of course like fire or explosion that cause damage of sufficient severity and magnitude to warrant major assistance from the Government.

2.0 OBJECTIVES

- a. Define disaster
- b. Explain types of disaster
- c. Describe triage in disaster nurses
- d. Discuss the care of communities in emergency

3.0 MAIN CONTENT

3.1.1 Types of Disaster: There are two types of disaster:

Natural and non-made: Natural disaster include tornadoes, flood, typhoon while non-made include war, accidents, food and water contamination.

3.1.2 IMPACT OF DISASTER:- The impact of disaster is determined by the following factors:-

- Vulnerability of population, the people that are most affected by disaster are the vulnerable people like those that are physical handicapped, mentally challenged young children.
- Environmental factors:- The environmental factors include time, weather condition, utilities like electricity, water supply.
- Warning time:- Situational variables include the amount of warning time before disaster occurs, the nature and severity and availability of emergency response.

3.1.3 DIMENSIONS OF DISASTER:- The dimensions of disaster include:

- Predictionability:- Some events are more easily predicted while some cannot be predicted.
- Frequency and location:- Most disasters appear in certain geographical location e.g. typhoon in Asia, and hurricanes in Caribbean islands.

- Controllability:- Some disaster have contract measure mitigation is a term used in disaster planning that describe actions that can be used to reduce the damage
- Scope and interiority:- Scope refers to the geographical area and social space dimension impacted by the disaster agent. Intensity refers to a disaster agent's ability to inflict damage and injury. The scope and intensity of disaster is considered reportedly in planning.

3.2 PHASES OF DISASTER:- The phases of disaster are

- **Prominent Phase:-** This is the phase before a disaster. This is the time for disaster planning and mitigation before the actual occurrence. This is the time for assessment of probabilities and risks of occurrence of certain types of disaster. The role of the nurse during the warning period varies depend on employer's role in disaster responsibility. Public Health Nurse may assist in preparing shelters, and establish contact with other emergency service group. Help the families to establish their own emergency responses. Emergency communications are also established.

IMPACT PHASE:- This is the phase of at which the disaster occurs. It is time of hardship, injury and people try to survive. It is time to render help. The impact phase continues till the threat is over. The nurse is responsible for assigning health needs and providing physical and psychological support to victims in the shelter. The nurses apply triage and morgue facilities are established and coordinated. Search and rescue operations are organized.

POST-IMPACT PHASE:- This phase had two component.

- The emergency phase begins at the end of the impact phase and ends when there is no longer any immediate threat of injury and destruction.
- Recovery phase begins during the emergency phase and ends with the normal community order and function. The more take part in the debriefing and the modification of disaster planning if need be.

3.3 THE ROLE OF COMMUNITY HEALTH NURSE IN DISASTER PLANING INCLUDE

- Help in developing a disaster response plan based on the threats.
- Educate the community on the disaster warning system and how to access it.
- Making a list of agencies that are available and coordinate training for them.
- Define the role of nurses and principles of triage.
- Locate all equipment and supplies needed for disaster management.
- Check the equipment to be sure they are working.
- The nurse takes part in disaster response by

- Activate the disaster plan
- Perform triage and direct the disaster victims
- Treat the victims physically and psychologically. At the post-disaster phase the nurse.
- Evaluate the area affected.
- Create on-going assessment and surveillance report
- Evaluating the efficiency of the disaster response team
- Estimate the length of time for recovering of the community.

3.4 ROLE OF COMMUNITY HEALTH NURSES IN DISASTER MANAGEMENT

The Public health nurse take part in the risk assessment by

- Determine population of risk within the community.
- Review the previous disaster history of the community. This include natural and man-made.
- Identify the community disaster plan.
- Identify the warning system available in the community.
- Outline the members of the disaster team eg volunteers, nurses, doctors, firemen etc.
- Evaluate the resources available hospital, shelter food and water storages.
- Means of evacuation should be identified.

MODULE 3 CARE OF ADULT AND ELDERLY

UNIT 1

. Introduction

The aging is part of a life course continuum and its beginning is not clearly demarcated at any one specific point in time and there is a great deal of individual variation among people regarded as elderly. Aging does not start at any one chronological point; instead it is the accumulation of some common characteristics with increasing age that help to identify an elderly. Illness tends to accumulate with increased age.

Objective

- (1) Explain the meaning of aging
- (2) Discuss family dynamics
- (3) Describe the home and institutional care of adults and elderly
- (4)

3.0 Content

3.1. MEANING OF AGING

The peak of physical maturity is reached during younger adulthood but the peak of psychological maturity, with regard to aspects such as wisdom, creativity, spirituality and emotional growth is likely to be reached in elderly. Development continued during this period. Old age is a continuum and is determined to a small degree by age related changes and to a more significant degree by pathological conditions, risk factors and other factors that affect ones wellness and functioning. Some elderly people will be extremely healthy and maintain a high level of independent functioning through old age

until their death, whereas others will have significant degrees of physical, mental or psychological impairment for brief and long periods of time. Gerontological view age identity on a continuum of subjective, wellness and this is based on assumption that old age accompanied by a decline in health. Consequently, people who feel younger and people who feel poorly will feel older. The only objective definition of aging is that it is a universal process that begins at birth and it is applied equally to young and old people.

Legally, an elderly person is a person of sixty-five years of age or above. The age of sixty-five is used not because of the actual physiological, psychological or sociological changes but because it is the age of retirement in most of the countries of the world.

Statistical analysis of research findings has shown that persons sixty-five and above constitute a group sufficiently different from others and that this grouping is well founded. Defining the population at risk as falling within a precise age-range (65 and above) makes it possible to plan a comprehensive services which will take account of the physical and emotional factors which many complicate old age. Certain events that commonly occur between the ages of 50 and 65 years foster sense of one's aging. These events include menopause, experiencing the deaths of parents and friends, being one of the oldest at work and having to face physical restrictions as well as retirement from work. Most of these are sociological in origin. The individual become more philosophical in approach to life, less irritable with minor issues. It is clear that those things that were previously ascribed to aging is as a result of disease or disuse. About one-third of functional decline in elderly is due to

disease, another one-third due to inactivity (disuse) and the remaining one-third due to aging proper.

3.1.2 ELDERLY POPULATION TREND

According to United Nation (2002), the profile of world aging is as follows:

1. The number of people in the world aged 60years and above will increase from about 600,000,000 in 2000 to almost 2,000,000,000 by 2050.
2. The fastest growing group of the older population is the group of people aged 80years and above.
3. The proportion of older adult are projected to increase globally from 10% in 1998 to 15% by 2025.
4. In Europe, the proportion of older adult will increase from 20% in 1998 to 28% in 2025.
5. Increases in the numbers of elderly will occur more dramatically in developing countries, where the older population is expected to quadruple in the next 50 years.
6. By mid-century, the old and young will represent equal proportions of the world population.

3.1.3 FAMILY DYNAMICS

Grand-parenting can be a positive experience for older adults because they obtain enjoyment, affection and sense of purpose from caring for their grandchildren without the stress of child-rearing responsibilities. Grandchildren provide new interest and meaning to

life. The relationship between siblings is stronger than any other relationship. Siblings drift apart during young and middle adulthood but reestablish stronger ties as older adults. At elderly stage, the siblings provide socialization, emotional, financial and household assistance. Marriages stabilize in elderly adults due to interdependency in life. The spouses provide to each other security and safety supports. They complement each other's action. The death of a spouse alters the life of older persons. It is usually difficult to adjust to loss of significant other added to the demand to learn the new task of living alone. Retirement is a major adjustment of an aging individual. It is often an individual's first experience of the impact of aging.

3.2 The Role of a Public-community Health Nurse in Home Care of the Elderly: The Home Care nurse function as a case manager through a multidisciplinary approach. They formulate the care plan based on the nursing process of assessing, diagnosing, planning, implementing and evaluating. The role of the nurse include:

1. Providing health rehabilitative and palliative therapies. Health promotional behaviour are viewed as a very important consequence of these therapies.
2. Educating the patient and caregivers about the illness or disability and mutually identified healthcare needs. Recommendation to promote optimal health or best level of functioning and self-care management follows.

3. Developing patient and care-giver competence, decision-making and judgement in self-care management at home.
4. Faster positive patient and caregiver adjustment to coping mechanism for change lifestyle, role and self-concept as a result of illness or disability.
5. Reintegrating the patient and caregiver back into the family, community and social support system.

These roles could be seen as having general purpose of providing the elderly and their caregivers with the understanding, support, treatment, information and caring need to successfully manage their healthcare needs at home.

3.3.1 The Role of Family in a Home Care of the Elderly: in home care of the elderly, the client must be viewed as a member of the family unit that are part of the health team and the therapeutic aims that must acknowledge the strengths and weaknesses of this team. The members of the family must be involved in planning and in actual care of the aged. This is the only way the family members will get the basic knowledge, skills and encouragement that are needed for extended period of care that are usually needed. The objective of the homecare nursing of the elderly is to maintain the elderly at home for as long as is consistent with his own health and happiness and the well-being of his relatives. When this is no longer possible, hospital resources should be used.

The home care given to an elderly person at home depends greatly on the willingness of the family members to cooperate in achieving a quality of life that is acceptable to the elderly in particular and the society in general. In

other to help the family members to cooperate with the care, the characteristics of the elderly must be explained to the family members. Some of the characteristics include:

- i. Elderly person are very slow in carrying out all their activities. Any effort to quicken their rate of action is met with resistance.
- ii. They always try as much as possible to claim independence from the family members even where it is well known that he/she has high level of dependency due to illness and disability.
- iii. Provision of safety environment is of cardinal importance in the home care of the elderly. This is to prevent accident due to ongoing body system.
- iv. In modern time, the elderly suffer for social isolations. To prevent social isolation, the family members should know that the elderly should be included in all the social activities of the family as much as their health can permit.
- v. The elderly may never complain of any problem or when they complain, they try to play it down. So any complain made by an elderly should be investigated. Their health conditions can change very fast.
- vi. The elderly love to be respected in all ramifications.
- vii. The care of the elderly requires interdisciplinary actions and the financial burden is carried by the family.

3.3.2 The Roles of the family include:

- (i) **Provision of physical comfort:** The physical comfort may include helping the elderly meet the needs of activities of daily living. This includes daily bath, oral care and other body grooming. The comfort provided to the elderly enhances his/her living, sleeping, cooking, laundering activities etc. Where the elderly has a lot of money care provided are usually adequate when compared with the poor ones and those with loss of memory. The physical comforts expected from the family also include provision of good light, correct height of bed, chairs, toilet seat etc.
- (ii) The family provides an environment that is handicap friendly with regard to the elderly person's disability. Environmental adjustment includes provision of physical structures that enhance the comfort of the client.
- (iii) The family should make specific effort to involve the elderly in the family social activities. The involvement should depend on the ability of the elderly. The elderly where applicable should be encouraged to be involved in religious activities.
- (iv) The first member of the health team to notice that the elderly is sick is the family members. The family members usually provide the initial care before calling the attention of the nurse and others that are involved in the care. The family members should be educated on the health problems of the elderly.
- (v) The family should provide sensory stimulation to the elderly in order to promote mental activities. This contributes to the feeling of well-being. The family must consider intellectual and recreational needs

of the individual. These will create interest in living and add meaning to life beyond mere physical existence. There should be balance between shared activities and individual activities.

- (vi) The family play significant role in rehabilitation of elderly. The family helps in speech therapy and physiotherapy.

3.3. 4 Community Resources for the Care of the Elderly: Home care of the elderly requires multi-disciplinary that include family unit, nurse, medical personnel, social workers, clinical psychologists and rehabilitation therapist. Apart from the therapeutic benefits of such approach, there is research gains from having access to comprehensive knowledge available in such resources. The united energies and interaction of the care members ensure the development of appropriate philosophies of action and training, research programmes both clinical and operational can be more broadly oriented. The specialized knowledge and skill about old age syndromes may be more readily acquired and taught.

The Primary Health Care teams are in the best position to give a comprehensive health care to the elderly. The care may be personal service like home help, meal on wheel and attendance to day care centres. They also pay attention to eyesight and hearing. Occupational therapy and physiotherapy should also be available in the community for the interest of the elderly. Night nursing should be arranged for short period of acute needs. The home visit has long been recognized as an essential care of the elderly. It is particularly valuable in the social assessment of the needs of the elderly. The behaviour of the elderly in out-patient unit is usually a deceptive. Home visiting offers the nurse the chance to assess the elderly in their natural

environment. A much more realistic view is obtained from the patient's home where moreover, the observed presence of social stresses or intergeneration stress may help to elucidate the present problems of the elderly. The two most important variables which determine whether the patient requires admission or home care are the quality of home support available and the aim and types of physical disability.

Good transport system is very essential community resources needed for home care of the elderly. When good transportation service is available, the elderly could be managed in hospital clinics without admission and progressive impairment will be controlled. This offers relief to relatives.

3.3.5 HELPING THE FAMILY WITH ELDERLY

Family members play a crucial role in the well-being of their elderly loved ones. Families play roles in both home care and institutional care of elderly. It is important that the nurse understand the impact of an elderly on the family and on the caregiver. The nurse provides information and support to the caregivers and the family in general. In our society, the family primary caregivers women, wives, daughters and daughter's-in-law, provide the care as unpaid resources (Steele C.D., 2010).

The nurse must understand whom the primary caregiver is, the aspects of care that are most burdensome and what the caregiver think is wrong with the elderly.

Assisting caregiver by the nurse:

The nurse assists caregiver by;

1. Educating caregiver: In educating the caregiver, the nurse should aim at improving communication and understanding by

- Use of simple language
- Start from known to unknown
- Reinforce, restate and repeat so that they can understand.
- Be patient specific. Note that problems of elderly are individualized, so teach the caregiver focusing on the problems of the patients they are caring for.
- Teach them the treatment options if any.
- Help caregivers to understand and cope with behavior problems.
- Help the caregivers to reach and implement end-of-life care.
- Help the caregiver find community resources.
- Help caregiver maintain emotional and physical well-being.

3.4 The Role of Public-Community Health Nurse in the institutional care of the Elderly

The fact that the main needs of the elderly may be nursing care needs, the institutions that care for the elderly adults are usually called Nursing Homes. Nurses working in such homes restore health and alleviate sufferings of the elderly. Unlike the acute care setting where the client are sent home when they get better, in case of nursing homes, the elderly is still retain in the homes. The reason being that there is no facility or a committed caregiver at home. The roles of the nurse in these institutional cares setting are not different from the fundamental roles of the nurse which include the following roles:

1. The nurse co-ordinates the work of others involved in the care of the elderly persons including the physician, the physical therapist, the social

workers etc. The nurse formulate the plan of care and make sure that the care is carried out as and when due. The nurse makes sure that the elderly person's appointment with the physician, for laboratory investigations, with the physiotherapist are kept. The work of homekeeper are checked and ensures that the catering staff service enough and adequate food to the elderly.

2. Provision of care-nurses provide continuous care to the elderly 24 hours a day. "When others have gone, Nurses stay". Nurses help the elderly to do what they should do for themselves if they have the ability. It is the duty of the nurse to ensure that the elderly in their care breathe properly, eat balanced diet, rest, sleep and remain comfortable. The nurses take care of the elimination needs and help them to avoid the harmful consequences of being immobile that are common in the elderly. Nurses use the nursing process to continually evaluate the conditions of the elderly and also plan for their care. The care of the physicians are called when the nurse identify a problem that requires medical treatment. The nurses carry out the prescribed treatment for the elderly in the care getting.
3. Protection of the Elderly: Elderly persons are more prone to infection and injury. The nurse ensures that the environment is safe and healthy. The nurse takes every precaution to prevent the spread of infection from one elderly to the other. The housekeepers are supervised to ensure that the rooms are clean, needles and other materials used for procedures are sterile, soiled materials are kept away from elderly. Sharp objects are placed in safety containers after use. The nurse washes hand with soap and water before and after care and ensure that the soap and water before and

after care and ensure that the elderly maintain a good hand washing habit. The nurse protects the elderly's dignity and tries to save the elderly from embarrassment or shame. The nurse makes sure that the elderly is physically safe in bed or when ambulating. The nurse protect the elderly against anything that might be harmful in the institution's environment.

- 4. Health Education:** Teaching is a major role of the nurse in restoring health, promoting health and preventing illness. The nurse demonstrates to the elderly deep breathing, active exercises bearing in mind the ability of the elderly. The nurse teaches the elderly self-care and how to minimize disability to maintain best quality of life.
- 5. Advocate for the Elderly:** Nurse spend all times with the elderly once admitted to the institution. The elderly share the most details of their lives with the nurses. They undress for nurses and trust them to perform different procedures on them. Nurses use the information they get from the client to speak on their behalf. Advancing is all about speaking on behalf of the elderly person and interceding when necessary. This advocacy is a part of the nursing care.

3.5.2 Practice and Prospect of Institutional Care

There are social arguments against institutionalizing elderly persons. The desire to return independence and/or to remain living in the community is strongly ingrained in our culture and should always be respected. People should be helped and encouraged to live in their homes and in their own communities for as long as they wish and able to do so.

Elderly people should at all times be given the facilities and opportunities to function independently and to retain their identity as individual persons irrespective of the care setting. The Ireland National Council for the aged takes the view that comprehensive repair and adaptation services to the house of the elderly, together with appropriately designed and serviced sheltered housing, supported by day care facilities, out and in-patient hospital facilities, respite and intermittent care in hospital and community support services are alternatives to institution care of the elderly.

Additionally, well organized nursing and home-help provision well serve as support to family doctors and the community caring network (family and voluntary workers) and so enable many more elderly people to remain living independently with or without their families and relatives.

In the cases of those whose physical or mental capacity is such that they cannot be cared for in the community, continuing nursing care home located as near to the elderly's home and family as possible and should be supported by a wide range of community services. In all instances of care, the service provision for elderly person should be based on the promise that elderly people's level of dependency changes over time.

UNIT 2 ADULT NUTRITION

Introduction: Aging process lead to a lot of physiological changes that have far reaching implications to the dietary needs of the individuals. In prescribing a diet for the elderly, care must be taken to provide dietary intake of energy and essential nutrients adequate in type and quantity. It should also be remembered that socio-cultural influences play a more important role than instincts in directing food choice (Okaka et al. 2006). In this unit, the nutritional need for the elders will be examined.

Objectives

3. Content

3.1 Definition: Nutrition is defined as the science of food, nutrients and substances therein, their activities, interactions and balance in relation to health and diseases and the process by which the organism ingest, digests, absorbs, transport, utilize and excretes food substances.

3.2 GERIATIC NUTRITION

For the maximum benefit from the foods, the needs of an elderly must be well planned. Meal planning for the elderly is not different from that of the middle-age adults since old age is a continuation of the past life with likes and dislikes for certain foods. The elderly is advised to continue to eat their

favourite foods with minimum modifications to take care of their new physiological and disease conditions.

The guide for planning geriatric nutrition include:

1. The intake of protein by the elderly should be increased for about 1.5g-2g per kilogram body weight in order to maintain a *Gerontological Nursing* balance since catabolism of protein increases in old age.
Excessive protein intake should be avoided since this puts a lot of stress to the liver and kidney whose efficiencies are reduced by the aging process.
2. Energy intake should be reduced in view of the reduced physical activities and metabolism. Excessive intake of calories reduces the life expectancy of the elderly by initiating metabolic disease like diabetes mellitus and hypertension. It has also been documented that maintenance of working weight in elderly has a protective effect. So an elderly should take enough calories to sustain their working weight.
3. Water and fluid intake of the elderly should be generous. About 1.5-2.5 litres a day provided not contradicted by medical conditions. These levels of hydration will ensure a urinary output of at least 1.5 litres a day.
4. Vitamins and mineral intakes by the elderly should be generous especially iron, calcium and vitamin C and B. sodium intake should be reduced because of high blood pressure and renal conditions common in elderly.
5. Joules derived from fat should be cut down to about 20% of the total joules. It should be mostly essential fatty acids.

6. The diet of the elderly should contain high fibre to prevent constipation.
7. Attention must be paid to the state of dentition of the elderly and their foods must be presented in form that can be handled by such dental state.
8. To satisfy the recommended intake of certain nutrients like vitamin C, B and A, it is necessary to introduce specific foods like fresh fruits and dark green vegetables and milk.
9. Empty calory foods should be avoided. Such foods include sugar, horny and oil. Foods with high nutrient density should be given considering the disease state of the elderly.
10. Food choice responds principal to learned conditioning which influence all the activities of the elderly. The elderly should be presented with food that they are families with.

UNIT 3 SPECIAL CARE OF THE ADULTS AND ELDERLY

INTRODUCTION

Mobility is essential for monitoring independence in the activities of daily living. It also plays a role in avoidance of fall. Fall is an age-related functional consequence. Fall is an unexpected event that resulted in a person coming to rest on the ground or other lower surface. Falls and mobility problems are caused by multiple, diverse and interacting factors. The role of a nurse is to identify the most likely causes and contributing conditions and to plan interventions that address these factors (Murdoch et al (1985).

3.0 MAIN CONTENT

3.1.1 The risk factors for fall in elderly are:

1. Age –related factors like:
 - a. Vision and hearing changes
 - b. Osteoporosis
 - c. Slowed reaction time
 - d. Altered gait, increased sway
 - e. Postural hypotension
 - f. Nocturia
2. Pathologic conditions and functional impairments
3. Medication effects and interactions
4. Environmental factors e.g.
 - a. Physical restraints
 - b. Glare

- c. Inadequate lighting
- d. Lack of handrails on stairs
- e. Slippery floor
- f. Thron rugs
- g. Cords
- h. Unfamiliar environment
- i. Highly polishing floors

The nursing diagnosis for a client having problem of mobility is “impaired physical mobility”. It is a state in which the individual experience is at risk of experiencing limitation of physical movement but is not immobile.

The nursing goals for an older adult with a nursing diagnosis of impaired physical mobility are to restore the person’s functional ability, to prevent further loss of function and to prevent full and other serious consequences of impaired mobility.

3.1.2 FALL PREVENTION IN ELDERLY

According to Miller (2009) fall can be prevented in elderly in the hospital by:

1. Identification of elderly at risk for falling by;
 - a. Identify any risks for falling and fall-related injuries e.g. medication and medical conditions
 - b. Address any risk factor for full
 - c. Reassess the risks for fall at predetermined times
2. Education of staff, patient and family on fall by;
 - a. Instruct the patient and family about fall prevention programmes and how to obtain help if fall occur.

- b. Use posters and fliers to heighten staff awareness of the fall prevention programmes.
- 3. Nursing intervention for all high-risk full patients;
 - a. Keep the call bell within reach at all times
 - b. Offer assistance with activities of daily living (ADL) and try to anticipate the person's needs before help is needed.
 - c. Encourage the person to call for help when needed
 - d. Frequently check all people who cannot be relied on to call for help.
 - e. Make sure the bed is in the lowest position possible and the wheels are locked.
 - f. Carefully and frequently assess the environment for factors that increase the risk of either falls or fall related injuries. Address all modified risk factors.
 - g. Consider the use of a movement detection device
 - h. Carefully evaluate the potential consequences of physical restraints, including bed rails.
 - i. If restraints are used, reevaluate their use every shift
 - j. If appropriate, orientation of person, place and time every shift and as needed.
 - k. Document fall prevention interventions on the persons chart.

3.2.1 Age-related changes affecting skin and their health implication

1. Decreased rate of epidermal proliferation. This leads to delay wound healing and increased susceptibility of infection.

2. There is flattened dermal-epidermal junction, thinning of dermis and collagen. There is increased quantity but decreased quality of elastin. These changes lead to decreased resiliency, increased susceptibility to injury, bruising mechanical and blister formation.
3. There are reductions in dermal blood supply and the number of melanocytes and langerhin calls. These lead to decreased intensity of tanning, irregular pigmentation, diminished dermal clearance, absorption and immunological responses.
4. There are reductions in subcutaneous fat and dermal blood supply. These will lead to decreased sweating and shivering, increased susceptibility to hypothermia and hyperthermia.
5. There is decreased moisture content which leads to dry skin and discomfort.
6. There is decreased number of meissners which leads to diminished tactile sensitivity and increased susceptibility to burns.
7. There is slowed nail growth which lead to increased susceptibility to cracking healing.
8. There is a change in hair color, quality and distribution which leads to negative impact on self-esteem.

3.2.2 Health Promotion on Skin Care

1. Maintaining healthy skin care;
 - a. Including adequate amount of fluid in the daily diet
 - b. Use humidifiers to maintain environmental humidity level of 40% to 60%.

- c. Apply emollient lotion twice daily or more often.
- d. Use emollient lotion immediately after bathing when the skin is still moist.
- e. Avoid massaging over bony prominences when applying lotions. Do not use rubbing alcohol.
- f. Avoid skin care products that contain perfumes and isopropyl alcohol.
- g. Avoid multiple-ingredient preparations because some activities may cause allergic response.

Personal care practices;

- a. When bathing use mild soap
- b. Water temperature for bathing should be about 90°f – 100°f
- c. Make sure skin is well rinsed after soap use.
- d. Apply emollient products after bathing, rather than using them in the bath water, to minimize the risk for falls on oily surfaces.
- e. If emollient products are applied to the feet, use slippers or socks before walking.
- f. Make sure the skin is dried thoroughly especially between toes and in other areas where skin rubs together.
- g. When drying skin use gentle, patting motions rather than harsh, rubbing motions

2. Avoiding sun damage;

- a. Wear wide – brimmed hats, sunglasses and long sleeved garments when exposed to the sun.

- b. Wear clothing made of cotton, rather than polyesters fabrics because ultraviolet rays can penetrate polyesters.

3. Preventing injury from abrasive forces;

- a. Do not use starch bleach or strong detergent when laundering clothing or linens.
- b. User soft terry or cotton washcloth
- c. If plastic-lined pads are necessary, make sure that an adequate amount of soft, absorbent materials is placed over the plastic.

4. Nutritional Consideration: Include adequate intake of zinc, magnesium, vitamin A, B-complex, C and E in the diet.

5. Prevention and managing pressure ulcers: pressure ulcers is attributed to;

- a. Impaired circulation
- b. External pressure and the key intervention for preventing skin breakdown is to ensure adequate circulation and minimal external pressure. Change position at minimum of 2-hour intervals.
- c. Pressure relieving measures are instituted to relieve any external pressure areas.

3.3.1 SLEEP AND REST IN ELDERLY

About one third of a person's lifetime is spent in sleep and rest activities. During periods of sleep and rest, many metabolic processes decelerate production of growth hormone increases and tissue repairs and protein synthesis accelerate. During the deeper stages of sleep, cognitive and emotion

is stored, filtered and organized,so physiological well-being are affected by the quality and quantity of sleep.

3.3.2 Age-Related Change in Sleep

There is increased number of shifts into non-rapid eye movement (NREM) in stage 1; there is steady increase of 10-20% of total sleep time (TSI) which is 5% of that of young adult. Stage II is 50% TST which is unchanged from young adults. Stage III is 10% TST which is also unchanged. Stage IV is very short or absent, especially in men while it is 10% TST in young adults. Rapid eye movement (REM) which is characterized by weak muscle tension, vivid dream is short, less intense, more evenly in adults where it is 25% TST.

Overall changes in sleep in elderly;

1. The required longer time to fall asleep
2. They have more frequent arousal.
3. They have different quality of sleep, with less time in deep sleep and spend more time in bed.
4. They have the same quantity of sleep during a 24-hour period as the younger adults.

3.3.3 SLEEP ALTERATION RISK FACTORS IN ADULT AND ELDERLY

1. Pains and discomfort from arthritis and other medical conditions

2. Alcohol which suppresses the REM sleep increase nightmares, early morning awakening
3. Medications like antidepressants anticholinergics, hypnotics which suppresses REM, increase awakening secondary to open.
4. Environmental factors like noise, very hot or cold condition.
5. Lack of day time activity or stimulation
6. Systematic disease like dementia.

3.3.4 HEALTH PROMOTION ON SLEEP IN ELDERLY

1. Establish a bedtime ritual that is effective for the client and try to follow it every night e.g. going to the toilet and taking a warm bath.
2. Maintain the same daily schedule for walking, resting schedule for waking, resting and sleeping.
3. In the afternoon, avoid foods, beverages and medications that contain caffeine which include tea, coffee and some over the counter drugs, alcohol, refined sugar.
4. Take pre-bed time that promote sleep include milk (warm) light snacks of complex carbohydrate e.g. whole grains.
5. Use one or more of the following relaxation methods: imagery, deep breathing, progressive relaxation, passive exercise, reading non-stimulating materials, watching non-stimulating television.
6. Perform daily moderate aerobic exercise, preferably before the late afternoon but avoid vigorous exercise in the evening.

7. Provide adequate intake of zinc, calcium, magnesium, manganese, vitamin-complex and vitamin C. vitamin E and folic are helpful for restless leg syndrome.

The following should be avoided to promote sleep:

1. Do not drink alcohol before bedtime because it may cause early awakening.
2. Do not smoke cigarettes in the evening because nicotine is a stimulant.
3. If bedtime is temporary changed, try to keep the waking time as close to the usual time, as possible and avoid staying in bed beyond your usual waking time.
4. Do not use bed for reading or other activities not associated with sleep.
5. If awoken during the night and cannot return to sleep, get out of bed after 30 minutes and engage in a non-stimulating activity such as reading in another room.
6. Arise at the usual time even if you have not slept well.

3.4.1 Age-Related Changes that Affect Thermoregulation in Elderly

The primary function of thermoregulation is to maintain a stable core body temperature in a wide range of environmental temperatures. With increased age, subtle alterations in the thermoregulation occur and these become important considerations in caring for healthy as well as frail older adults.

The age-related changes in thermoregulation in elderly include:

1. Decreased subcutaneous tissue.
2. Inefficient vasoconstriction

3. Delayed and diminished shivering
4. Decreased peripheral circulation
5. Improved ability to acclimatize to heat
6. Inefficient sweating mechanism
7. The above changes result in;
 - a. Lower “normal” temperature
 - b. Increased susceptibility to hypothermia
 - c. Increased susceptibility to heat-related illnesses
 - d. Diminished febrile response to infection

Risk factors for alteration in thermoregulation in elder include:

1. Dehydration
2. Extremes in environmental temperature
3. Diseases like infection, diabetes cardiovascular disease etc.
4. Inactivity and immobility
5. Age of 75 and above.
6. Medications like anticholinergics
7. Alcohol

3.4.2 HEALTH PROMOTION ON THERMOREGULATION IN ELDERLY

1. Maintain room temperature as close to 28-30°C in the tropical countries and 21.1°C - 23°C in temperate countries.
2. Put on close knit undergarment to prevent heat loss.
3. Put on a hat and gloves when outdoor, nightcap and socks for sleep.
4. Provide flannel bed sheets or blankets of night

5. Use fans to circulate the air and cool the environment
6. During hot weather, the elder should spend more time in shaded open space
7. Drink extra non-caffeinated non-alcoholic liquids even if you are not feeling thirsty.
8. Use umbrella to protect self against sun and rain when outside.
9. Eat small, frequent meals rather than heavy meals.

3.5 HEALTH PROMOTION ON SEXUAL ACTIVITY IN ELDERLY

Older people remain fully capable of enjoying orgasm but their response to sexual stimulation usually is slower, less intense and of shorter duration. Increasing the amount and diversity of sexual stimulation and experimenting with different positions can compensate for these changes and increase sexual enjoyment.

The following habits enhance sexual enjoyment:

- Exercising regularly
- Limiting consumption of alcohol.
- Monitoring optimal health and nutrition.
- Using hearing aids and corrective lenses as needed.
- Enjoying in sexual activities when relaxed and energy level is at its peak.

Health promotion intervention for hot flashes resulting from menopause in women. I advise the women to;

- i. Engage in regular exercise especially aerobic exercise.

- ii. Avoid caffeine, alcohol, hot beverages and spicy foods.
- iii. Perform relaxation techniques like slow deep breathing several times daily and at the onset of a hot flash.
- iv. Keep environmental temperature cool
- v. Engage in regular weight-bearing exercises for prevention of osteoporosis
- vi. Provide daily intake of 1,500mg calcium and 600IU vitamin D for prevention of osteoporosis.
- vii. Perform pelvic muscle exercises to prevention of urinary incontinence.

4. 6.1 COGNITIVE FUNCTION IN ELDERLY

The age-related change in cognitive functions of the elderly is that elderly may show decline in some intellectual skills but they are capable of cognitive growth and intellectual development throughout adulthood. The dysfunction in cognitive function includes:

1. Slight decline in short-term memory.
2. No decline in crystallized intelligence like wisdom, creativity, common sense and breadth of knowledge.
3. There is slight and gradual decline in fluid intelligence like abstraction, calculation, spatial orientation and inductive reasoning.
4. There is slower processing of information.

The risk factors for impaired cognitive function include:

1. Impaired sensory function.
2. Alcohol consumption

3. Medications like anticholinergics
4. Physiologic disorders like malnutrition.
5. Psychosocial influences like anxiety and depression.
6. Environmental distractions
7. Lack of motivation.
8. Lack of stimulation

Elderly people have minor changes in cognitive ability but as the age increases due to pathologic conditions, more serious cognitive dysfunction may occur. Impairment of cognitive functioning causes loss of abilities that affects all aspects of functioning. This is one of the most devastating losses that confront the elderly and their caregivers. The two major conditions that cause cognitive dysfunction in elderly are delirium and dementia.

3.6.2 ADAPTIVE TECHNIQUE FOR CARE OF ELDERLY WITH IMPAIRED COGNITIVE FUNCTION

1. Modify the environment to compensate as much as possible for sensory deficits and other functional impairments.
2. Use clocks, calendars, daily newspapers, radio and simple written cues for orientations.
3. Use simple pictures, colour codes for identifying items and places.
4. Place pictures of familiar people in highly visible places.
5. Turn light on as soon as or before it begins to get dark.
6. Avoid over stimulation.

3.7. ENSURE SAFETY

1. Make sure the person carries some form of identification along with the phone number of someone to call.
2. Adapt the environment for safety by using alarm devices for doors to prevent wandering.
3. Keep the environment uncluttered.
4. Keep medication, cleaning solutions and any poisonous chemicals in inaccessible places.
5. Enroll the person in a protective programme such as the Safe Return Program.

3.8 FACILITATE ACTIVITY OF DAILY LIVING

1. Keep all activities as simple and routine as possible.
2. Establish routines that allow for maximum independence and the least amount of frustration.
3. While keeping the routines as consistent as possible, it must be recognized that they will have to be changed as the person's level of function changes.
4. If the person need assistance with hygiene, use matter-of-fact statement, such as "it's time for your bath".
5. Arrange personal care items, such as grooming and hygiene aids, in a visible and uncluttered place, in the order in which the items are to be used.
6. Offer finger foods and nutritious snacks if the person will not sit at the table to eat a meal.

3.9 AFFECTIVE FUNCTION

The commonest impaired affective functions found in elderly are depression and it is the most undetected and untreated of the treatable mental disorders in elderly. The signs and symptom of late-life depression include;

- i. Loss of appetite
- ii. Weight loss
- iii. Digestive system complaints, especially dysphasia, flatulence, constipation, stomach distress.
- iv. Insomnia awakening, other sleep disorders
- v. Fatigue
- vi. Pains
- vii. Blues
- viii. Feel empty.
- ix. Low self-esteem

NURSING INTERVENTION

1. Help the client develop a positive self-concept. Opportunities for success should be provided and they are helped to form new goals.
2. Encourage the elderly to express their feelings. Nurses should afford time to listen and guide patients through these feelings. In addition to verbalize feelings.
3. Avoid minimizing feelings. Avoid statements like "do not worry, things will get better". Or "do not talk that way; you have a lot to be thankful to God". These statements are not helpful to the client's feeling.

4. Ensure that physical needs are met. Good nutrition, activity, sleep and regular bowel movement are among the factors that enhance as healthy physical state, which in turn strengthen the patient's capacities to work through depression (Eliopoulos, 2010).
5. Offer hope to the elderly: The nurse by words and deeds convey the belief that the future will have meaning and that the elderly's life is of value.

3.10 DEMENTIA IN ELDERLY

Dementia is a global intellectual decline of sufficient severity to impair social and or occupational functioning that occurs in normal consciousness. According to Steel (2010) the elements to the dementia are;

- The impairment are global and affect reasoning, using and understanding language, coordinating learned motor movement.
- There is a decline from previous level of functioning.
- It interferes with normal functioning in everyday life.
- The patient is awake and alert. It occurs in 7% of elderly from 65 years and 75-85 years.

Causes of dementia include:

- Alzheimer disease causes 50% of dementia. This is an incurable neurodegenerative disease.
- Front temporal dementia 15% of all cases of dementia. It affects the frontal and anterior lobes.
- Levy body dementia leads to 15% of all cases of dementia. It leads to progressive cognitive decline.

- Vascular dementia account for 10% of all cases of dementia. It results from impaired blood supply to the brain.

4.11.1 MEALTIME CHALLENGES IN ELDERLY

Mealtime challenges must be addressed because the elderly are at risk for dehydration and malnutrition for many reasons. Elderly may forget to eat or may be distracted and leave the food unfinished. They may have problem of chewing due to dental problems. Some of them may have poor appetite due to side effect of drugs.

3.11.2 MEALTIME NURSING CARE

- The nurse should
- Adhere to mealtime routine by providing chair and tube.
- Follow former preferences and mealtime rituals.
- Maximize vision and hearing by putting on light and serving food with clean utensils.
- Offer more frequent small regular meals.
- Keep healthy snacks visible and available.
- Maximize the amount of food provide at the time the elderly is most likely to eat. Largest meal at breakfast is encouraged.
- Minimize noise by turning off television.
- During meals chat with the patient about social themes, their early lives and what their mother uses to cook. This makes meals social occasion.

Where the patient needed assistance, the following should be done:

- Serve food into bite-size pieces before presenting to the patient.

- Do not cut the food in his presence to preserve his dignity.
- When feeding an elderly, sit alongside, rather than standing over the patient.
- Note that thick liquids are easier to swallow than thin ones.
- Use simple language such as “chew” and “swallow”.
- Offer fluids between bites of food to facilitate swallowing and hydration.

3.12 INCONTINENCE

One of the most challenges in care of the elderly is monitoring continence. Elderly patients may wet or soil themselves because they cannot find the bathroom in time or undress quickly enough.

NURSING INTERVENTION

- Make the bathroom visible: keep doors open and lights on.
- Use loose-fitting clothing that is easy for the patient to manipulate.
- Assist patient with hygiene after voiding, to prevent the risk for urinary tract infection.
- Males need routine prostate examination.
- Place the elderly on a toilet schedule. This involves taking the patient to the restroom every 2 hours.
- At late stage incontinence, products should be introduced. They should be referred to as “underwear” instead of diapers for they will resist the use of diaper.

3.13 END-OF-LIFE CARE

The last thing man like to talk about is death because human can be very reluctant to accept their mortality. In reality, 100% of elderly we care for die sooner or later. So nurses who care for the elderly must understand how to handle the complex nature of end-of-life. Nurses offer humanistic approach to caring for the dying patient. The dying elderly is given holistic care by recognizing that family members and significant others play a vital roles in the dying process and are also considered.

Dying process is unique for every human being, so individualized nursing intervention is required. The care involves interdisciplinary effort to address physical, emotional and spiritual needs of the individual and family.

